

**BEFORE THE DENTAL BOARD
OF THE STATE OF IOWA**

IN THE MATTER OF:)	Case Nos. 19-0181, 20-0011,
)	20-0143 and 20-0198
THOMAS COONEY, D.D.S.)	
)	FINDINGS OF FACT,
Respondent,)	CONCLUSIONS OF LAW,
)	DECISION AND ORDER
)	

On January 6, 2021, the Dental Board of the State of Iowa (Board) found probable cause to issue a Notice of Hearing and Statement of Charges and Emergency Adjudicative Order (January 6, 2021 Notice and Order) charging Thomas Cooney, D.D.S. (Dr. Cooney or the Respondent) with five separate violations of Iowa statutory and regulatory law. Discipline for the offenses is allowed pursuant to Iowa Code chapters 147, 153 and 272C and Iowa Administrative Code Rules 650-30 and 650-51. (Exh. 1).

The disciplinary hearing originally was scheduled for January 28, 2021. By mutual agreement of the parties, however, the January 28, 2021 hearing subsequently was limited to whether the Board should lift Dr. Cooney's license suspension during the pendency of the disciplinary proceeding. The disciplinary hearing itself was rescheduled to June 25, 2021. (Exh. 3 at 9).

The following Board members presided at the June 25, 2021 hearing: Chairperson Monica Foley, D.D.S.; Lisa Holst, D.D.S.; Jonathan DeJong, D.D.S.; James Nemmers, D.D.S.; Megan Clatt, R.D.H.; Bruce Thorsen and Candace Bradley. Also attending was Iowa Dental Board Program Planner Christel Braness. Administrative Law Judge Carla J. Hamborg assisted the Board in conducting the hearing. Assistant Attorney General Laura Steffensmeier represented the State of Iowa. Attorney James Blackburn represented Dr. Cooney, who appeared for the hearing and testified.

At Dr. Cooney's election, the hearing remained open to the public, pursuant to Iowa Code section 272C.6(1)(2021) and Iowa Administrative Code Rules 645- 11.19(10) and

650-51.20(13).¹ The hearing was recorded by Certified Court Reporter Theresa Kenkel. After hearing the testimony and examining the exhibits, the Board convened in closed executive session, pursuant to Iowa Code section 21.5(1)(f), to deliberate its decision. The Board directed the administrative law judge to draft the Board's written decision, consistent with the deliberations, for Board review and approval.

THE RECORD

The record includes the testimony of Daniel Caplan, D.D.S., Ph.D.; Iowa Dental Board Interim/Associate Director Tiffany Allison; and Dr. Cooney; as well as State Exhibits 1-39, and Respondent's exhibits A – Y, and AA -AD.²

FINDINGS OF FACT

General Background

The factual findings made in the Board's February 26, 2021 Order Concerning Request to Lift License Suspension During the Pendency of this Proceeding are incorporated by reference. Briefly, on July 1, 1988, Dr. Cooney was issued license number 07310 to practice general dentistry in the State of Iowa. Since that time, Dr. Cooney has been the subject of numerous patient complaints and resulting Board investigations. One such complaint raised questions about his competency to treat periodontal disease. On August 3, 2018, Dr. Cooney entered into a settlement agreement placing his license in a probationary status for a five-year period, with restrictions established to ensure Dr. Cooney corrected identified deficiencies in this area. (Exh. 4 at 11-17; Exh. 38 at 245).

On September 27, 2019, the Board filed a subsequent Notice of Hearing and Statement of Charges, charging Dr. Cooney with failing to comply with infection control standards. This charge stemmed from an infection control inspection conducted by a Board investigator that identified numerous violations of infection control protocols. On June 5, 2020, the matter was resolved pursuant to a settlement agreement. The settlement agreement required, among other conditions, that Dr. Cooney comply with the remaining terms of his original probationary period, and identify an infection

¹ Prior to the hearing, counsel for both parties agreed that all exhibits containing patient names and/or dental records shall not be publicly disclosed without appropriate redaction of patient-identifying information.

² Page numbers for State exhibits reflect the State's central numbering system, rather than numbers found in individual documents.

control monitor willing and able to inspect Dr. Cooney's office pursuant to terms specified in the agreement. (Exh. 5 at 23 -27).

On December 22, 2020, Dr. Cooney's infection control monitor, John Campbell, D.D.S., submitted a report to the Board in which he outlined numerous violations which rendered Dr. Cooney's office unsafe for the practice of dentistry. This report, Dr. Cooney's failure to fully comply with the terms of his probation, and recent patient complaints precipitated the January 6, 2021 Notice and Order.³ The five-count document charges Dr. Cooney with the following: 1) failing to comply with an order of the Board; 2) failing to comply with infection control standards; 3) failing to maintain adequate safety and sanitary conditions for a dental office; 4) repeatedly failing to maintain patient records in accordance with Board rules; and 5) retaliating against patients for filing a complaint with the Board. (Exh. 1, at 3-4; Exh. 6 at 39-59).

In an order dated February 26, 2021--following an evidentiary hearing--the Board denied Dr. Cooney's request to lift the suspension during the pendency of the disciplinary proceeding. The Board left open the *possibility* for such action in the future if Dr. Cooney completed the following:

- 1) File written operating procedures for his dental practice explaining how all CDC guidelines and the requirements in the Board's Safe Transition Back to Practice document will be followed;
- 2) File a letter detailing his understanding of the infection control standards that was sufficient to demonstrate his knowledge of the applicable standards, the need for such standards and his commitment to implementing them in his practice; and
- 3) Complete Board-approved in-office training for himself and all office personnel, including anyone involved in patient care or otherwise in the operation of the office, in standard dental operating procedures, including in infection control and patient care. This should include scenario training, and a report of the training and *successful completion must be filed.*
- 4) Have a Board approved infection control monitor conduct an inspection of Dr. Cooney's office after the forgoing training. A report must be submitted along with a plan for unannounced inspections of Dr. Cooney's office every two weeks during a time Dr. Cooney is seeing patients.

³ The patient complaints at issue were received on November 26, 2019, January 14, 2020 and September 8, 2020. Other complaints against the Respondent have been received and investigated since 1988. These are the three complaints received during the pendency of his probationary period, however. (Exh. 15 at 56-58; Exh. 16 at 74-76; Exh. 28 at 159-61).

(Exh. 13, at 52-53 (emphasis added)).

Dr. Cooney did not complete the above requirements prior to the June 25, 2021 hearing. His license therefore remains suspended to date.

Findings Made Following June 25, 2021 Hearing

The Board makes the following additional findings of fact based on evidence presented during the June 25, 2021 hearing:

Probation Violations

Among other conditions to be satisfied during the pendency of his probation, the August 3, 2018 Order required:

- successful completion of at least twenty (20) hours of additional continuing education in periodontics that has received prior approval of the Board;
- within thirty (30) days of the August 3, 2018 Order, selection for Board approval of a practice monitor willing to conduct a random review of patient records to ensure the appropriate diagnosis and treatment of periodontal disease. Dr. Cooney must also ensure the practice monitor submit monthly written reports to the Board and immediately report any competency concerns. After one year, the Board maintained the discretion to decrease the frequency of the reviews.;
- submission of a \$2,000 civil penalty to the Board in installment payments, within ninety (90) days of the August 3, 2018 Order.;
- that Dr. Cooney make monthly written reports detailing his compliance with the terms of the Order for the first six months, and quarterly thereafter; and –
- that Dr. Cooney pay \$300 per quarter for the duration of his five-year probationary period, in reimbursement for costs incurred by the Board in monitoring Dr. Cooney's compliance. (State's Exh. 4; Allison Testimony).

Additional requirements imposed in the June 5, 2020 Order include:

- within thirty (30) days of the June 5, 2020 Order, selection for Board approval of an infection control monitor with sufficient expertise in the area of infection control who is willing to perform inspections for a one-year period;
- once approved, the monitor shall perform monthly inspections of Dr. Cooney's office for six months, followed by two inspections during months nine and twelve;

- Dr. Cooney shall ensure the monitor submits to the Board a report following each inspection;
- the infection control monitor shall make recommendations for changes in protocol, with which Dr. Cooney must comply;
- Dr. Cooney shall be solely responsible for the costs of the monitoring, including the fee charged by the approved monitor;
- within ninety (90) days of the June 5, 2020 Order, Dr. Cooney must complete a minimum of six hours of Board-approved continuing education in the area of infection control. If Dr. Cooney chooses to take the training on-line, he must submit to the Board a letter explaining what he learned through the coursework and changes he will make to his practice in light of the training.

(Exh. 5 at 25-26).

Dr. Cooney did not comply in full with the terms of either Order. Of the requirements contained in the August 3, 2018 Order, Dr. Cooney submitted only three of his first four monthly written reports on-time, and failed to submit a report for November 2018. He then submitted reports sporadically between January and November 2019 and three reports in all of 2020. He arguably has not been required to submit reports in 2021, due to the suspended status of his license. (Exh. 6 at 29-30; Exh. 31 at 214-29; Exh. 37 at 242-44; Allison Testimony).

Second, although Dr. Cooney appears to have paid the \$2,000 civil penalty in a timely manner, he failed to pay his quarterly \$300 monitoring fees until prompted by Board staff to do so. He remained delinquent with his payments until January 27, 2021. Last, Dr. Cooney did not obtain prior Board approval of his continuing education in periodontics. (Exh. 32 at 230; Exh. 34 at 240; Exh. 36 at 242; Allison Testimony).

Dr. Cooney likewise did not comply with all conditions required under the June 5, 2020 Order. First, Dr. Cooney did not ensure that his infection control monitor, Dr. Campbell, submitted monthly reports until prompted to do so by Board staff. In fact, Dr. Campbell's first and only report was not submitted until December 22, 2020—more than five months after the first report was due. Second, and perhaps most importantly, despite numerous violations cited by Dr. Campbell in his report, Dr. Cooney did not make any changes in his infection control protocol as of January 28, 2021. Last, although Dr. Cooney appears to have completed six hours of on-line continuing education in the area of infection control, he did not submit a letter to the Board summarizing what he learned and changes he will make to his practice. (Exh. 6 at 42; 36 at 242; Allison Testimony).

Record-keeping Violations

The State retained Dr. Caplan to review a random sampling of Dr. Cooney's patient records--as well as the records of the three individuals who had filed recent patient complaints against Dr. Cooney--to provide an opinion regarding the sufficiency of record-keeping and standard of care provided. Dr. Caplan currently is a tenured professor in the Department of Cden-Preventive & Community Dentistry of the University of Iowa College of Dentistry. In addition to his Doctorate of Dental Surgery, which he obtained in 1988, Dr. Caplan also holds a Ph.D. in Epidemiology. He has been involved in general dentistry and/or higher education continuously since 1988, and is well-qualified to provide an opinion in these areas. (Exh. 17 at 96; Exh. 29 at 172-208; Caplan Testimony).

Dr. Caplan concluded that twelve of the thirteen records he reviewed failed to meet the standard of care for dental record-keeping.⁴ The most common deficiency was the lack of a completed odontogram. Most records also lacked documentation of Dr. Cooney's exam findings and periodontal charting. The records for patient B.E. undoubtedly posed the most significant concerns, however. The sole periapical radiograph provided did not support Dr. Cooney's decision to extract two teeth. Furthermore, Dr. Cooney not only failed to document the clinical evaluation he performed to determine the diagnosis, but also failed to indicate the type and quantity of anesthesia used for the procedure. Additionally, he did not document evidence of B.E.'s informed consent. (Exh. 30 at 209-13; Caplan Testimony).

In addition to record-keeping violations, Dr. Caplan concluded that at least one patient, B.C., was charged for treatment not provided. Specifically, Dr. Cooney's office billed B.C. (and her insurance company) for 4 bitewing x-rays when the chart contained evidence of only two bitewing x-rays. Patient A.B. also complained of inappropriate billing, alleging that Dr. Cooney billed for examining her son, J.H., when in fact no such exam was conducted. Although Dr. Caplan stated that his "tendency would be to believe the patient," he emphasized the documents provided to him were not conclusive in this regard. (Exh. 30 at 209; Caplan Testimony).

Dr. Cooney vigorously denied that he ever billed for services not provided, and questioned the patients' recollections of the encounter. He also testified that although

⁴ Dr. Caplan clarified in his report that the source he relied upon for the "applicable standards" for documentation was in fact Iowa Administrative Code Rule 650-27-11. (Exh. 30 at 209).

his record-keeping may not be compliant under the Board rules, it was sufficient for his own purposes. (Cooney Testimony).

Dr. Cooney did not challenge the lack of documentation in patient B.E.'s chart regarding the type and amount of anesthesia used. He disputed, however, that the x-ray he took was insufficient to support his diagnosis. Dr. Cooney further noted that he saw B.E. only on one occasion for an emergency consultation/procedure. Dr. Cooney attempted to contact B.E. to check on his condition at least twice after the encounter, and B.E. would not take his calls. (Cooney Testimony).

Infection Control Practices and General Office Conditions

A summary of Dr. Cooney's violations of infection control standards was contained in the February 26, 2021 Order. On April 19, 2021, as a condition precedent to possible reinstatement, Dr. Cooney retained Annette Hayes, a technology advisor for Patterson Dental, to conduct in-office infection control training. She also performed a general inspection of Dr. Cooney's office and infection control practices. During her inspection, Ms. Hayes observed that Dr. Cooney kept his dental instruments exposed in drawers, rather than bagged, autoclaved and stored until use. She also noted that the slow-speed adaptor and air/water tips were simply disinfected, rather than autoclaved, between patients as required by CDC and Iowa OSHA guidelines. Additionally: "Instruments, endodontic files, burs, [and] cotton pliers were laying on "clean towels, rather than bagged. There also was no chemical indicator that sterilization had been either monitored or completed. (Exh. AD, citing <https://www.cdc.gov/oralhealth/infectioncontrol/summary-infection-prevention-practices>; see also <https://www.iowaworkforcedevelopment.gov>).

Additionally, Ms. Hayes commented on the general cleanliness of the office, noting that the floors were in need of vacuuming, the floorboards were "filthy," and the sterilization area "was in need of a good scrubbing." She also observed a towel in the "clean" area but was unsure how often the towel was changed. There were no Sharps disposal containers visible in the sterilization area, despite the fact the CDC and OSHA standards specified that one container should be available for each type of medical waste. (Exh. AD, citing <https://www.cdc.gov/oralhealth/infectioncontrol/summary-infection-prevention-practices>; see also <https://www.iowaworkforcedevelopment.gov>).

Alleged Retaliatory Conduct

Included in the exhibits for the June 25, 2021 hearing were three patient-dismissal letters Dr. Cooney sent to B.C., A.B., and B.E. Each letter contained the same language, informing the patient:

[A] dentist is able to approach perfection only when he is working in an atmosphere of complete confidence, trust, and respect I have not been able to reach this mutual inspiration and understanding with you. For this reason I feel you will be able to obtain more beneficial services if you consult with another dentist. I will be available to treat any emergency you might have for the next 30 days. Let us know where you would like any x-rays sent.

(State's Exh. 15, at 66; Exh. 16 at 86; Exh. 28 at 169).

Along with his other review, the State asked Dr. Caplan determine whether Dr. Cooney acted appropriately in sending the letters to individuals whose records had been subpoenaed by the Board. Dr. Caplan noted in his report that the dismissal letters to patients B.C. and A.B. were sent shortly after Dr. Cooney received the respective subpoenas. The dismissal letter for patient B.E. was issued ten days *prior* to the Board's subpoena, however. Dr. Caplan confirmed in his report that dentists may terminate a patient as long as the procedures for doing so are documented either in the office policy or patient brochure. Although concerned by the dates on two of the three dismissal letters, Dr. Caplan could not draw a firm conclusion regarding Dr. Cooney's motivation without evaluating other dismissal letters sent by Dr. Cooney during his years in practice. (State's Exh. 30, at 209-13; Caplan Testimony).

Dr. Cooney testified in turn that he has dismissed numerous patients since 1988, based largely on the deterioration of trust between him and the patient. He adamantly denied that he dismissed patients B.C., A.B. or B.E. in retaliation for their complaints to the Board. (Cooney Testimony).

CONCLUSIONS OF LAW

Governing Law

Iowa Code section 147.55 (2021) provides, in relevant part:

147.55 Grounds.

A licensee's license to practice a profession shall be revoked or suspended, or the licensee otherwise disciplined by the board for that profession, when the licensee is guilty of any of the following acts or offenses:

....

3. . . . engaging in . . . practice harmful or detrimental to the public. Proof of actual injury need not be established.

....

7. Willful or repeated violations of the provisions of this chapter, Chapter 272C, or a board's enabling statute.

9. Other acts or offenses as specified by board rule.

Iowa Code section 147.55 (2021).

Pursuant to this authority, the Board has established rules governing the conduct of its licensees. In particular, Iowa Administrative Code Rule 650-30.4 authorizes the Board to impose a disciplinary sanction when it determines the licensee is guilty of:

....

30.4(6)"a". Failure to maintain adequate safety and sanitary conditions for a dental office;

30.4(6)"b". Failure to comply with standard precautions for preventing and controlling infectious diseases and managing personnel health and safety concerns related to infection control, as "required" or "recommended" for dentistry by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services and the Iowa occupational safety and health administration.

....

30.4(7)"e". Failure to comply with an order of the Board;

....

30.4(8)"e". Retaliating against . . . any person for filing a complaint with the board
.....

650-30.4; *see also* Iowa Code section 153.34(4) (2021) (authorizing discipline against a licensed dentist "[f]or willful or repeated violations of this chapter, this subtitle, or the rules of the board.

Iowa Administrative Code Rule 650-27.11 requires in turn that dentists "shall" maintain dental records for all patients, containing personal data, dental and medical history, reason for visit, clinical examination notes and informed consent. Iowa Admin. Code r. 650-27.11.

Count I: Failure to Comply with an Order of the Board

Count I charges the Respondent with failure to comply with an order of the Board, in violation of Iowa Code section 153.34(4) and Iowa Administrative Code Rule 650-30.4(7)"e." As set forth in the factual findings above, the Respondent's dental license has been in probationary status subject to conditions outlined in two Board Orders issued on August 3, 2018 and June 5, 2020.⁵ The evidence of record shows that Dr. Cooney became noncompliant in submitting required reports to the Board within three months of his initial probationary period. He then failed to submit either reports or monitoring fees until he received a letter from Board staff reminding him of his responsibilities. The fact Dr. Cooney ultimately became current in his payments does not excuse his earlier noncompliance.

Dr. Cooney did complete the required continuing education, but did not obtain prior approval from the Board as required for the periodontal coursework. He likewise did not submit a letter to the Board summarizing his infection control classes and steps he planned to take to correct deficiencies in his office.

Perhaps most importantly, Dr. Cooney did not ensure his infection control monitor, Dr. Campbell, made prompt, monthly inspections and submitted corresponding reports to the Board. By the time Dr. Campbell submitted his December 2020 report, numerous infection control violations were noted. The State has met its burden to prove the charge set forth under Count I by a preponderance of the evidence.

⁵ It is noted that both Orders were issued in *settlement* of then-pending disciplinary proceedings; the Respondent *agreed* to the terms imposed.

Count II: Failure to Comply with Standards for Infection Control

Count II charges Dr. Cooney pursuant to Iowa Code section 153.34(4) and Iowa Administrative Code Rule 650-30.4(6)"b" with failing to comply with standard precautions for preventing and controlling infectious diseases and managing personnel health and safety concerns related to infection control, as "required" or "recommended" for dentistry by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services and the Iowa occupational safety and health administration. To support this charge, the State relies on evidence produced during and prior to the January 28, 2021 hearing, coupled with findings made by the Board in its February 26, 2021 Order.

Dr. Cooney has not attempted to refute any of the Board's findings regarding the state of his practice as of January 2021. Rather, he has relied on Ms. Hayes' April 21, 2021 email, which followed her April 19, 2021 visit to Dr. Cooney's office. According to Ms. Hayes' email, however, as of April 19, 2021 – almost two months into Dr. Cooney's suspension from practice – "multiple infection control protocols" were left to be rectified. A preponderance of the evidence therefore establishes that the Respondent violated Iowa Administrative Code rule 650-30.4(6)"b" with failing to comply with "required" or "recommended" infection control standards.

Count III: Failure to Maintain Adequate Safety and Sanitary Conditions

Under Count III, Dr. Cooney is charged with failure to maintain adequate safety and sanitary conditions for a dental office, in violation of Iowa Code section 153.34(4) and Iowa Administrative Code Rule 650-30.4(6)"a." As with Count II, the State produced its initial evidence under this count in conjunction with the January 28, 2021 hearing. In particular, Dr. Campbell wrote in his report that the sterilization area was cluttered, and that Dr. Cooney's office had no service to dispose of the Sharps containers, when full.

Multiple sanitation concerns remained during Ms. Haye's visit to the office in April 2021. In particular, Ms. Hayes commented on the condition of the carpet, sterilization area and floorboards. She also noted the lack of *any* visible Sharps containers. A preponderance of the evidence supports the charge set forth under Count III.

Count IV: Repeatedly Failing to Maintain Patient Records

Count IV charges Dr. Cooney pursuant to Iowa Code section 153.34(4) and Iowa Administrative Code Rule 650-30.4(2)"j" with repeatedly failing to maintain patient

records in accordance with the requirements set forth in Iowa Administrative Code Rule 650-27.11. Rule 650-27.11, which pertains to record keeping, requires in relevant part that dentists maintain records for *each* patient containing all of the following information: personal data; dental and medical history; reason for visit; clinical examination progress notes; and informed consent. 650-27.11.

As set forth above, Dr. Caplan opined in his report and during the June 25, 2021 hearing that Dr. Cooney's record-keeping in all but one of the thirteen records he reviewed failed to comply with the requirements of Rule 650-27.11. That Dr. Cooney's record-keeping may have been sufficient for his own purposes does not excuse his noncompliance. Nor does the fact there has been no documented adverse patient impact *to date*. For example, If B.E. suffered an adverse reaction from the anesthetic and Dr. Cooney himself was unavailable, another provider would have had no way to identify the source of the reaction.

The items set forth in Rule 650-27.11 are *requirements*—not suggestions. Notably, to maintain licensure, all dentists in Iowa must complete a minimum of one hour each biennium of continuing education in the area of jurisprudence. Iowa Admin. Code r. 650-25.4(5); *see also* <https://www.dentalboard.iowa.gov/practioners/continuing-education> (summarizing continuing education requirements). A posting of all continuing education sponsors also is available on the Dental Board website. Dr. Cooney therefore has no excuse for his ignorance and/or unwillingness to comply with the requirements of Rule 27.11. A preponderance of the evidence supports the charge set forth under Count IV.

Count V: Retaliating Against a Person for Filing a Complaint

Count I charges the Respondent with retaliating against a patient for filing a complaint with the Board, in violation of Iowa Code section 153.34(4) (2021) and Iowa Administrative Code Rule 650-30.4(8)"e." This count stems from the three dismissal letters Dr. Cooney issued to patients B.C., A.B., and B.E.—each of whom filed complaints with the Board against Dr. Cooney.

Neither section 153.34(4) nor Rule 650-30.4(8) provides guidance as to what constitutes "retaliation" in this context. The Board likewise has been unable to locate case law on the issue.

Assuming termination of the dentist-patient relationship falls within the scope of Rule 650-30.4(8), Dr. Cooney sent only two of the three dismissal letters produced by the State after receiving the Board subpoena for the patient's respective records. Dr. Cooney

issued the third dismissal letter—to B.E.—prior to being informed of his daughter’s complaint to the Board.

Notably, Dr. Caplan indicated both in his report and during the hearing that he could not determine definitively whether the three dismissal letters were inappropriate without reviewing a larger sampling of such letters sent by Dr. Cooney over the years. With Dr. Caplan’s statement and testimony in mind, it is plausible Dr. Cooney in fact sent the letters due to the general deterioration of trust between him and the three individuals, rather than the fact they each had filed Board complaints. The State therefore has failed to prove the charge set forth in Count V by a preponderance of the evidence.

Appropriate Disciplinary Action

In conclusion, the State has established four of the five charges made against Dr. Cooney by a preponderance of the evidence. The State has recommended a complete revocation of Dr. Cooney’s dental license.

The Board agrees that revocation is the only sanction that will reasonably ensure adequate protection for the public. As set forth above, Dr. Cooney has been given repeated opportunities to correct identified deficiencies in infection control through continued education, inspection and reporting. Despite these opportunities, several infection control violations and general safety issues remained as late as April 2021.

Notably, despite being suspended from practice, Dr. Cooney did not complete the four requirements outlined in the February 26, 2021 Order as a condition precedent for re-opening his office. He also failed to at least improve the office’s general cleanliness during the four-month period between his January suspension and Ms. Haye’s April 2021 visit. If Dr. Cooney was unwilling and/or unable to comply with Board rules and requirements during his initial periods of probation and suspension, there is no reason to believe he will change his conduct during a future probationary period.

DECISION AND ORDER

IT IS THEREFORE ORDERED that Respondent Thomas Cooney, D.D.S.' license to practice general dentistry is REVOKED for a minimum period of two (2) years. Any reinstatement request will be subject to the provisions of Iowa Administrative Code Rule 650-51.34, which places the burden of proof on the Respondent to establish that the basis for the revocation no longer exists and that it is in the public interest for his license to be reinstated.

Pursuant to Iowa Code section 272C.6, the Respondent is ordered to pay \$75.00 for fees associated with this disciplinary hearing and \$440.00 for the court reporter fees. The total fees of \$515.00 shall be paid within thirty (30) days of receipt of this decision.

Dated this 6th day of August, 2021.



Monica Foley, D.D.S., Chair
Dental Board of the State of Iowa

cc: Laura Steffensmeier, Assistant Attorney General
James Blackburn, Attorney for Respondent

Pursuant to Iowa Code sections 17A.19, 153.33(3)(g)(h) (2021) and Iowa Administrative Code Rule 650-51.31, any appeal to the district court from a decision in a contested case shall be taken within 30 days from the issuance of the decision by the board. The appealing party shall pay the full costs for the transcript of the hearing. 650-51.24.