STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF DENTISTRY,

Petitioner,

vs. Case No. 15-6268PL

HAYDEE ARANDA, D.D.S.,

Respondent.
_____/

RECOMMENDED ORDER

On March 2, 2016, Administrative Law Judge J. Lawrence Johnston held the final hearing in this case in Naples, Florida.

APPEARANCES

For Petitioner: Bridget Kelly McDonnell, Esquire
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For Respondent: Sean Michael Ellsworth, Esquire
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STATEMENT OF THE ISSUE

The issue in this case is whether the Board of Dentistry should discipline the Respondent on charges set out in an Amended Administrative Complaint filed by the Petitioner.

PRELIMINARY STATEMENT

The Amended Administrative Complaint in this case charges the Respondent with: making deceptive, untrue, or fraudulent representations in or related to the practice of dentistry in violation of section 466.028(1)(l), Florida Statutes (2009), by falsely characterizing "active" orthodontic appliances as "passive" space maintainers (Count I); and delegating irremediable tasks (hand-scaling and permanently cementing a dental appliance) to a dental assistant not qualified to perform those tasks, in violation of sections 466.028(1)(z) and 466.024(1), and Florida Administrative Code Chapter 64B5-16 (Count II).[1/] The Respondent disputed the allegations and asked for a disputed fact hearing under section 120.57(1).[2/]

At the hearing, the Petitioner called as witnesses Stephanie Vick; Dr. Edward F. Zapert, D.M.D.; Frank Sierra, D.M.D.; Laurie A. Housworth, D.D.S.; and Paul Beingolea. The Petitioner's Exhibits 1 through 6, 8, 9, 12 through 17, 19 through 22, and 24 through 31 were admitted in evidence. Ruling was reserved on objections to the Petitioner's Exhibits 7, 10, 11, 18, and 23. Those objections are sustained, and the exhibits are excluded.[3/] The Respondent testified, and offered no exhibits in evidence.

A Transcript of the final hearing was filed on April 15, 2016. The parties filed proposed recommended orders that have been considered in the preparation of this Recommended Order.

The Respondent also filed a motion for sanctions under section 57.105, Florida Statutes, and the Petitioner filed a response in opposition.

FINDINGS OF FACT

1. The Respondent is a licensed dentist in the state of Florida, having been issued license DN 14819.

2. The Respondent was employed by the Collier County Health Department (CCHD) from 2001 to February 10, 2010. She began her employment as a dental assistant, worked as a dentist when she became licensed in Florida, and eventually became the director of the CCHD's dental clinic.

3. Prior to June 2008, the Respondent received training in providing "pre-orthodontic appliance therapy." This therapy used appliances to move teeth to create and maintain space in the mouths of pediatric patients to facilitate future orthodontic therapy. The Respondent provided pre-orthodontic appliance therapy, and the CCHD billed Medicaid for reimbursement.

4. As Respondent was starting to provide these services, Medicaid notified the CCHD that Medicaid would pay for them only

if provided by an orthodontist or pediatric dentist. The Respondent's billings would not be paid.

5. When the CCHD was told this, its administrator, Stephanie Vick, told the Respondent and instructed her not to provide pre-orthodontic appliance therapy because Medicaid would not pay for it. Ms. Vick allowed the Respondent to complete cases already begun but not to initiate any new pre-orthodontic appliance therapy.

6. After the conversation between the Respondent and Ms. Vick, Ms. Vick was told that the Respondent was prescribing new orthodontic appliances for patients, contrary to her instructions to the Respondent.

7. On July 15, 2008, Ms. Vick gave the Respondent a written reprimand for "[p]oor performance" and "[v]iolation of law or agency rules." The reprimand cited the use of orthodontic appliances for the dual purposes of maintaining space and actively moving teeth and other dental structures. It also stated that these appliances were being billed to Medicaid improperly as space maintainers. Ms. Vick discussed the reprimand with the Respondent.

8. After the reprimand, Ms. Vick thought the Respondent was complying with her instructions. Her quarterly reviews of CCHD documentation seemed to corroborate her beliefs. However, at some point, Ms. Vick was told by dental clinic employees that

the Respondent persisted in the conduct described in the reprimand. Ms. Vick investigated by reviewing additional documentation, including invoices from the E.P. Orthodontic Laboratory (the lab), which filled the CCHD's prescriptions for dental appliances, and by interviewing clinic employees.

9. The lab's invoices led Ms. Vick to believe that the Respondent was violating her instructions regarding pre-orthodontic care and treatment while attempting to conceal her actions.

10. On February 10, 2010, Ms. Vick confronted the Respondent with the results of her investigation and discussed the matter. After the discussion, the Respondent resigned from her employment. She did not admit to wrongdoing. On February 12, 2010, Ms. Vick made a notation in the Respondent's personnel file that included: "The results of this review [of dental patient records from July 2009] supported that Dr. Aranda has continued to engage in improper charting of services, incorrect/legal billing code use and practices regarding interceptive orthodontic treatment and the need for signed protocol structures." The notation continued to say that the Respondent was disciplined for the same issues in July 2008 and was persisting in those practices; that these matters were discussed; and that the Respondent chose to resign.

11. The notation mentioned nothing about improper delegation. However, it appears that Ms. Vick came to believe during the course of her investigation of the Respondent that the Respondent was having a dental assistant named Paul Beingolea scale teeth and cement appliances, which he was not qualified to do. Ms. Vick confronted Mr. Beingolea with her belief. He denied it but chose to resign his employment.

12. After the Respondent and Mr. Beingolea resigned, Ms. Vick notified the Agency for Health Care Administration (AHCA), which runs Florida's Medicaid program, that the CCHD improperly billed and collected payment for pre-orthodontic therapies. AHCA and CCHD agreed to repayment to Medicaid for the resulting overpayments.

Count I

Deceptive, Untrue or Fraudulent Representations

13. Count I is based on the Respondent's dental care and treatment for eight Medicaid patients: M.B.; J.C.; K.E.; D.G.; M.G.; M.M.; T.N.-D.; and P.M. Specifically, Count I alleges that the Respondent prescribed pre-orthodontic active appliances for patients, made impressions to be used to fabricate the appliances, ordered them, fit them, and adjusted them.

14. These appliances included Schwartz appliances, rapid palate expanders (RPEs), and anterior bite/inclined planes. These appliances are considered to be "active" because they move

teeth and dental structures when "activated" by turning a screw or expanding loops. After the desired space is obtained through use of the appliances, it is common to leave the appliance in temporarily to maintain the space until the bone fills in and solidifies. In this mode, the appliance becomes "passive" and functions as a temporary retainer, but it is still considered to be an "active" appliance.

15. Count I alleges essentially that the Respondent made deceptive, untrue or fraudulent representations in the patient's charts, and in documents used to bill Medicaid for their dental care and treatment, by disguising pre-orthodontic care and treatment using active appliances, which was not covered by Medicaid, as non-orthodontic care and treatment using passive retainers that Medicaid would cover and pay.

16. It is clear that the Respondent did not benefit financially from Medicaid's payment of the care and treatment at issue. The Respondent was on a straight salary. She did not work overtime and got no bonuses.

17. No actual Medicaid bills were in evidence. Instead, the Petitioner introduced documentation from the CCHD's "HMS" system. The HMS system recorded patient demographics, personal information, insurance and billing information, and services provided. The HMS billing information was used by the clerical staff of the CCHD to bill Medicaid.

18. The Respondent did not enter the billing information into the HMS system. This also was done by the clerical staff based on documentation referred to as a "super bill." The CCHD's dental practitioners, including the Respondent, created super bills based on their dental care and treatment of patients.

19. After super bill information was entered into the HMS system, the super bill was discarded. None were in evidence. No member of the CCHD's clerical staff testified, and there was no evidence about the Respondent's actual entries on the super bill. There was no clear and convincing evidence as to what part the Respondent played in the generation of HMS billing information or the actual billing of Medicaid by the CCHD.

20. Some of the entries in the patient's charts probably could be attributed to the Respondent based on handwriting (although no witness identified the Respondent's signature or handwriting). Some entries in the charts were followed by a stamp of a practitioner's printed name and what appears to be her signature. Sometimes, a number of a day's worth of charting (up to 30 or more patients) was done at one time in a collaborative fashion by several practitioners. Sometimes there was confusion and mix-ups. Sometimes, one practitioner mistakenly would stamp and/or sign an entry for another practitioner's work.

21. The charts in evidence included copies of prescriptions that appear to have been written by the Respondent for fabrication by the lab. At the CCHB, the prescription was written on a form called a "Retainers Prescription" that generated a carbonless copy when used. Typically, the white original (top) of the prescription form was sent to the lab, and the yellow carbonless copy was retained in the patient's chart. Although the exhibits offered in evidence were copies, and all appeared to be white, the witnesses were able to tell the difference between the original (top) of the prescription forms and the bottom carbonless copies of the forms.

22. As part of the investigation conducted by Ms. Vick, copies of what appear to be the lab's invoices to the CCHD, and copies of what appear to be the original (top) of prescription forms, were obtained from the lab. Ms. Vick believed there were incriminating discrepancies between the documents she got from the lab and some of the carbonless copies of prescriptions in some of the patient charts. However, the documents obtained from the lab were excluded from evidence in this case and cannot support a finding that discrepancies existed. See Preliminary Statement and Endnote 3.

23. The Respondent does not dispute that she prescribed Schwartz appliances, RPEs, and inclined planes for children who needed to regain a little space lost after baby teeth fell out

and then maintain the lost space for permanent teeth that were coming in. She denies trying to hide what she was doing by making deceptive, untrue or fraudulent representations. The evidence as a whole supports the Respondent's position.

Patient M.B.

24. The chart for M.B. indicates that the Respondent took upper and lower impressions on June 25, 2009, and wrote a prescription for a "Schwartz to regain space for # A. or space maintainer with loops."

25. M.B.'s chart referred to the appliance as a space maintainer. There also was an entry on August 21, 2009, indicating that the patient was instructed to "come back for adjustment" to alleviate discomfort and one on February 10, 2010, indicating that the appliance was checked and adjusted.

26. There was HMS documentation indicating that the CCHD billed Medicaid for "diagnostic casts" on June 25, 2009.

Patient J.C.

27. The Respondent took upper and lower impressions and did a wax bite registration of the teeth of patient J.C. on May 14, 2009. The chart included two undated prescriptions. One was for a lower bilateral space maintainer. (The chart included two copies of this prescription.) The other was for an upper and lower Schwartz and included a notation that the upper Schwartz was to address "[r]ight side cross bite."

28. The patient chart referred to the delivery of a "lower bilateral space maintainer (modified)" on July 9, 2009, but there also were notes in the chart referring to orthodontic bands.

29. There were two HMS entries dated July 9, 2009. One indicated "DEN SPACE MAINTAINER-FIX" was provided. The other indicated that a Medicaid bill was initiated.

Patient K.E.

30. The patient K.E. began receiving dental treatment at the CCHD dental clinic on September 8, 2005.

31. On May 28, 2009, the Respondent signed and stamped clinical notes made in the patient's chart by a dental assistant for upper and lower impressions, a bite registration, and orthodontic bands. Below the Respondent's signature is an added entry by the Respondent stating, "note: B.S. Maintainer (RPE)." The Respondent also wrote and signed an undated prescription for an "upper RPE."

32. On August 18, 2009, the Respondent signed and stamped a dental assistant's clinical notes in the patient's chart indicating that a space maintainer was cemented using Fuji brand permanent cement.

33. On September 30, 2009, the Respondent signed and stamped a dental assistant's clinical notes in the patient's

chart indicating that the patient came to the clinic with a loose space maintainer that was re-cemented.

34. There was HMS documentation indicating that the CCHD provided "diagnostic casts" for the patient K.E. on May 28, 2009; provided "DEN SPACE MAINTAINER-FIX" on August 18, 2009; provided "DEN RE-CEMTATION [sic] OF SPACE" on September 30, 2009; and initiated billing of Medicaid on those dates (but indicates there was no charge to Medicaid for re-cementing the appliance on September 30, 2009.

Patient D.G.

35. The patient D.G. began receiving dental treatment at the CCHD dental clinic on May 17, 2005.

36. On August 19, 2009, the Respondent signed and stamped clinical notes made in the patient's chart by a dental assistant indicating: that a bilateral space maintainer was fitted and delivered to the patient D.G.; that the patient's father was instructed in how the patient should wear, clean, adjust and clean it; and that the adjustments were to be performed once a week.

37. On October 7 and December 2, 2009, the Respondent signed and stamped clinical notes made in the patient's chart by a dental assistant indicating that the patient presented with a loose space maintainer. On both occasions, the parent was instructed in how to take care of the appliance.

38. The patient chart for D.G. is missing the carbonless copy of the prescription for the appliance. There was no evidence as to why it was missing or what it said.

39. There was HMS documentation indicating that the CCHD provided "DEN SPACE MAINTAINER-FIX" on August 19, 2009; provided "DEN RE-CEMTATION [sic] OF SPACE" on October 7 and December 2, 2009; and initiated billing of Medicaid on those dates (but indicates there was no charge to Medicaid for any of those dates.

Patient M.G.

40. The patient M.G. began receiving dental treatment at the CCHD dental clinic on November 26, 2008.

41. On April 23, 2009, the Respondent signed and stamped clinical notes made in the patient's chart by a dental assistant for a diagnostic cast and a bite registration for an inclined plane. The chart also has the carbonless copy of the prescription written by the Respondent for an inclined plane.

42. On June 25, 2009, the Respondent signed and stamped clinical notes made in the patient's chart by a dental assistant indicating that a "space maintainer appliance" was delivered and that the family was given instruction on how to use it.

43. On July 2, 2009, the Respondent signed and stamped clinical notes made in the patient's chart by a dental assistant

indicating that the patient's mother was adjusting the appliance (identified in the note as an "upper RPE") once a week.

44. On August 6, 2009, the Respondent signed and stamped clinical notes made in the patient's chart by a dental assistant indicating that the appliance (identified in the note as an "inclined plane") was "working fine" and that the appliance was "trimmed today to improve the bite."

45. On October 20, 2009, the Respondent signed and stamped clinical notes made in the patient's chart by a dental assistant indicating that the patient's teeth were "corrected of crossbite."

46. There was HMS documentation indicating that the CCHD provided "DEN SPACE MAINTAINER-FIX" on June 25, 2009, and initiated billing of Medicaid on that date (but indicates there was no charge to Medicaid).

Patient M.M.

47. The patient M.M. began receiving dental treatment at the CCHD dental clinic on April 27, 2004.

48. On March 17, 2009, the Respondent signed and stamped clinical notes made in the patient's chart by a dental assistant indicating that an existing space maintainer was removed, impressions were taken and bands, and bite separators were placed. The patient's chart confirms that a space maintainer

was provided for the patient about two years earlier, when the patient was six years old.

49. No copy of a prescription for a new appliance is in the patient's chart.

50. On April 21, 2009, clinical notes were made by a dental assistant in the patient's chart indicating that an appliance was received from the lab.

51. On May 21, 2009, the Respondent signed and stamped clinical notes made in the patient's chart by a dental assistant indicating that an upper bilateral space maintainer was cemented and that the patient's mother was explained how to adjust it. The Respondent struck the words "FAN appliance" and "use" and wrote the words "upper bilateral space maintainer" and "adjust" (respectively) above the stricken words.

52. There was HMS documentation indicating that the CCHD provided "DEN SPACE MAINTAINER-FIX" on May 21, 2009, and initiated billing of Medicaid on that date.

Patient T.N-D.

53. The patient T.N-D. began receiving dental treatment at the CCHD dental clinic on July 8, 2008.

54. On August 27, 2009, the Respondent signed and stamped clinical notes made in the patient's chart by a dental assistant indicating that an upper and lower bilateral space maintainer was modified, fitted, and delivered.

55. On September 2, 2009, the Respondent signed and stamped clinical notes made in the patient's chart by a dental assistant indicating that the upper and lower bilateral space maintainers were modified and adjusted and that the patient's mother was instructed to open the appliance once a week and have the patient use it whenever not in school. Under the Respondent's signature and stamp was a note in her handwriting: "modify space maintainer to regain lost space."

56. There was HMS documentation indicating that the CCHD provided "DEN SPACE MAINTAINER-FIX" on August 27, 2009, and initiated billing of Medicaid on that date.

Patient P.M.

57. The patient P.M. began receiving dental treatment at the CCHD dental clinic on August 22, 2002.

58. On July 2, 2009, the Respondent signed and stamped clinical notes made in the patient's chart by a dental assistant indicating that upper and lower impressions were taken and bands were placed. The chart also has a copy of a prescription written by the Respondent for an upper RPE and a lower space maintainer.

59. A clinical note signed by a dental assistant indicated that the clinic received an appliance for the patient on August 24, 2009.

60. On October 28, 2009, the Respondent signed and stamped clinical notes made in the patient's chart by a dental assistant indicating that an upper space maintainer was cemented using Fuji cement.

61. On February 5, 2010, there are notes in the patient's chart signed by another dentist that seem to indicate that the patient's occlusion was adjusted. There was no testimony to explain the meaning of this, or other notes made by the dentist regarding "optibands" and removal of "canes(?)."

62. On February 10, 2010, the Respondent signed and stamped clinical notes made in the patient's chart by a dental assistant indicating that a lower bilateral space maintainer was fitted and adjusted with Fuji cement. There also were notes regarding care for the appliance. One note, written by the dental assistant, said: "Aunt was taught how to take care of appliance, she'll be doing it twice a week." That note was stricken and under the Respondent's signature was a note in her handwriting: "Space maintainer needs to only observe for the properly works [sic]." See Finding 73, infra.

63. There was HMS documentation indicating that the CCHD provided "DEN SPACE MAINTAINER-FIX" on October 28, 2009, and February 10, 2010, and initiated billing of Medicaid on those dates.

Summary

64. The Petitioner did not prove by clear and convincing evidence that the Respondent made deceptive, untrue or fraudulent representations in the charts for these patients. The charts would suggest that, to the contrary, the Respondent was not disguising the nature of her care and treatment of these patients (or was doing a poor job of it if she was trying to). The documentary evidence used to support the charges generally was unclear, confusing, and not well explained.

65. The Respondent may have been insubordinate in providing pre-orthodontic care and treatment to patients against the instructions of her supervisor, which may have been grounds to terminate her employment, and the clinical notes in the patient charts may have been subject to criticism for being less than clear and completeness, but those were not the charges against the Respondent in this case, and no such charges were tried or proven in this case.

Count II

Improper Delegation

66. Count II alleges that the Respondent delegated tasks to her dental assistant, Paul Beingolea, that he was not qualified to do.

Patient F.C.

67. On January 15, 2010, the Respondent signed and stamped a clinical note made in the chart of the patient F.C. It appears that some of the notes were made by a dental assistant named Irma Pineros and indicated that the patient received an examination and "prophy (Hygienist)."

68. It appears that someone else wrote some of the notes in F.C.'s chart for that day, including notes saying "soft tissue inflamed," "calculus present," "localized gingivitis," and "hand scaling." From the handwriting, it appears that the Respondent may have written some, if not all of the notes that do not appear to be written by Irma Pineros. However, there was no testimony from her, the Respondent, or anyone else as to who wrote what part of the notes.

69. Another dentist at the clinic named Laurie Housworth testified that she saw the Respondent examine the patient F.C. on January 15, 2010, and call in a dental assistant, named Paul Beingolea, who performed work on the patient for another 30 minutes or so. However, Dr. Housworth testified that she could not see exactly what Mr. Beingolea was doing at the time, and she did not observe the patient continuously for the full 30 minutes. It is possible that the Respondent returned to the examination room unbeknownst to Dr. Housworth.

70. Dr. Housworth later pulled the chart to review the clinical notes and interpreted the chart to be indicating that hand-scaling was performed by a hygienist. Since there was no hygienist available at the clinic on that day, she believed the work was done by Mr. Beingolea.

71. The Respondent and Mr. Beingolea denied that he performed hand-scaling on the patient F.C. on January 15, 2010. The Respondent testified that she never instructed a dental assistant to perform hand-scaling.

72. Dr. Housworth did not confront the Respondent or either dental assistant at the time with her suspicion that hand-scaling was performed by Paul Beingolea. Nor did she report any improprieties to Ms. Vick at the time. During the investigation of the Respondent by Ms. Vick, Dr. Housworth related to her the incident concerning the patient F.C. on January 15, 2010.

Patient P.M.

73. On February 10, 2010, Dr. Housworth came to work early and observed Mr. Beingolea seating patient P.M. while the Respondent was working in another room with a different patient. Dr. Housworth testified that she saw that Mr. Beingolea had Fuji permanent cement and looked to her like he was placing something in the patient's mouth. After that, she saw Mr. Beingolea release the patient. Later, she checked the chart and saw that

Mr. Beingolea had made a clinical note saying: "Lower bi-lateral space maintainer fitted, and adjusted with fuji L." He had then written: "Aunt was taught how to take care of appliance, she'll be doing it twice a week (unreadable). Follow up 2 weeks." The second part of the note was stricken, and it appears that the Respondent wrote: "Space maintainer needs to only observe for the properly works [sic]." Mr. Beingolea's signature appears after the first two entries; the Respondent's stamp and signature appears under the amendment to the notes.

74. From what she had observed and these entries in the patient chart, Dr. Housworth believed that Mr. Beingolea was cementing a space maintainer in the patient's mouth.

75. Mr. Beingolea and the Respondent denied that he cemented the space maintainer. He testified that he placed the cement in the bands for the Respondent, she placed the space maintainer in the patient's mouth and left, and he removed excess cement from the space maintainer. The Respondent testified that she never instructed a dental assistant to perform cement space maintainers or any appliances in a patient's mouth using permanent cement.

76. Dr. Housworth did not confront the Respondent or Mr. Beingolea at the time with her suspicion that Mr. Beingolea cemented a space maintainer in P.M.'s mouth using permanent cement. Instead, she reported it to Ms. Vick because she

thought it was relevant to Ms. Vick's investigation of the Respondent and Mr. Beingolea.

Summary

77. The Petitioner did not prove by clear and convincing evidence that the Respondent delegated to Mr. Beingolea the tasks of hand-scaling F.C.'s teeth or cementing a space maintainer in P.M.'s mouth using permanent cement.

CONCLUSIONS OF LAW

78. The Department of Health, Board of Denistry, regulates the dental professions in Florida.

79. The Amended Administrative Complaint in this case charges the Respondent with: making deceptive, untrue, or fraudulent representations in or related to the practice of dentistry in violation of section 466.028(1)(l), Florida Statutes (2009), by falsely characterizing "active" orthodontic appliances as "passive" space maintainers (Count I); and delegating irremediable tasks (hand-scaling and permanently cementing a dental appliance) to a dental assistant not qualified to perform those tasks, in violation of sections 466.028(1)(z) and 466.024(1), and Florida Administrative Code Chapter 64B5-16 (Count II).

80. Disciplinary proceedings are considered to be penal in nature. In prosecuting a disciplinary action, the prosecutor is limited to proving the allegations and charges pled in the

administrative complaint. Cf. Trevisani v. Dep't of Health, 908 So. 2d 1108 (Fla. 1st DCA 2005); Aldrete v. Dep't of Health, Bd. of Med., 879 So. 2d 1244 (Fla. 1st DCA 2004); Ghani v. Dep't of Health, 714 So. 2d 1113 (Fla. 1st DCA 1998); Willner v. Dep't of Prof'l Reg., Bd. of Med., 563 So. 2d 805 (Fla. 1st DCA 1990).

81. In a penal proceeding, the prosecutor must prove the allegations and charges by clear and convincing evidence. See Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

82. Clear and convincing evidence "requires more proof than a 'preponderance of the evidence' but less than 'beyond and to the exclusion of a reasonable doubt.'" In re Graziano, 696 So. 2d 744, 753 (Fla. 1997). As stated by the Florida Supreme Court, the standard:

> [E]ntails both a qualitative and quantitative standard. The evidence must be credible; the memories of the witnesses must be clear and without confusion; and the sum total of the evidence must be of sufficient weight to convince the trier of fact without hesitancy.

In re Davey, 645 So. 2d 398, 404 (Fla. 1994) (citing with approval, Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983)); see also In re Henson, 913 So. 2d 579, 590 (Fla. 2005). "Although this standard of proof may be met where the evidence

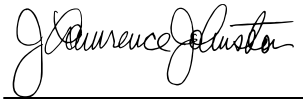
is in conflict, it seems to preclude evidence that is ambiguous." Westinghouse Elec. Corp. v. Shuler Bros., 590 So. 2d 986, 989 (Fla. 1991).

83. Using these standards, the charges in the Amended Administrative Complaint against the Respondent were not proven by clear and convincing evidence.

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Department of Health, Board of Dentistry, enter a final order dismissing the charges against the Respondent.

DONE AND ENTERED this 24th day of May, 2016, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 24th day of May, 2016.

ENDNOTES

[1/] The statutes alleged to have been violated are in the 2009 Florida Statutes. The rules are those in effect at the times of the alleged violations in 2009 and 2010.

[2/] Citations the Administrative Procedure Act are to the 2015 version of the Florida Statutes, which was in effect at the time of the final hearing.

[3/] Even if the objections were overruled and the exhibits admitted in evidence, they would be hearsay, which may be used for the purpose of supplementing or explaining other evidence, but would not be sufficient, alone, to support a finding unless they would be admissible over objection in a civil action. § 120.57(1)(c), Fla. Stat. The proffered hearsay exception was the business record exception under section 90.803(6), but the requirements for that hearsay exception were not met.

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.