STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH,
BOARD OF DENTISTRY,

Petitioner,

vs. Case No. 20-2517PL

TATYANA STEPANCHUK, D.M.D.,

Respondent.
_____/

RECOMMENDED ORDER

On November 18, 2020, a final hearing was held by Zoom conference before E. Gary Early, an Administrative Law Judge assigned by the Division of Administrative Hearings ("DOAH").

APPEARANCES

For Petitioner: Ellen LeGendre Carlos, Esquire
Gabriel Girado, Esquire
Zachary Bell, Esquire
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For Respondent: Linda A. McCullough, Esquire
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STATEMENT OF THE ISSUES

The issues to be determined are whether Respondent violated the applicable standards of care in the practice of dentistry in violation of section 466.028(1)(x), Florida Statutes, and the dental record-keeping requirements

in violation of section 466.028(1)(m) and (mm), and Florida Administrative Code Rule 64B5-17.002(1), as alleged in the Administrative Complaint; and, if so, the appropriate penalty.

PRELIMINARY STATEMENT

On March 16, 2020, Petitioner, Department of Health ("Petitioner" or "Department"), filed its Administrative Complaint No. 2018-00406 ("Administrative Complaint") against Respondent, Tatyana Stepanchuk, D.M.D. ("Respondent" or "Dr. Stepanchuk"), a licensed dentist in the state of Florida. The complaint charged Respondent with failing to place a dental implant in accordance with the minimum standards of diagnosis and treatment in the practice of dentistry, in violation of section 466.028(1)(x); and with failing to keep written dental records and medical history records to document the measurements of the patient's edentulous site in the area of tooth 19 prior to placing an implant in that area, in violation of section 466.028(1)(m) and (mm), and rule 64B5-17.002(1). Respondent filed an Election of Rights in which she disputed the allegations, and requested an administrative hearing.

On June 1, 2020, the case was referred to DOAH and assigned as DOAH Case No. 20-2517PL. The final hearing was originally scheduled for August 19, 2020. Upon motion, the final hearing was rescheduled for November 18, 2020, by Zoom conference.

On November 4, 2020, Petitioner filed a Notice of Intent to Seek to Admit Records Pursuant to Section 90.803(6)(c), Florida Statutes ("Notice of Intent") regarding records of the patient, I.D., kept by Respondent and by Youssef Obeid, D.D.S.

On November 13, 2020, the parties filed their Joint Pre-hearing Stipulation ("JPS"). The stipulated facts set forth therein have been incorporated in this Recommended Order. The JPS also contained stipulations regarding issues of law on which there was agreement. Those stipulations, which are determined to accurately set forth applicable issues of law, are incorporated in this Recommended Order.

On November 17, 2020, a series of five motions in limine were filed by Respondent. The Motion in Limine to Prevent Petitioner from Presenting any Evidence or Witness not Previously Designated, which sought to limit the introduction of evidence "not previously disclosed or included within the Joint Pre-Hearing Stipulation" was granted, in part, for reasons set forth on the record. Rulings on the remaining four motions were reserved. Since rulings on admissibility were made on the record as evidence was offered, further evidentiary rulings as requested in the remaining motions in limine are unnecessary. Therefore, the Motion in Limine to Prevent Improper Bolstering of Witnesses, Motion in Limine to Bar Improper Rebuttal Evidence, Motion in Limine to Prevent Petitioner Experts from Offering Opinions at Final Hearing beyond those Disclosed in Deposition or as Previously Limited by the Court, and Motion in Limine to Prevent Petitioner from Presenting any Expert Opinions which are Based upon Pyramiding of Inferences are denied as moot.

On November 18, 2020, prior to the commencement of the final hearing, Respondent filed her Objection to Petitioner's Attempt to Introduce Previously Unidentified/Unlisted Exhibit into Evidence, which sought to limit the introduction of Respondent's deposition as substantive evidence. In general, the deposition of a party is admissible as evidence pursuant to Florida Rule of Civil Procedure 1.330(a)(2)("any part or all of a deposition may be used against any party ... in accordance with any of the following

provisions: ... (2) The deposition of a party ... may be used by an adverse party for any purpose."). However, in the JPS, Petitioner listed as an exhibit "Deposition of Respondent (impeachment purposes)." Regardless of whether Respondent's deposition transcript is admissible "for any purpose," Petitioner stipulated to a self-imposed limitation on its use. Parties are bound by agreed upon and properly entered joint stipulations. *Delgado v. Ag. for Health Care Admin.*, 237 So. 3d 432, 436-37 (Fla. 1st DCA 2018). Thus, the motion seeking to limit the use of the deposition to impeachment purposes was granted. The deposition of Dr. Stepanchuk was ultimately not offered in evidence for impeachment purposes, nor was it proffered as an exhibit.

The final hearing was convened on November 18, 2020.

At hearing, Joint Exhibits 1 through 7, consisting of Dr. Stepanchuk's dental records for Patient I.D.; curriculum vitae for several witnesses; and exhibits to the deposition of Dr. Gordon Roswell Isbell, IV, were received in evidence.

The Department offered the testimony of Dr. William J. Kinzler, who was accepted as an expert in general dentistry and placing dental implants. Petitioner's Exhibit 2, consisting of the records of Dr. Obeid that were the subject of the Department's November 4, 2020, Notice of Intent, was received in evidence.

Respondent testified on her own behalf, and offered the testimony of Dr. Luke Matranga, and Dr. Gordon Roswell Isbell, IV, both of whom were found to possess the knowledge, skill, experience, training, and education to testify as experts, with Dr. Matranga generally testifying as to the standards of general dentistry and the restoration of dental implants, and Dr. Isbell generally testifying as to the standards of general dentistry and the

placement of dental implants. Respondent's Exhibit 3, pages 3, 4, 9, and 12, was received in evidence.

The two-volume final hearing Transcript was filed on December 3, 2020. Both parties timely filed Proposed Recommended Orders that were considered in preparation of this Recommended Order.

This proceeding is governed by the law in effect at the time of the commission of the acts alleged to warrant discipline. *See McCloskey v. Dep't of Fin. Servs.*, 115 So. 3d 441 (Fla. 5th DCA 2013). Thus, references to statutes are to those in effect at the time of the alleged violations, unless otherwise noted.

FINDINGS OF FACT

Stipulated Facts

1. At all times material hereto Respondent was and is a duly licensed dentist within the State of Florida, having been issued license number DN 18478.

2. Respondent has no disciplinary history or record of any adverse dental incident in the State of Florida apart from the instant pending matter.

3. Respondent's current address of record is 8750 Perimeter Park Boulevard, Suite 101, Jacksonville, Florida 32216.

4. Previously, Respondent's address of record was 978 Mineral Creek Drive, Jacksonville, Florida 32225.

5. On or about November 27, 2017, Patient I.D. presented to Respondent for an implant consultation in the area of tooth 19.

6. Patient I.D. had tooth 19 extracted by another provider approximately six months prior to presenting to Respondent for implant consultation.

7. On or about November 27, 2017, Patient I.D. signed a General Dentistry Informed Consent form in the office of Respondent.

8. On or about December 11, 2017, Patient I.D. returned to Respondent for placement of an implant in the area of tooth 19.

9. On or about December 11, 2017, Patient I.D. initialed and signed a four-page form entitled Consent Form: Dental Implant(s) for Tooth #19.

10. On or about December 11, 2017, Respondent placed an implant in the area of tooth 19.

11. On or about December 11, 2017, Respondent's dental assistant took radiographs prior to, during, and after the implant placement procedure.

Additional Evidentiary Findings

The Administrative Complaint

12. The Administrative Complaint identified the following as the factual bases for its determination in Count One that Respondent departed from the minimum standards of performance in the diagnosis and treatment of Patient I.D.:

> A. By failing to utilize an appropriately sized implant by placing an implant which was too small for Patient I.D.'s ridge;
>
> B. By failing to place the implant in the correct location by placing the implant in the distal root socket in the area of tooth 19, and therefore too far from adjacent tooth 20;
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> C. By failing to place the implant at an angle that would allow the implant to be restored and/or limit stress on the implant by placing the implant at a high angle; and/or,
>
> D. By failing to obtain a post-operative radiograph to assess the final position of the placed implant.

13. The Administrative Complaint identified the following as the factual basis for its determination in Count Two that Respondent failed to keep written dental records and medical history records justifying the course of treatment of Patient I.D.:

> Respondent has failed to maintain records ... by failing to document the measurements of Patient I.D.'s edentulous site in the area of tooth 19 prior to placing an implant in that area.

Implants

14. Implants are used to anchor dentures in bone to replace a tooth or teeth. The implant consists of three parts: the implant, which is essentially a device that screws into bone at the location of the missing tooth; the abutment, which is attached to the implant with a hexed screw and locked into place, and which provides a post for the final restoration; and the final restoration, or crown.

15. Implant sizing is a recommendation based on the amount of bone available at the location of the missing tooth. The bone is below the gum, and not directly visible. To determine the amount of bone, a dentist typically uses a periapical radiograph and a clinical exam on the patient. The clinical exam may include palpation of the jaw in the area of the proposed implant, and a measurement using a calibrated probe to measure across and between the teeth. The radiograph also provides information as to the location of any nerve structures below the tooth. Those measurements establish the "box to work in."

16. Standards applicable to dental implant placement call for there to be a minimum of two millimeters of bone surrounding the implant. In addition, there should be a minimum of two millimeters of space between the end of the implant and any nerves running through the jaw. Those measurements establish the maximum size of the implant that can be safely placed.

17. The human jaw is akin to a hinged nutcracker, with the greatest force being exerted close to the temporal mandibular joint at the back of the mouth (the "hinge"), with molars exerting as much as 200 pounds of force, and less force being exerted by the incisors, with the pre-molars being somewhere in between. Tooth 19 is a molar.

18. In general, smaller diameter implants are suitable for replacement of incisors, where the ridge of bone is thinner and the stress exerted on the implant is less, and larger diameter implants are suitable for replacement of molars, where the ridge of bone is thicker and the stress exerted on the implant is greater.

19. Osseointegration is the process by which bone biologically bonds to the titanium implant, anchoring it into place. Larger diameter implants not only provide greater mechanical stability from the threads screwing into the bone, but provide more surface area for osseointegration of the implant.

20. The greater weight of the evidence established that, although larger implants are preferable, implants of four millimeters or greater are considered to be "wide body" implants and are suitable for the replacement of molars.

Selection of the Implant

21. When Patient I.D. presented at Respondent's office on November 27, 2017, Respondent took Patient I.D.'s medical history. The documentation was complete, but for an identification of whether Patient I.D. was taking prescription medications and, if so, the identification of those medications.

22. When Patient I.D. was ready for her consultation, Respondent began by palpating the ridge of Patient I.D.'s lower jaw in the area of tooth 19 to measure the width of bone. There were no obvious cavitations in the bone. Respondent also used a calibrated periodontal probe to determine the mesiodistal distance, i.e., the space between tooth 18 and tooth 20; the buccal/lingual width, i.e., the width of the bone from the buccal (cheek) side to the lingual (tongue) side; and the height of the ridge. She determined that Patient I.D. had nine millimeters of bone width. Those measurements provided sufficient information to guide Respondent in her decision on the size of the implant. However, the measurements were not recorded in Patient I.D.'s chart.

23. Respondent had several periapical radiographs of Patient I.D.'s teeth, including the area around tooth 19, taken prior to I.D.'s consultation. The radiographs were sufficient to show the bone, the mesiodistal width, and the location of the inferior alveolar nerve ("IAN") underneath tooth 18. The trajectory of the IAN in that area of the jaw is known, so there was no need to take additional radiographs to determine its location at tooth 19.

24. Respondent did not believe that, after her physical measurements, she needed additional imaging. Her belief was substantiated by the testimony of Dr. Matranga, which is credited. The evidence was not sufficient to demonstrate that her decision to forego additional imaging was a violation of the dental standard of performance or care.

25. The IAN ran along Patient I.D.'s posterior mandible about 15 to 16 millimeters from the top of the ridge. Thus, the longest implant suitable while maintaining two millimeters of bone between the implant and the IAN would have been 13 millimeters in length.

26. To maintain a minimum of two millimeters of bone surrounding the implant, the largest diameter implant suitable for Patient I.D. would have been five millimeters in diameter, i.e., nine millimeters minus two millimeters on each side.

27. Respondent originally intended to install a five-millimeter by 11.5-millimeter implant in Patient I.D.'s mouth. Because of difficulty in accessing Patient I.D.'s mouth, and the obstacle to inserting a longer drill into the limited space, she modified her plan to the placement of a 4.2-millimeter by eight-millimeter implant. During the course of placing the implant, a 4.2-millimeter by 10-millimeter implant was substituted for the 4.2-millimeter by eight-millimeter implant.

28. The implant diameter was smaller than the maximum allowable 5 millimeters but, at 4.2 millimeters, not dramatically so. There is little difference in survivability between a 4.2-millimeter implant and a five-millimeter implant. An implant of 5.7 millimeters in diameter, as

recommended by Dr. Kinzler, could not have been accommodated in the nine millimeters of bone width while maintaining two millimeters of bone on each side.

29. In implant dentistry, the width of the implant is more important than its length. The evidence established that an implant length of between 9 and 14 millimeters is suitable for replacement of a molar in the posterior mandible. The evidence further established that an implant of 10 millimeters in length was suitable for the replacement of Patient I.D.'s tooth 19.

30. The evidence, taken as a whole and given its appropriate weight, does not support a finding that Respondent departed from the minimum standards of performance in the diagnosis and treatment of Patient I.D. by selecting a 4.2 millimeter by 10-millimeter implant for placement at Patient I.D.'s tooth 19.

Placement of the Implant

31. When Patient I.D. presented on December 11, 2017, for placement of the implant, she completed a comprehensive informed consent form for the implant. Dental procedures are not a perfect science, and a procedure can "fail" without a violation of any standard of care. The consent form fully disclosed that placement of an implant came with risks of failure. Though an informed consent does not create a defense to a violation of the standard of care, it establishes both a recognition and acceptance of the risks, and authorization for a provider to proceed in light of the risk. Patient I.D. consented to the procedure and executed consent forms supplied and maintained by Respondent.

32. The furcation bone is the area of mature bone between the roots of a molar. When a molar is extracted, it leaves a void where the roots were removed. Bone will eventually grow into the voids left by the roots, but that bone is, for a substantial period, softer "immature" bone. The length of time for the replacement bone to mature was not defined, but is longer than six months.

33. The furcation bone at Patient I.D.'s tooth 19 was about 4.4 millimeters wide. The selection of the 4.2 millimeter in diameter implant allowed for it to be placed in the furcation bone with some bone around it, though it was a narrow window. Use of a 5.7 millimeter in diameter implant, though having more surface area, would have obliterated the furcation bone.

34. Patient I.D. had difficulty in opening her mouth wide, or for any appreciable length of time. A typical person can open their mouth to 35 millimeters. Patient I.D. could open her mouth to a maximum of 25 millimeters. Thus, there was little space to work in Patient I.D.'s mouth.

35. Patient I.D. could not tolerate keeping her mouth open for much more than a minute or two. In typical dental procedures, a patient is provided with a "bite block," which allows the patient to keep their mouth open while relaxing the jaw. Bite blocks come in three sizes -- adult, small, and pediatric. Patient I.D. could not even tolerate a pediatric bite block. During Patient I.D.'s implant procedure, Respondent would often get staged and ready to work, only to be stopped by Patient I.D.'s complaint and need to close her mouth. As stated by Dr. Kinzler, "Respondent had a tough time with this patient."

36. Respondent drilled a "pilot" hole into Patient I.D.'s furcation bone, followed by an eight-millimeter hole to the depth required for the planned implant. She was hampered in her drilling by the teeth above tooth 19 due to Patient I.D.'s inability to open her mouth wide. Respondent then attempted to place a 4.2 millimeter by eight-millimeter implant. That implant proved to be insufficient to fully engage with the furcation bone. It was, in the words of Dr. Kinzler, a "spinner." Respondent then decided to move up to a 4.2 millimeter by 10-millimeter implant.

37. The evidence established that, under the circumstances, the use of a 4.2 millimeter by 10-millimeter implant was appropriate at the tooth 19 location. But for the overtightening of the implant as discussed herein, there was no evidence that the implant could not have been successfully placed in

its intended position. Thus, the Department failed to prove, by clear and convincing evidence, that Respondent failed to utilize an appropriately sized implant by placing an implant which was too small for Patient I.D.'s ridge in violation of the established dental standard of care.

38. Respondent drilled to accommodate the additional two millimeters of length, but Patient I.D. was tiring quickly. However, Patient I.D. was goal oriented, and wanted to proceed. Respondent then placed the implant with a hand wrench. The implant went into the drilled space in the furcation bone, and appeared to be holding in a generally vertical position along the axial line. An x-ray taken during the procedure showed the implant and the attached driver to be in a perfect position in the furcation zone.

39. As Respondent was placing the implant, it was her intent to provide as secure a placement of the implant into the furcation bone as possible. The implant was advancing vertically into the tooth 19 furcation bone as planned. Respondent then tried to screw the implant one turn too many. Bone can crack, shift, or change as a device is being tightened. As a result of the final turn of the screw, the distal wall of the furcation bone cracked, and the implant moved off center. The immature bone in the tooth 19 distal root provided a path of least resistance for the over-torqued implant, and the implant slid into that space.

40. As the implant moved into the distal root opening, it tipped on an angle, as the top remained fixed in the mature furcation bone, and the bottom tipped towards the immature root bone.

41. Angulation of an implant is related to the force that is placed on the implant in the future. The greater the angle, the greater the stress on the implant. Nonetheless, an implant is restorable even if it is at an angle, provided the angle is not too great.

42. When an implant is angled, an angled abutment (analogous to a pipe elbow) is screwed into the angled implant, and forms the "core" or platform

for the crown, allowing tooth surface of the crown to align properly between the adjoining teeth and the opposing teeth.

43. An angled implant is not ideal, because the stress forces (e.g. from chewing) exerted on the implant increase with the angle. However, angled implants are not uncommon, and angled abutments are well accepted in dentistry. Their use is not, by itself, a violation of the standard of care.

44. By use of an angled abutment, the crown for Patient I.D. would have fit evenly between tooth 18 and tooth 20. Those teeth would have provided support for the implant, and helped offset the stress from the angle.

45. The evidence established that the tooth 19 implant was not intentionally placed in the distal root socket. The accidental overtightening of the implant which caused the furcation bone to crack was neither pled nor proven to be a violation of a dental standard of care. The Department failed to establish, by clear and convincing evidence, that Respondent failed to place the implant in the correct location by placing the implant in the distal root socket in the area of tooth 19 and, therefore, too far from adjacent tooth 20.

46. The greater weight of the evidence established that an implant at an angle of 30 degrees or less is capable of being restored by use of an angled abutment without resulting in a failure of the implant.

47. The calculation of the angle of the tooth 19 implant varied from 33 degrees (Dr. Kinzler), to 22 degrees (Dr. Matranga), to 25 degrees (though possibly as little as 17 to 23 degrees) (Dr. Isbell), to 15 to 24 degrees (Respondent). Each of the witnesses established their calculation by use of a protractor, either a physical protractor on a paper copy of the post-placement radiograph, or a computerized protractor on a digital image. Each had indicia of reliability, with differences seemingly based on the point of the measurement. The evidence was not clear and convincing that the angle of the implant was greater than 30 degrees.

48. The Department did not establish, by clear and convincing evidence, that Respondent failed to place the implant at an angle that would allow the

implant to be restored and/or limit stress on the implant in violation of the established dental standard of care.

49. The implant was, in its final position, partially below the crestal ridge of Patient I.D.'s mandible. Since the implant was at an angle, the top of the implant at the distal edge was at the crest of the bone, and the top of the implant at the mesial edge was slightly below the crest. Though not an ideal situation, the evidence was not clear and convincing that the subcrestal location at which the implant ended up was a violation of the dental standard of performance or care.

50. Respondent's records for Patient I.D. include several radiographic images of the implant as it was being screwed into the furcation bone, and in its final, angled position. The evidence was persuasive that the operative and post-operative radiographs were sufficient to assess the final position of the placed implant. The evidence was not clear and convincing that Respondent failed to obtain a post-operative radiograph to assess the final position of the placed implant.

51. After the implant was placed, Patient I.D. was advised that the implant had gone in at an angle, but that the implant was restorable. Patient I.D. was given the option of having the implant removed, but she declined and left with the implant in place.

52. A surgical follow-up was scheduled for December 18, 2017. However, Patient I.D.'s husband was upset at the outcome, and appeared at Respondent's practice the next day, December 12, 2017, to obtain Patient I.D.'s file, including radiographs.

53. Patient I.D. returned to Respondent's practice on December 18, 2017. Due to disagreements arising at that time that are unrelated to allegations in the Administrative Complaint, no further work was performed on Patient I.D.'s implant.

54. Patient I.D. subsequently had the implant removed by Dr. Obeid. Dr. Obeid did not testify, and his records were insufficient to establish that

Respondent's placement of the implant to replace in Patient I.D.'s tooth 19 violated any dental standard of care.

Records

55. The records created and maintained by Respondent for Patient I.D. were complete but for two items.

56. First, Respondent's medical history for Patient I.D. did not include the prescription medications being taken by Patient I.D. However, the medical history form was filled out by Patient I.D., not Respondent. Though Respondent could have asked Patient I.D. whether she meant to leave the prescription medication question blank, or whether it was an oversight, the question was not asked. Nonetheless, Petitioner did not allege Respondent's medication history as a violation of any applicable standard in the Administrative Complaint. Therefore, it cannot form the basis for a violation of the statutes or rules cited in Count Two.

57. The second deficiency in the records, and the only deficiency pled as a violation, was Respondent's failure to record the edentulous bone measurements derived from her palpation of Patient I.D.'s posterior mandible, and the measurements derived from a calibrated dental probe.

58. Although the evidence established that Respondent had sufficient information of the edentulous site in the area of tooth 19 to ascertain that Patient I.D. was a candidate for an implant before she placed the implant in that area, including both physical measurements and radiographic images, she did not record those physical measurements in Patient I.D.'s dental records.

59. The purpose of dental records is to provide successor dentists with the information necessary to recreate the conditions. In general, one should put in as much detail as one can to facilitate that need. Each of the witnesses acknowledged that it would be impossible to write down everything that happens during a patient's appointment. However, each acknowledged the importance and usefulness of the transference of information. The evidence

was persuasive that information as fundamental and critical to the decision-making process as examination results, including the measurement of the implant placement site, is information necessary to recreate the pre-operative conditions of a patient, and should have been included in the dental records for Patient I.D.

60. The Department proved by clear and convincing evidence that Respondent failed to meet the applicable dental standard of care by failing to document the measurements of Patient I.D.'s edentulous site in the area of tooth 19, although such measurements were taken prior to placing an implant in that area.

CONCLUSIONS OF LAW

A. Jurisdiction

61. DOAH has jurisdiction over the parties and the subject matter of this proceeding. §§ 456.073(5), 120.569, and 120.57(1), Fla. Stat. (2020).

62. The Department is the agency of the state of Florida charged with the authority to regulate the practice of dentistry pursuant to section 20.43, and chapters 456 and 466, Florida Statutes, and to investigate disciplinary matters and file administrative complaints charging violations of the laws governing dentists pursuant to section 456.073.

B. Standards

63. This proceeding is governed by the standards in effect at the time the alleged violations occurred. The administrative complaint alleges violations of sections 466.028(1)(m), (x), and (mm) that occurred from November 27 to December 11, 2017. Section 466.028 was most recently amended in 2017, before the alleged violation (Ch. 2017-41, § 17, Laws of Fla.).

64. Sections 466.028(1)(m), (x), and (mm) provided, at all relevant times and in pertinent part, that:

> (1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):
>
> * * *
>
> (m) Failing to keep written dental records and medical history records justifying the course of treatment of the patient including, but not limited to, patient histories, examination results, test results, and X rays, if taken.
>
> * * *
>
> (x) Being guilty of incompetence or negligence by failing to meet the minimum standards of performance in diagnosis and treatment when measured against generally prevailing peer performance. ...
>
> * * *
>
> (mm) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

65. Rule 64B5-17.002, which was last amended on April 17, 2016, provides, in pertinent part, that:

> A dentist shall maintain patient dental records in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken.
>
> (1) Dental Record: The dental record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, ... examination results....

C. Burden and Standard of Proof

66. The scope of review in this case is *de novo*. § 120.57(1)(k), Fla. Stat.

67. The Department bears the burden of proving the specific allegations that support the charges alleged in the Administrative Complaint by clear and convincing evidence. *Dep't of Banking & Fin., Div. of Sec. & Inv. Prot. v. Osborne Stern & Co.*, 670 So. 2d 932 (Fla. 1996); *Ferris v. Turlington*, 510 So. 2d 292 (Fla. 1987); *Fox v. Dep't of Health*, 994 So. 2d 416 (Fla. 1st DCA 2008); *Pou v. Dep't of Ins. & Treasurer*, 707 So. 2d 941 (Fla. 3d DCA 1998).

68. 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). The clear and convincing evidence level of proof:

> [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.
>
> > Clear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

In re Davey, 645 So. 2d 398, 404 (Fla. 1994) (quoting, 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. 1st DCA 1991).

69. A proceeding to suspend, revoke, or impose other discipline upon a license is penal in nature. *State ex rel. Vining v. Fla. Real Estate Comm'n*, 281 So. 2d 487, 491 (Fla. 1973). Penal statutes must be construed in terms of their literal meaning and words used by the Legislature may not be expanded to broaden the application of such statutes. Thus, the provisions of law upon which this disciplinary action has been brought must be strictly construed, with any ambiguity construed against Petitioner. *Elmariah v. Dep't of Bus. & Prof'l Reg.*, 574 So. 2d 164, 165 (Fla. 1st DCA 1990); *see also Griffis v. Fish & Wildlife Conserv. Comm'n*, 57 So. 3d 929, 931 (Fla. 1st DCA 2011); *Beckett v. Dep't of Fin. Servs.*, 982 So. 2d 94, 100 (Fla. 1st DCA 2008); *Whitaker v. Dep't of Ins.*, 680 So. 2d 528, 531 (Fla. 1st DCA 1996); *Dyer v. Dep't of Ins. & Treasurer*, 585 So. 2d 1009, 1013 (Fla. 1st DCA 1991).

70. The allegations of fact set forth in the administrative complaint are the grounds upon which these proceedings are predicated. *Trevisani v. Dep't of Health*, 908 So. 2d 1108, 1109 (Fla. 1st DCA 2005); *see also Christian v. Dep't of Health, Bd. of Chiropractic Med.*, 161 So. 3d 416, 417 (Fla. 2d DCA 2014)("Section 120.60(5), Florida Statutes (2005), requires that an administrative complaint must afford 'reasonable notice to the licensee of facts or conduct which warrant the intended action.'"); *Cottrill v. Dep't of Ins.*, 685 So. 2d 1371, 1372 (Fla. 1st DCA 1996)("Predicating disciplinary action against a licensee on conduct never alleged in an administrative complaint ... violates the Administrative Procedure Act."). Thus, the scope of this proceeding is properly restricted to those matters as framed by Petitioner. *M.H. v. Dep't of Child. & Fam. Servs.*, 977 So. 2d 755, 763 (Fla. 2d DCA 2008)("At the administrative hearing, the ALJ properly restricted his consideration of the matter to the specific question that DCF itself had framed as the issue to be decided.").

71. The violations alleged in Count One are "standard of care" violations related to deficiencies in Respondent's diagnosis and treatment of Patient

I.D. as measured against generally prevailing peer performance under section 466.028(1)(x).

72. The violation alleged in Count Two is not a "standard of care" violation, but is a simple and straight-forward recordkeeping violation under section 466.028(1)(m). *See Barr v. Dep't of Health, Bd. of Dentistry*, 954 So. 2d 668, 669 (Fla. 1st DCA 2007)("We believe there is a significant difference between improperly diagnosing a patient, which constitutes a subsection (x) [standard of performance] violation, and properly diagnosing a patient, yet failing to properly document the actions taken on the patient's chart, which constitutes a subsection (m) [recordkeeping] violation."); *see also Dep't of Health, Bd. of Med. v. Jose Suarez-Diaz*, Case No. 07-0096PL, RO at ¶¶ 46-48 (Fla. DOAH Mar. 13, 2008; Fla. DOH June 19, 2008)("As to whether Dr. Suarez-Diaz violated the Standard of Care simply because of his failure to keep adequate medical records, this allegation is inadequate as a matter of law to support a Standard of Care violation. ... The rationale of the *Barr* decision applies equally to this case, to the extent that the Department has alleged that Dr. Suarez-Diaz violated the Standard of Care based solely on his inadequate record keeping. Neither the law, nor the facts, support this allegation.") Thus, the issue for determination in Count Two is not whether the records at issue meet generally prevailing peer performance, but whether the records, under a *de novo* review, contain sufficient detail to document the course and results of treatment accurately, including examination results.

D. Analysis

73. The Administrative Complaint, Count One, alleged that Respondent failed to meet the minimum standards of performance in diagnosis and treatment when she failed to utilize an appropriately sized implant by placing an implant which was too small for Patient I.D.'s ridge, in violation of section 466.028(1)(x). As set forth in the Findings of Fact herein, the Department failed to meet its burden to establish, by clear and convincing evidence, that Respondent violated the standard of performance as alleged.

74. The Administrative Complaint, Count One, alleged that Respondent failed to meet the minimum standards of performance in diagnosis and treatment when she failed to place the implant in the correct location by placing the implant in the distal root socket in the area of tooth 19 and, therefore, too far from adjacent tooth 20, in violation of section 466.028(1)(x). As set forth in the Findings of Fact herein, the Department failed to meet its burden to establish, by clear and convincing evidence, that, under the circumstances, Respondent violated the standard of performance as alleged.

75. The Administrative Complaint, Count One, alleged that Respondent failed to meet the minimum standards of performance in diagnosis and treatment when she failed to place the implant at an angle that would allow the implant to be restored and/or limit stress on the implant by placing the implant at a high angle, in violation of section 466.028(1)(x). As set forth in the Findings of Fact herein, the Department failed to meet its burden to establish, by clear and convincing evidence, that, under the circumstances, Respondent violated the standard of performance as alleged.

76. The Administrative Complaint, Count One, alleged that Respondent failed to meet the minimum standards of performance in diagnosis and treatment when she failed to obtain a post-operative radiograph to assess the final position of the placed implant, in violation of section 466.028(1)(x). As set forth in the Findings of Fact herein, the Department failed to meet its burden to establish, by clear and convincing evidence, that Respondent violated the standard of performance as alleged.

77. The Administrative Complaint, Count Two, also alleged that Respondent failed to keep written dental and medical history records to document the measurements of Patient I.D.'s edentulous site in the area of tooth 19, in violation of section 466.028(1)(m) and (mm), and rule 64B5-17.002(1). As set forth in the Findings of Fact herein, the Department met its burden to establish, by clear and convincing evidence, that Respondent failed to record the results of her physical palpation and measurement of Patient

I.D.'s edentulous site in the area of tooth 19, although the evidence established that such measurements were made prior to placing an implant in that area.

E. Penalty

78. Pursuant to section 456.072(2), the Board of Dentistry may impose one or more of the following penalties: suspension or permanent revocation of a license; restriction of practice or license; imposition of an administrative fine; issuance of a reprimand or letter of concern; placement of the licensee on probation for a period of time; corrective action; refund of fees billed and collected from a patient; and remedial education.

79. Florida Administrative Code Rule 64B5-13.005 establishes the range of penalties against an existing license for violations of section 466.028. The disciplinary guidelines in effect at the time of the violations are those to be applied. Therefore, the version of rule 64B5-13.005 that became effective on April 25, 2017, are applied here.

Section 466.028(1)(m)

80. Rule 64B5-13.005(1)(m) establishes the range of penalties against an existing license for a first offense of section 466.028(1)(m) as a minimum of a $500 fine, to probation with conditions and a $7,500 fine.

Section 466.028(1)(x)

81. Rule 64B5-13.005(1)(x) establishes the range of penalties against an existing license for a first offense of section 466.028(1)(x) as a minimum of a $500 fine, to probation with conditions and a $10,000 fine.

Section 466.028(1)(mm)

82. Rule 64B5-13.005(1)(*ll*) establishes the penalty against an existing license for a first offense of section 466.028(1)(mm), including any violation of chapter 466 or any rule adopted pursuant thereto, as a minimum of a $750 fine, to probation with conditions and a $10,000 fine.

Aggravating and Mitigating Factors

83. Rule 64B5-13.005(2) establishes aggravating and mitigating circumstances, which may be applied when a deviation from the recommended penalty is warranted. Given the broad penalty range, deviation is not necessary. Nonetheless, it should be noted that for the only violation proven, i.e., the failure to record the measurements of Patient I.D.'s edentulous site in the area of tooth 19, those measurements were actually taken and used in the decisions leading to the placement of the implant. That, in addition to the lack of previous discipline against Respondent over her years of practice, would allow for consideration of the following mitigating factors identified in rule 64B5-13.005(2):

(a) The danger to the public -- None;

(b) The number of specific offenses, other than the offense for which the licensee is being punished -- None;

(c) Prior discipline that has been imposed on the licensee -- None;

(d) The length of time the licensee has practiced -- D.M.D. conferred 2006; and

(e) The actual damage, physical or otherwise, caused by the violation -- None.

84. The violations of section 466.028(1)(m) and (mm), and rule 64B5-17.002(1), arise from a single act, i.e., failure to record the physical examination of Patient I.D.'s edentulous site in the area of tooth 19. Separate penalties calculated under both subsections 466.028(1)(m) and (mm) for that violation is not warranted.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Department of Health, Board of Dentistry, enter a Final Order:

a) Dismissing Count I of the Administrative Complaint;

b) Determining that Respondent failed to document the physical measurements of Patient I.D.'s edentulous site in the area of tooth 19; and

c) Imposing an administrative fine of $750.

DONE AND ENTERED this 22nd day of December, 2020, in Tallahassee, Leon County, Florida.

E. GARY EARLY
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 22nd day of December, 2020.

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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.