GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION AND LICENSING ADMINISTRATION
BOARD OF DENTISTRY

In Re:	**:**
	:
Allena Willis, D.D.S.	**:**
	:
License No.: DEN1000484	**:**
	:
Respondent	**:**

ORDER REVOKING LICENSE

Jurisdiction

This matter comes before the District of Columbia Board of Dentistry (the "Board") pursuant to D.C. Official Code § 3-1201.01 *ff.*, otherwise known as the Health Occupations Revision Act (the "HORA"). The HORA, at D.C. Official Code § 3-1202.01(b), authorizes the Board to regulate the practice of dentistry in the District of Columbia.

Background

On or about July 21, 2022, the Board issued a Notice of Intent to Take Disciplinary Action against Respondent's dental license ("the Notice"). The Notice charged the Respondent with the following:

> **Charge I: You violated your negotiated settlement with the Board, in violation of D.C. Code § 3-1205.14(a)(27), for which the Board may take the proposed action under D.C. Code § 3-1205.14(c).**
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> **Charge II: You willfully practiced dentistry with an unauthorized person, in violation of D.C. Code § 3-1205.14(a)(12), for which the Board may take the proposed action under D.C. Code§ 3-1205.14(c).**
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> **Charge III: You discontinued treatment for your patients without providing notice and an opportunity to obtain services from another dentist, in violation of 17 DMCR § 4213.25, for which the Board may take the proposed action under D.C. Code §§ 3-1205.14(a)(25) and (c).**

Charge IV: You closed your practice without notifying your patients of the ceasing operation or how to obtain complete dental files, in violation of 17 DMCR § 4213.63, for which the Board may take the proposed action under D.C. Code §§ 3-1205.14(a)(25) and (c).

Charge V: You failed to protect the confidentiality of your patient records, in violation of 17 DCMR § 4213.8, for which the Board may take the proposed action under D.C. Code §§ 3-1205.14(a)(25) and (c).

Charge VI: You failed to adequately maintain medical records, in violation of 17 DCMR § 4213.4, for which the Board may take the proposed action under D.C. Code §§ 3-1205.14(a)(25) and (c).

Charge VII: You failed to cooperate in an investigation by failing to respond to two subpoenas served by the Board, in violation of D.C. Code § 3-1205.14(a)(42), for which the Board may take the proposed action under D.C. Code § 3-1205.14(c).

Charge VIII: You financially exploited your patients, in violation of D.C. Code § 3-1205.14(a)(51), for which the Board may take the proposed action under D.C. Code § 3-1205.14(c).

In accordance with Title 17 DCMR § 4105.2(c), the Notice was mailed on or about July 25, 2022, by U.S. Postal Service Certified Mail, return receipt requested, to both of Respondent's mailing addresses on file with or known to the Board. The Post Office records show the Notice mailed to Respondent's Washington, D.C. address was "Delivered, Left with Individual" on August 1, 2022, at 3:26pm. The Notice mailed to Respondent's Arkansas address[1], was unable to be delivered, the Postal Service tracking documented on August 2, 2022, that the Forwarding Order was expired. The mail was sent for return to the Board and documented as having arrived at a Washington, DC distribution center on August 11, 2022. However, the last entry in the USPS tracking system on August 15, 2022, was "In Transit to Next Facility." Pursuant to Title 17 DCMR § 4105.5, the Respondent was deemed served on August 1, 2022. The Notice

[1] The address on the certified mail receipt record, and presumably the envelope, incorrectly identified the state abbreviation as "AZ" instead of "AR". However, the correct zip code was documented on the mail receipt. The post office tracking records confirm that the mail was correctly sent to Fort Smith, Arkansas.

informed Respondent that she had the right to request a hearing within twenty (20) days of receiving service of the Notice. The Respondent did not request a hearing in the time allotted.

Investigative Findings of Fact

Based upon the content of the Board's file in this matter, the Board hereby makes the following findings of fact:

1. Respondent was issued a dentist license in the District of Columbia on July 19, 2005, and maintained an active District of Columbia dentist license until June 1, 2019.

2. On May 28, 2019, The Board issued an Order Approving Joint Settlement Proposal and Issuance of Consent Order adopting the negotiated Joint Settlement Proposal (the "Consent Order") Respondent entered into with the Board.

3. Under the Consent Order, effective June 1, 2019, the Respondent's District of Columbia dental license was suspended for eighteen (18) months, Respondent was required to pay a fine in the amount of thirteen thousand dollars ($13,000.00) within 120 days from June 1, 2019, and Respondent's dental license was placed on probation for (4) years,

4. Under the Consent Order, Respondent was required to serve six (6) months active suspension beginning June 1, 2019, with the remaining 12 months to be stayed pending successful completion of her period of probation.

5. After being contacted by one of Respondent's patients who stated that they needed a follow-up for orthodontic treatment but was told by Respondent's office that Respondent was on a leave of absence, the Board inquired of the Respondent as to who was treating Respondent's patients during her suspension.

6. The Respondent replied by email on July 17, 2019, and wrote, "Good afternoon. I have several doctors for emergency care and [Dentist A] is covering on specific days for routine care. For now, I've explained the software is being changed. A mass email was sent out regarding this fact. I also explained that the patient can receive a copy of the records by email. It takes a week to gather documents. My hands are tied otherwise, Best, [Respondent]."

7. The Respondent was requested to provide a copy of the mass email that she asserted she provided to her patients.

8. The Respondent did not provide a copy of the email as requested. Instead, the Respondent replied on that same date writing, "It's ironic that the board seems to have done more harm than good in this situation."

9. Later that same evening, the Respondent wrote, "Your efforts to punish me for unintentionally breaking the rules for medical marijuana has left more than 500 children and 400 adults without continued care for orthodontics because this is not feasible…"

10. On July 18, 2019, the Respondent was asked to clarify whether she arranged for coverage for her patients during her six-month active suspension and for a copy of the email she stated that she sent to her patients.

11. The Respondent replied on July 22, 2019, writing, "I have taken all the steps to cover for my patients, but no one loves and cares for your patients the way you do. Patients feel that. They feel vulnerable. So even though all of these things have been done, repeated emails, placing an associate there part-time, having several collegians [sic] cover, they feel vulnerable and viruses [sic] right now. The way people are reacting is emotional. So, it's time for all hands on deck to be sure my patients feel safe, Carla.'

12. The Board received a new complaint against the Respondent from Patient #1 on July 24, 2019, which stated that Respondent had been providing Invisalign treatment to Patient #1 and the patient was now having difficulty communicating with Respondent other than by text message, and that the patient had been stuck in the same aligners for three (3) months.

13. Patient #1 stated that Respondent sent text messages to her patients, which had indicated*, inter alia*, that she had decided to sell the practice.

14. The mother of Patient #4 stated to the Board investigator that she and her son went to the Respondent's dental office on July 11, 2019, where her son was scheduled to be examined by the Respondent. She stated that the Respondent and a front desk assistant were present along with a third person who the Respondent told her was a businessperson related to selling her practice.

15. A Board Investigator conducted an unannounced inspection of the Respondent's dental office on July 24, 2019.

16. The investigator arrived at the dental office at approximately 1:00 p.m. The office was open for business. The investigator observed patients in the waiting room, a sign-in sheet with eleven (11) patient names signed in on it, and a patient being taken to an examination room. The investigator observed that the sign-in sheet had several patient names and signatures on it for the time period of 8:30 am to 1:00 p.m. The receptionist told the investigator that the Respondent should be in the office in about ten minutes.

17. The investigator observed a patient being taken to be seated in one of the exam rooms.

18. After the office staff informed the Board investigator that the Respondent was present, the investigator attempted to enter Respondent's office to speak with the Respondent.

19. The Respondent blocked the doorway, refusing the investigator entry and then verbally assaulted the investigator.

20. In response to questioning by the Investigator, Respondent stated, *"I rebuke you [investigator] in Jesus' name"* and called the Investigator *"the devil.*

21. The investigator asked the Respondent who was seeing the patients that day. The Respondent did not answer the question. Instead, the Respondent raised her voice and said repeatedly, while referring to her clothing, "Does this look like I'm in the office practicing!"

22. The Board investigator observed that the Respondent was wearing a white dental jacket with a black work-out sweatpants suit underneath.

23. The Respondent stated that she was cleaning the office.

24. The investigator observed that there were no other dentists in the dental office that day.

25. Both the Respondent and her dental assistant denied that the Respondent was treating patients that day.

26. The exchange between the Respondent and the investigator was interrupted by a staff member who informed the Respondent that one of the male patients in the office was upset because he had been waiting a long time to be seen by the dentist.

27. The Respondent then went to the waiting room and escorted the patient out of the office, stating that she was taking him to be seen by a dentist on the second floor of the building. The dentist located on the second floor subsequently informed the Board investigator that he did not receive any patient referrals from the Respondent.

28. The Board's investigation found that the patient did not receive services that day from any dentist located in the building.

29. The investigator advised the Respondent to notify her patients of her suspension, and to post a notice on the dental office's door identifying the treating dentist who would be providing services during the Respondent's suspension period.

30. The next day the investigator returned to the dental office and observed that the office was closed but there was no notice posted for patients on the front or back doors to inform patients about the closure or how to obtain their dental files.

31. The Board's investigation found that Dentist A began working in the Respondent's dental office in April 2019, once a week, and then worked from June 1, 2019, to July 2019 in the dental office one day per week, and that Dentist A stopped working in the Respondent's dental office after July 24, 2019, because the Respondent informed her that the office was having software issues and was closed.

32. The Board's investigation found that Respondent directly and indirectly provided dental services to patients by phone while her license was suspended.

33. Patients reported having conversations with the Respondent through text messages and Facetime video calls about dental treatments.

34. On June 20, 2019, Respondent communicated with Patient #1 about the patient's Invisalign aligners. The following day, the Respondent had a video call with Patient #1 and advised him which aligner the patient should wear.

35. On July 19, 2019, the Respondent prescribed a new aligner for Patient #1.

36. The Respondent submitted billing to insurance for services provided to Patient #2 on June 1, 2019, and July 1, 2019.

37. The Board investigator interviewed the Respondent's dental assistant, Employee #1, on August 20, 2019. Employee #1's dental assistant registration expired on December 31, 2017. Employee #1 stated that the Respondent knew that the registration was expired.

38. Employee #1 stated that during the period of Respondent's suspension, the Respondent directed Employee #1 to perform dental work on patients without a dentist being in the office.

39. Employee #1 stated that the dental work she performed without a dentist in the office included taking impressions, pouring up the impressions, making retainers, scanning teeth, taking photos, and providing patients' Invisalign trays.

40. Employee #1 stated that the Respondent texted her instructions on how to provide dental care.

41. The Board investigator asked Employee #1 who provided the dental services to the patients that were in the dental office on July 24, 2019. (The date that the investigator made an unannounced office visit.) Employee #1 stated that she provided impressions, made retainers, and gave out trays to the patients. Employee #1 stated that there was no dentist in the office, but the Respondent came in later after the investigator had arrived at the office.

42. Patient #3 confirmed that Employee #1 was often the only individual in the dental office providing care.

43. The Respondent did not notify her patients of her June 1, 2019, licensure suspension.

44. On or about July 15, 2019, Respondent sent a mass email to her patients stating that her office was undergoing software changes and that she would not see patients until further notice while the new system was being implemented.

45. On July 31, 2019, Respondent sent a mass email to her patients that explained that she was taking a break, and that Dentist A. would take over the office.

46. After July 31, 2019, the Respondent left the District of Columbia and moved to Arkansas, closing her District of Columbia dental practice without notifying her patients.

47. Despite her claim that Dentist A was taking over the office, Respondent failed to follow through with making arrangements with another dentist to take over the dental office.

48. By August 14, 2019, the phone line for the Respondent's dental office was disconnected.

49. On July 25th, 2019, and December 13th, 2019, the Respondent was served with subpoenas for patient records. The Respondent failed and refused to produce the patient records.

50. After the Respondent moved to Arkansas, the landlord of the office building where her dental office was located contacted the Board and notified the Board that numerous patient files had been left behind in the Respondent's dental office.

51. On February 21st and 25th, 2020, DC Health investigators took possession of her patients' dental files to protect the records. There were approximately four (4) file cabinets of patient records.

52. The voluminous records taken into possession by DC Health were reviewed for the patient files that were responsive to the subpoenas. Of the fifteen (15) requested patient files, eleven (11) were missing. Of the four (4) files that were included in the records, the relevant dates were missing, or the file folders were empty containing no information.

53. The Board investigator found patient sign-in sheets containing patient names for June 4th, 2019, and July 18th, 2019. None of the files for the patients seen on June 4th were in the patient records, and only some of the files for the patients seen on July 18th were in the patient records.

54. The Respondent was notified by the Board and requested to collect the records, but the Respondent made no attempt to take possession of the records.

55. Respondent failed to secure her office's patient files, and instead left the patient files in her abandoned dental office accessible to the property landlord and other unauthorized individuals.

56. The Board investigation found that Respondent submitted billing claims for dental services in which the Respondent was listed as the provider while her license was actively suspended.

57. The Attorney General's Office of Consumer Protection notified the Board of two (2) complaints it received against the Respondent on or about September 5, 2019.

58. The Attorney General's Office of Consumer Protection notified the Board of a third complaint against Respondent on or about September 10, 2019.

59. The District of Columbia sued Respondent and her dental practice in January 2020 for violating the Consumer Protection Procedures Act (CPPA).

60. On November 20, 2020, the Superior Court of the District of Columbia entered a default judgment against Respondent and her dental practice for violating the CPPA.

61. The Superior Court found that Respondent misrepresented that the dental services would be provided by properly licensed dental professionals, when in fact, the Respondent and her dental assistant lacked valid licenses.

62. The Superior Court found that Respondent obtained thousands of dollars in upfront fees for dental services that they advertised as 'comprehensive' but which they never completed.

63. The Superior Court found that on at least eighty-nine (89) occasions, Respondent made material misrepresentations or omissions to District consumers and received at least $274,234.81 in ill-gotten profits.

64. The Superior Court ordered Respondent to pay $719,234.81 in restitution and civil penalties and enjoined the Respondent for ten (10) years from advertising or providing dental services in the District of Columbia without providing advance notice to the District.

Conclusions of Law

D.C. Official Code § 3-1205.14 provides in pertinent part:

> (a) Each board, subject to the right of a hearing as provided by this subchapter, on an affirmative vote of a majority of a quorum of its appointed members may take one or more of the disciplinary actions provided in subsection (c) of this section against any Applicant,

licensee, or person permitted by this subchapter to practice the health occupation regulated by the board in the District who:

(12) Willfully practices a health occupation with an unauthorized person or aids an unauthorized person in the practice of a health occupation;

(25) Violates any District of Columbia or federal law, regulation, or rule related to the practice of a health profession or drugs, or fails to conduct business with honesty and fair dealing with employees or students in his or her school of nursing or nursing program, the District of Columbia, a state, the federal government, or the public;

(27) Violates an order of the board or the Mayor, or violates a Consent Order or negotiated settlement entered into with a board or the Mayor;

(42) Fails to cooperate in an investigation or obstructs an investigation ordered by a board;

(51) Engages in the financial exploitation of a patient, client, or employer;

(c) Upon determination by the board that an applicant, licensee, registrant, person certified, or person permitted by this subchapter to practice in the District has committed any of the acts described in subsection (a) of this section, the board may:

(1) Deny a license, registration, or certification to any applicant or an application to establish a school of nursing or nursing program;

(2) Revoke or suspend the license, registration, or certification of any licensee, registrant, or person certified or withdraw approval of a school of nursing or nursing program;

(3) Revoke or suspend the privilege to practice in the District of any person permitted by this subchapter to practice in the District;

(4) Reprimand any licensee, registrant, person certified, or person permitted by this subchapter to practice in the District;

(5) Impose a civil fine not to exceed $5,000 for each violation by an applicant, licensee, registrant, person certified, or person permitted by this subchapter to practice in the District;

(6) Require a course of remediation, approved by the board, which may include:

(A) Therapy or treatment;

(B) Retraining;

(C) Reexamination, in the discretion of and in the manner prescribed by the board, after the completion of the course of remediation; and

(D) Require participation in continuing education and professional mentoring.

(7) Require a period of probation; or

(8) Issue a cease and desist order pursuant to § 3-1205.16.

Charge I: Violating the Negotiated Settlement Agreement

Pursuant to the May 28, 2019 Consent Order, the Respondent was required to serve six (6) months active suspension beginning June 1, 2019, with the remaining 12 months to be stayed pending successful completion of her period of probation, the Respondent was required to pay a fine in the amount of thirteen thousand dollars ($13,000.00) within 120 days from June 1, 2019, and the Respondent's dental license was placed on probation for four (4) years.

On July 24, 2019, a Board investigator arrived at the Respondent's dental office at approximately 1:00 p.m. The office was open for business. The investigator observed patients in the waiting room, a sign-in sheet with eleven (11) patient names signed in on it, and a patient being taken to an examination room. The investigator observed that the sign-in sheet had several patient names and signatures on it for the time period of 8:30 am to 1:00 p.m. The receptionist told the investigator that the Respondent should be in the office in about ten minutes.

While she waited for the Respondent to arrive at the dental office, the investigator observed a patient being taken to be seated in one of the exam rooms. Later, after the office staff informed the Board investigator that the Respondent was present, the investigator attempted to enter Respondent's office to speak with the Respondent. The Respondent blocked the doorway, refusing the investigator entry and then verbally assaulted the investigator. In response to questioning by the Investigator, Respondent stated, *"I rebuke you [investigator] in Jesus' name"*

and called the Investigator *"the devil.* The investigator asked the Respondent who was seeing the patients that day. The Respondent did not answer the question. Instead, the Respondent raised her voice and said repeatedly, while referring to her clothing, "Does this look like I'm in the office practicing!" The Board investigator observed that the Respondent was wearing a white dental jacket with a black work-out sweatpants suit underneath. The Respondent stated that she was cleaning the office. The investigator observed that there were no other dentists in the dental office that day.

The Board's investigation found that on July 24, 2019, the Respondent's dental office was open and operating and that patients were being seen in the dental office despite the fact that no dentist was on duty. The investigation found that despite knowing that she was suspended from practicing dentistry for six (6) months, Respondent had only arranged coverage with another dentist for one day a week in her office. The investigation found that while the Respondent's license was actively suspended, the Respondent directly and indirectly provided dental services in the District of Columbia. Specifically, she communicated with her patients regarding treatment over text-messages and through FaceTime video calls. These communications included the Respondent talking with Patient #1 on June 20, 2019, regarding his Invisalign aligners, and the Respondent having a video call with Patient #1 the next day, June 21, 2019, in which she advised Patient #1 which aligners he should wear. Additionally, Respondent prescribed to Patient #1 new aligners on July 19, 2019. The Respondent also submitted billing to insurance for services she provided to Patient #2 on June 1, 2019, and July 1, 2019.

The mother of Patient #4 stated to the Board investigator that she and her son went to the Respondent's dental office on July 11, 2019, where her son was scheduled to be examined by the

Respondent. She stated that the Respondent and a front desk assistant were present along with a third person who the Respondent told her was a businessperson related to selling her practice.

The investigation also found that Respondent indirectly practiced dentistry through her unregistered dental assistant. Respondent's dental assistant, Employee #1 admitted to the Board investigator that during the time that the Respondent's license was actively suspended, the Respondent directed Employee #1 to perform dental work on patients without a dentist being present in the office. Employee #1 stated that the dental procedures she performed at the Respondent's direction without a dentist being present in the office included, taking impressions, pouring up the impressions, making retainers, scanning teeth, taking photos, and providing patients Invisalign trays. Employee #1 stated that the Respondent texted instructions to her as to how to provide the dental care to the patients. Patient #1 confirmed to the Board investigator that Employee #1 was often the only individual in the dental office providing dental care.

Based on the aforementioned, the Board finds that while her dental license was actively suspended, the Respondent directly engaged in the practice of dentistry in the District of Columbia through calls, text messages, and video calls, and indirectly engaged in the practice of dentistry through her dental assistant. The Board finds that the Respondent's actions of practicing dentistry directly and indirectly while her license was actively suspended violated the Consent Order.

Therefore, the Board finds by a preponderance of the evidence and concludes as a matter of law that Respondent violated her negotiated settlement with the Board, in violation of D.C. Code § 3-1205.14(a)(27), for which the Board may take the proposed action under D.C. Code § 3-1205.14(c).

Charge II: Willful Practice of Dentistry with an Unauthorized Person

The findings of fact and conclusions of law made in Charge I are hereby incorporated by reference.

The Respondent's dental assistant, Employee #1's, District of Columbia dental assistant registration expired on December 31, 2017. Employee #1 stated that she began employment in the Respondent's dental office in April 2019 and that the Respondent was aware that her registration was expired and had stated that she would help her get her registration.

Pursuant to 17 DCMR § 9001.1, no person is permitted to perform dental assisting duties in the District of Columbia without a registration issued by the Board. Further, pursuant to D.C. Official Code § 3-1205.13(a)(1), all licensees and registrants are required to display their license or registration conspicuously in their place of business or employment.

Employee #1 stated that the Respondent knew that her dental assistant registration was expired. Additionally, since Employee #1's dental assistant registration was already expired when the Respondent hired her, the Board finds that the Respondent either knew that the registration was expired when she hired her or the Respondent failed to confirm that Employee #1 had a valid registration. Therefore, based upon Employee #1's statement as well as the Respondent's obligation to ensure that her dental assistant had a valid registration, the Board finds that Respondent knew, or at a minimum should have known, that the registration was expired.

The Board's investigation found that after the Respondent's suspension took effect, the Respondent directed Employee #1 to perform dental work on patients without a dentist being present in the office. Employee #1 stated that the dental procedures she performed at the Respondent's direction without a dentist being present in the office included, taking impressions,

pouring up the impressions, making retainers, scanning teeth, taking photos, and providing patients Invisalign trays. Employee #1 stated that the Respondent texted instructions to her as to how to provide the dental care to the patients. Patient #1 confirmed to the Board investigator that Employee #1 was often the only individual in the dental office providing dental care. In a written statement, Employee #1 wrote, "The days that the office was closed I was instructed by [Respondent] by text messages what to do on the patients. Those patients would come in for emergencies and some would come in for trays from Invisalign. Once [Board investigator] came in the office, I immediately stopped seeing patients. This was July 24th."

Based upon the aforementioned, the Board finds that the Respondent employed a dental assistant while knowing that the dental assistant's registration was expired, and that the Respondent directed that dental assistant to perform dental assisting duties. Further, the Respondent directed the unregistered dental assistant to engage in the practice of dental assisting without a dentist present in the office in violation of the District's law that requires dental assistants to work under the direct supervision of a licensed dentist, which by definition requires the dentist to be onsite, personally diagnose the condition to be treated, and to review and evaluate the dental assistant's work before dismissing the patient[2].

Therefore, the Board finds by a preponderance of the evidence and concludes as a matter of law that the Respondent willfully practiced dentistry with an unauthorized person in violation of D.C. Official Code § 3-1205.14 (a)(12), for which the Board can take the proposed action pursuant to D.C. Official Code § 3-1205.14(c).

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[2] *See*, Definition of Direct supervision, 17 DCMR § 9099.1.

Charge III: Discontinuation of Treatment for Patients Without Adequate Notice

Charge IV: Failure to Communicate Closure and File Retrieval Process for Patients

The findings of fact and conclusions of law made in Charges I and II are hereby incorporated by reference.

As set forth in the findings of fact, the Respondent entered into a Consent Order in which she agreed that her District of Columbia dental license would be suspended for six (6) months beginning June 1, 2019. Despite being aware that she would be prohibited from practicing dentistry and treating her patients during this six (6) month period, the Respondent only arranged for another dentist to cover her practice for one (1) day per week. Additionally, instead of telling her patients the truth, that her license was suspended for six (6) months, the Respondent told her patients that the office was updating its software, and that she was suffering from a disability, and gave a range of other excuses leaving patients confused and in the dark as to when, how, and if they would receive the dental services they needed and in most cases had already paid for in advance.

Further, instead of arranging for a District of Columbia licensed dentist to fully cover her practice during the period of suspension, the Respondent directed her unregistered dental assistant through text messages regarding how to perform the dental services for the patients.

On July 24, 2019, a Board investigator conducted an unannounced visit to the office and found it open and seeing patients without a dentist being present in the office. The Respondent was instructed to notify her patients of her suspension, and to post a notice on the dental office's door identifying the treating dentist who would be providing services during the Respondent's

suspension period. However, when the investigator returned to the dental office the next day, the investigator observed that the office was closed, but there was no notice posted for patients on the front or back doors to inform patients about the closure or how to obtain their dental files.

On or about July 15, 2019, Respondent sent a mass email to her patients stating that her office was undergoing software changes and that she would not see patients until further notice while the new system was being implemented. The email provided a telephone number to call for emergencies, however, that number was disconnected.

On July 31, 2019, Respondent sent a mass email to her patients that explained that she was taking a break, and that Dentist A. would take over the office. However, Dentist A never took over the office, and after July 31, 2019, the Respondent left the District of Columbia and moved to Arkansas, closing her District of Columbia dental practice without notifying her patients. By August 14, 2019, the phone line for the Respondent's dental office was disconnected.

The Board and the District of Columbia Office of the Attorney General received numerous patient complaints from the Respondent's patients about treatments suspended midway through treatment, inability to contact the Respondent or any agent of the office about the patient's care or to schedule appointments, or to receive reimbursement for services paid for but not provided. Patients who had already paid for their treatment upfront, had to ultimately incur additional expenses to have the treatment provided by other dentists due to the Respondent failing to reimburse the fees that had already been paid to her for the services she failed to provide.

17 DCMR § 4213.25 mandates that:

> "Once a dentist has undertaken a course of treatment to provide services to a patient, the dentist shall not discontinue that treatment without first giving the patient adequate notice

and the opportunity to obtain the services of another dentist and ensuring that the patient's oral health will not be jeopardized in the process."

17 DCMR § 4213.63(a)-(b) states:

"Whenever an entire dental practice or office moves to a new location or ceases operation, the owner or responsible dentist shall not later than 30 days after the change or closing:

(a) Notify the patients of the change of address or closing by U.S. Mail, a note posted conspicuously on the door of the office that is closing for at least 30 consecutive days, telephone message on the office number activated for at least 30 consecutive days, or any combination of the above; and

(b) Notify the patients as to how they may obtain copies of their complete dental files, radiographs, and models, by any of the means set forth in subparagraph (a)."

On or about July 15, 2019, Respondent sent a mass email to her patients stating that her office was undergoing software changes and that she would not see patients until further notice while the new system was being implemented. After being contacted by one of Respondent's patients who stated that they needed a follow-up for orthodontic treatment but was told by Respondent's office that Respondent was on a leave of absence, the Board inquired of the Respondent as to who was treating Respondent's patients during her suspension. The Respondent replied by email on July 17, 2019, and wrote, "Good afternoon. I have several doctors for emergency care and [Dentist A] is covering on specific days for routine care. For now, I've explained the software is being changed. A mass email was sent out regarding this fact. I also explained that the patient can receive a copy of the records by email. It takes a week to gather documents. My hands are tied otherwise, Best, [Respondent]."

The Respondent was requested to provide a copy of the mass email that she asserted she provided to her patients. The Respondent did not provide a copy of the email as requested. Instead, the Respondent replied on that same date writing, "It's ironic that the board seems to

have done more harm than good in this situation." Later that same evening, the Respondent wrote, "Your efforts to punish me for unintentionally breaking the rules for medical marijuana has left more than 500 children and 400 adults without continued care for orthodontics because this is not feasible…"

On July 18, 2019, the Respondent was asked to clarify whether she arranged for coverage for her patients during her six-month active suspension and for a copy of the email she stated that she sent to her patients. The Respondent replied on July 22, 2019, writing, "I have taken all the steps to cover for my patients, but no one loves and cares for your patients the way you do. Patients feel that. They feel vulnerable. So even though all of these things have been done, repeated emails, placing an associate there part-time, having several collegians [sic] cover, they feel vulnerable and viruses right now. The way people are reacting is emotional. So, it's time for all hands on deck to be sure my patients feel safe, Carla."

On July 31, 2019, Respondent sent a mass email to her patients that explained that she was taking a break, and that Dentist A. would take over the office. After July 31, 2019, the Respondent left the District of Columbia and moved to Arkansas, closing her District of Columbia dental practice without notifying her patients.

Despite her claim that Dentist A was taking over the office, Respondent failed to follow through with making arrangements with another dentist to take over the dental office. By August 14, 2019, the phone line for the Respondent's dental office was disconnected.

Respondent failed to secure her office's patient files, and instead left the patient files in her abandoned dental office accessible to the property landlord and other unauthorized individuals. On February 21st and 25th, 2020, DC Health investigators took possession of her patients' dental files after receiving notice from the landlord that the records had been left in the

abandoned dental office. There were approximately four (4) file cabinets of patient records. The Respondent was notified by the Board and requested to collect the records, but the Respondent made no attempt to take possession of the records.

The Respondent left the District of Columbia and closed her practice without notifying her patients and securing the necessary arrangements for another dentist to continue office operations. Numerous former patients submitted complaints that their treatments were suspended mid-treatment and that they could not contact Respondent or office staff regarding care and appointments.

The Respondent sent two mass emails to her patients before she closed her dental office and moved to Arkansas. Neither email met the requirements of 17 DCMR § 4213.63(a)-(b).

On or about July 15, 2019, the Respondent sent an email to her patients that stated the office was performing a new software change during the month of July and that the Respondent would not be seeing patients until further notice when the new system is operating. The email stated that for emergency visits only the patients should call the provided telephone number.

Two weeks later, on July 31, 2019, the Respondent sent a second email to her patients. In the email she stated that she was on disability and that she had decided to sell the practice. Then after writing a host of personal information about herself, the Respondent stated that Dentist A was taking ownership of the office and that she would begin seeing patients again in August. The Respondent further stated that she was taking a break but that she would return to help "you guys" in the near future.

However, Dentist A told the Board investigator that she cut off ties with the Respondent on July 24th. After sending the email on July 31st, the Respondent subsequently left town and moved to Arkansas. No dentist purchased her practice or resumed treatment of her patients in that

dental office. By August 14th, the telephone number to the Respondent's dental office was disconnected.

The Board finds that neither the July 15th nor July 31st email gave the Respondent's patients adequate notice that dental treatment in her office would be discontinued, the opportunity to obtain the services of another dentist, or ensured that the patient's oral health would not be jeopardized. In neither email did the Respondent tell her patients that her District of Columbia dental license had been suspended and that she could not practice dentistry for six (6) months. Instead, she said the office was updating its software and that the software change was the reason she had to cease treatment until further notice. Then two weeks later, she stated that she was selling her dental practice, and that another dentist was taking ownership of the office and would resume services in August. However, on or about the next day she left town. The dental office remained closed, and no new dentist took ownership or resumed services. By August 9th the office phone was disconnected leaving all of the Respondent's patients in the midst of treatment without any means to obtain their records or refunds for services paid for but not provided.

It is noted that the July 15th email addressed emergency visits. However, many if not most of the Respondent's patients were receiving Invisalign treatment. The Board is aware based upon the education, training, and experience of its dentist members, that as part of routine dental care, the Respondent's patients would need to be scanned and examined to receive their new trays, and that leaving patients in the same tray for an extended period of time is not within the intended use of the Invisalign product.

Further, neither email provided a mechanism for the patients to obtain their dental records and a refund of the fees already paid for services not yet rendered. Moreover, the emails left the patients in limbo as they did not state that the practice was closing. Both emails led the patients

to believe that the dental services would be resumed in August. Even after the Respondent left town and completely closed her dental practice, the Respondent still failed to post notices about the closure of the office or notify her patients that the office had in fact been closed.

The Board further finds that the Respondent failed to comply with the requirements of 17 DCMR § 4213.63(a) and (b). The Respondent failed to within thirty (30) days of closing her dental office notify her patients that the office permanently closed, and failed to notify her patients how to obtain copies of the complete dental files, radiographs, models.

Based upon the aforementioned, the Board finds that the Respondent closed her practice without appropriately notifying her patients of the date that she was ceasing operations, and of how to obtain their dental files. The Board finds that the Respondent led her patients to believe that the office would continue operations under Dentist A when the Respondent knew or should have known that she did not have a contact of sale in place with Dentist A, and that the Respondent closed the office and left town without leaving valid contact information for patients to reach her or a representative. The Board finds that the Respondents actions left patients unable to obtain their records, unable to complete treatment for the fees already paid, and caused patients delay in treatment, and to incur additional expenses seeking treatment from other dental providers for services that had already been paid to the Respondent and for which the Respondent failed to reimburse the patients after she abandoned them and left town.

Therefore, the Board finds by a preponderance of the evidence and concludes as a matter of law that the Respondent discontinued treatment for her patients without providing notice and an opportunity to receive services from another dentist in violation of 17 DCMR § 4213.25 for which the Board can take the proposed action pursuant to D.C. Code § 3-1205.14(a)(25) and (c).

The Board also finds by a preponderance of the evidence and concludes as a matter of law that the Respondent closed her practice without notifying her patients of the ceasing operation or how to obtain complete dental files in violation of 17 DCMR § 4213.63, for which the Board can take the proposed action pursuant to D.C. Code § 3-1205.14(a)(25) and (c).

Charge V: Failure to Protect Confidentiality of Patient Records

17 DCMR § 4213.8, states, "A dentist shall protect the confidentiality of patient records and maintain patient records in a manner consistent with the protection of the welfare of the patient and all applicable District of Columbia and federal laws."

After the Respondent moved to Arkansas, the landlord of the office building where her dental office was located contacted the Board and notified the Board that numerous patients files had been left behind in the Respondent's dental office. On February 21st and 25th, 2020, DC Health investigators took possession of the Respondent's patients' dental files after receiving notice from the Respondent's landlord that the patient records had been left in the abandoned dental office. The Investigators found patient files and records in unlocked file cabinets. There were approximately four (4) file cabinets of patient records. The Respondent was notified by the Board and requested to collect the records, but the Respondent made no attempt to take possession of the records. The voluminous records taken into possession by DC Health were reviewed for the patient files that were responsive to the subpoenas. Of the fifteen (15) requested patient files, eleven (11) were missing. Of the four (4) files that were included in the records, the relevant dates were missing, or the file folders were empty containing no information. The Board investigator found patient sign-in sheets containing patient names for

June 4th, 2019, and July 18th, 2019. None of the files for the patients seen on June 4th were in the patient records, and only some of the files for the patients seen on July 18th, 2019, were in the patient records.

The Respondent failed to secure her office's patient files, and instead left the patient files in her abandoned dental office unlocked and accessible to the property landlord and other unauthorized individuals. The Board finds that by leaving patients' dental records in unlocked file cabinets after she closed and abandoned her office, which her landlord continued to have access to and in fact subsequently did access the office and found the abandoned patient files, the Respondent compromised patient confidentiality. The Board further notes that it was the building landlord that undertook efforts to safeguard the patient files by contacting the Board. The Board finds that the Respondent demonstrated complete disregard for the confidentiality and safekeeping of the patient records. She utterly did not care what happened to them. Further, even after the Board notified her that that DC Health had taken possession of the files for safekeeping and directed her to make arrangements to collect the records, the Respondent failed and refused to respond or to take possession of the records again.

Therefore, the Board finds by a preponderance of the evidence and concludes as a matter of law that the Respondent failed to protect the confidentiality of her patients' records in violation of 17 DCMR § 4213.8, for which the Board can take the proposed action pursuant to D.C. Official Code § 3-1205.14(a)(25) and (c).

<u>Charge VI: Failure to Adequately Maintain Medical Records</u>

The findings of fact and conclusions of law made in Charges I-V are hereby incorporated by reference.

17 DCMR § 4213.4. states:

"A dentist shall maintain a record for each patient which shall:

(a) Accurately reflect the evaluation and treatment of the patient and which may include the following:

(1) Patient's name and the date of treatment;
(2) Updated health history;
(3) Treatment plan;
(4) Informed consent document(s);
(5) Clinical findings, diagnosis and treatment rendered;
(6) List of drugs prescribed, administered, dispensed and the quantity;
(7) Radiographs;
(8) Patient financial/billing records;
(9) Name of dentist and/or dental hygienist providing service(s); and
(10) Laboratory work orders; and

(b) Be kept for three (3) years after last seeing the patient or three (3) years after a minor patient reaches eighteen (18) years of age."

Before DC Health took possession of the Respondent's patient records for safekeeping, the Respondent was issued subpoenas for office records and patient records on July 25, 2019, and December 13, 2019. The Respondent failed to produce any records in response to the subpoenas.

After DC Health took possession of the Respondent's patient records, the records were reviewed for the documents responsive to the subpoenas. However, among fifteen (15) patients, the Investigator could only locate four (4) of the patient file folders. However, these four (4) file folders contained no information. The Investigator also found patient sign-in sheets for June 4, 2019, and July 18, 2019, but no files associated with the June 4th sign-in sheet, and only some from the July 18th sheet.

Based upon the aforementioned, the Board finds that at least fifteen (15) of the Respondent's patient files were destroyed or went missing, as well as the files for the patients that were listed on the patient sign-in sheet for June 4, 2019, and some of the patients listed on the patient sign-sheet on July 18, 2019.

Therefore, the Board finds by a preponderance of the evidence and concludes as a matter of law that the Respondent failed to adequately maintain medical records, in violation of 17 DCMR § 4213.4, for which the Board may take the proposed action pursuant to D.C. Official Code § 3-1205.14(a)(25) and (c).

Charge VII: Failure to Cooperate in an Investigation

The findings of fact and conclusions of law made in Charges I-VI are hereby incorporated by reference.

The Respondent failed and refused to produce documents in response to the Board's subpoenas issued to her on July 25, 2019, and December 13, 2019. In a telephone communication with the Board's Counsel, the Respondent stated that she was in Arkansas and would provide the requested patient records by sending her external drive to the Board Investigator. However, Respondent never sent the external drive. The Respondent did not provide the records and instead claimed that she had no records of any patients seen on or after June 1, 2019. Her statement was proven untrue by the patient sign-in sheets for June 4, 2019, and July 18, 2019, obtained by the Board Investigator and by numerous patient complaints and statements regarding receiving services from the Respondent after June 1, 2019.

Further, as previously stated, after DC Health took possession of the Respondent's patient records, the records were reviewed for the documents responsive to the subpoenas. However, among fifteen (15) patients, the Investigator could only locate four (4) of the patient file folders. However, these four (4) file folders contained no information. The Investigator also found patient sign-in sheets for June 4, 2019, and July 18, 2019, but no files associated with the June 4th sign-in sheet, and only some from the July 18th sheet.

Based upon the aforementioned, the Board finds that at least fifteen (15) of the Respondent's patient files were destroyed or went missing, as well as the files for the patients that were listed on the patient sign-in sheet for June 4, 2019, and some of the patients listed on the patient sign-sheet on July 18, 2019.

Based upon the aforementioned, the Board finds that after being served with two (2) subpoenas for office and patient records, the Respondent either willfully failed to produce the documents or the Respondent intentionally destroyed the records, which would have proven that she continued practicing dentistry while her license was suspended in violation of the Consent Order.

Therefore, the Board finds by a preponderance of the evidence and concludes as a matter of law that failed to cooperate in a Board investigation in violation of D.C. Code § 3-1205.14(a)(42), for which the Board can take action under D.C. Code § 3-1205.14(c).

Charge VIII: Financial Exploitation of Patients

The findings of fact and conclusions of law made in Charges I-VII are hereby incorporated by reference.

Respondent charged her patients for services not rendered. In January 2020, the District of Columbia Office of the Attorney General sued Respondent and her dental practice for violating the Consumer Protection Procedures Act (CPPA), D.C. Code § 28-3904. On November 20, 2020, the Superior Court of the District of Columbia entered a default judgment against the Respondent and her dental practice for violating the CPPA. Specifically, the Superior Court found that Respondent "(1) misrepresented that their dental services would be provided by properly licensed dental professionals, when in fact [Respondent] and [her] dental assistant

lacked valid licenses; and (2) obtained thousands of dollars in upfront fees for dental services that they advertises [sic] as 'comprehensive' but which they never completed." The Court found that on at least eighty-nine (89) occasions the Respondent made material misrepresentations or omissions to District consumers and received at least $274,234.81 in ill-gotten profits. The Court ordered the Respondent to pay $719,234.81 in restitution and civil penalties and enjoined her for ten years from, among other things, advertising or providing dental services in the District of Columbia without providing advance notice to the District.

Further, as previously discussed, the Respondent left town without notice to her patients, and did not provide her patients with valid contact information or ability to obtain refunds or reimbursement for the fees and charges already paid to her for the services that she left incomplete and unfinished. As such, the patients had to incur additional expenses to have the unfinished dental services performed by other licensed dentists.

Based upon the aforementioned, the Board finds by a preponderance of the evidence and concludes as a matter of law that the Respondent financially exploited her patients in violation of D.C. Code § 3-1205.14(a)(51), for which the Board can take action under D.C. Code § 3-1205.14(c).

Decision

In formulating its decision as to the appropriate sanction to be imposed, the Board took into consideration the nature of the charges and the Board's paramount duty to protect the public.

The Board has found that the Respondent (1) violated the negotiated settlement agreement with the Board, (2) willfully practiced dentistry with an unauthorized person, (3) discontinued treatment for patients without notice and opportunity for alternative arrangements,

(4) closed her practice without notifying her patients of such and how to retrieve their records, (5) compromised the confidentiality of her patient records, (6) failed to adequately maintain her patient records, (7) failed to cooperate in a Board investigation, and (8) financially exploited her patients. The Board finds that any of these charges are sufficient to justify the imposition of the sanction imposed by the Board, separate and apart from the others.

The fundamental purpose of a health licensing board is to protect the public. *See In re Murdter*, 131 A.2d 355, 357 (D.C. 2016). When a violation has been committed, the Board must determine which sanction, or combination of sanctions, will appropriately address, remediate, deter, and protect against future violations. D.C. Official Code § 3-1205.14(c) authorizes the Board to impose various types of disciplinary actions ranging from a reprimand to revocation of licensure.

The Board must act to ensure that the District's residents are protected from health professionals that place their own interests above the best interests of their patients. In the case at bar, the Board finds that the Respondent has not accepted responsibility for her actions, or evidenced remorse for the harm that she caused to her patients. The Board finds that the Respondent has failed to act in the best interests of her patients. She misled them, abandoned them in the midst of treatment, left an unregistered dental assistant alone without the supervision of a licensed dentist to perform dental procedures upon them based only upon directions provided via text message, left town without providing patients notice or an ability to obtain their records or refunds for services not rendered, and left their patient files and confidential protected health information in her abandoned dental office accessible to the landlord and other unauthorized individuals.

The Board finds that every action the Respondent took was to protect herself. She acted to protect her reputation from discovery of the disciplinary action taken against her dental license, and to protect her financial interests by keeping the office open even though she did not have a licensed dentist in place at all times to provide the dental services, and she acted to protect herself from further disciplinary action by concealing or destroying patient records instead of producing them as required by Board subpoenas.

The Board finds the Respondent's conduct wholly unacceptable, and that it is in the best interests of the health, safety, and welfare of the District's residents that she no longer be permitted to practice dentistry in the District of Columbia.

ORDER

Based upon the aforementioned, it is hereby ORDERED that the District of Columbia dentist license of Allena Willis, D.D.S., #DEN1000484, is hereby REVOKED, effective upon service of this Order.

5/28/2024
Date

John R. Bailey, DDS
Chairperson
District of Columbia Board of Dentistry

Judicial and Administrative Review of Actions of Board

Pursuant to D.C. Official Code § 3-1205.20 (2001):

> Any person aggrieved by a final decision of a board or the Mayor may appeal the decision to the **District of Columbia Court of Appeals** pursuant to D.C. Official Code

§ 2-510 (2012).

Pursuant to D.C. Court of Appeals Rule 15(a):

> Review of orders and decision of an agency shall be obtained by filing with the clerk of this court a petition for review within thirty (30) days after the notice is given.

This is the Final Order of the Board in this disciplinary matter and a public record and shall be posted on the Department of Health's website and Board newsletter and reported to the National Practitioner Data Bank and the Healthcare Integrity Protection Data bank.

Copies to:

Allena B. Willis, DDS
Respondent

Kimberly Johnson, Section Chief
Civil Enforcement Section
Office of the Attorney General
Washington, D.C. 20001