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8
9 **BEFORE THE**
DENTAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. DBC 2012-47

13 RICHARD THOMAS HANSEN, JR.
1031 Rosecrans Avenue, Suite 104
14 Fullerton, CA 92633

**FIRST AMENDED
ACCUSATION**

15 Dental License No. 26070

16 and

17 ANDY SANG YOON
2271 W. Malvern Avenue, #370
18 Fullerton, CA 92833

19 Dental License No. 42717

20
21 Respondents.

22 Complainant alleges:

23 **PARTIES**

24 1. Karen Fischer (Complainant) brings this First Amended Accusation solely in her
25 official capacity as the Executive Officer of the Dental Board of California, Department of
26 Consumer Affairs, State of California.

27 2. On or about October 5, 1976, the Dental Board of California issued Dental License
28 Number 26070 to Richard Thomas Hansen, Jr. (Respondent Hansen). The Dental License was in

1 full force and effect at all times relevant to the charges brought herein, and will expire on
2 January 31, 2015, unless renewed.

3 3. On or about July 21, 1995, the Dental Board of California issued Dental License
4 Number 42717 to Andy Sang Yoon (Respondent Yoon). The Dental License was in full force
5 and effect at all times relevant to the charges brought herein, and will expire on April 30, 2014,
6 unless renewed.

7 JURISDICTION

8 4. This First Amended Accusation is brought before the Dental Board of California
9 (Board), Department of Consumer Affairs, under the authority of the following laws. All section
10 references are to the Business and Professions Code (Code) unless otherwise indicated.

11 5. Section 118, subdivision (b), of the Code provides that the suspension, expiration,
12 surrender or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a
13 disciplinary action during the period within which the license may be renewed, restored, reissued
14 or reinstated.

15 6. Section 1625 of the Code states:

16 Dentistry is the diagnosis or treatment, by surgery or other method, of
17 diseases and lesions and the correction of malpositions of the human teeth,
18 alveolar process, gums, jaws, or associated structures; and such diagnosis or
19 treatment may include all necessary related procedures as well as the use of drugs,
20 anesthetic agents, and physical evaluation. Without limiting the foregoing, a
21 person practices dentistry within the meaning of this chapter who does any one or
22 more of the following:

23 (a) By card, circular, pamphlet, newspaper or in any other way advertises
24 himself or represents himself to be a dentist.

25 (b) Performs, or offers to perform, an operation or diagnosis of any kind, or
26 treats diseases or lesions of the human teeth, alveolar process, gums, jaws, or
27 associated structures, or corrects malposed positions thereof.

28 (c) In any way indicates that he will perform by himself or his agents or
servants any operation upon the human teeth, alveolar process, gums, jaws, or
associated structures, or in any way indicates that he will construct, alter, repair, or
sell any bridge, crown, denture or other prosthetic appliance or orthodontic
appliance.

(d) Makes, or offers to make, an examination of, with the intent to perform
or cause to be performed any operation on the human teeth, alveolar process,
gums, jaws, or associated structures.

(e) Manages or conducts as manager, proprietor, conductor, lessor, or otherwise, a place where dental operations are performed.

7. Section 1626 of the Code states:

It is unlawful for any person to engage in the practice of dentistry in the state, either privately or as an employee of a governmental agency or political subdivision, unless the person has a valid, unexpired license or special permit from the board.

The following practices, acts and operations, however, are exempt from the operation of this chapter:

(a) The practice of oral surgery by a physician and surgeon licensed under the Medical Practice Act.

(b) The operations, in dental schools approved by the board, of bona fide students of dentistry or dental hygiene in the school's clinical departments or laboratories or in a dental extension program approved by the board or in an advanced dental education program accredited by the Commission on Dental Accreditation of the American Dental Association or a national accrediting body approved by the board.

(c) The practice of dentistry by licensed dentists of other states or countries while appearing and operating as bona fide clinicians or instructors in dental colleges approved by the Dental Board of California.

(d) The practice of dentistry by licensed dentists of other states or countries in conducting or making a clinical demonstration before any bona fide dental or medical society, association, or convention; provided, however, the consent of the Dental Board of California to the making and conducting of the clinical demonstration shall be first had and obtained.

(e) The construction, making, verification of shade taking, alteration or repairing of bridges, crowns, dentures, or other prosthetic appliances, or orthodontic appliances, when the casts or impressions for this work have been made or taken by a licensed dentist, but a written authorization signed by a licensed dentist shall accompany the order for the work or it shall be performed in the office of a licensed dentist under his or her supervision. The burden of proving written authorization or direct supervision is upon the person charged with the violation of this chapter.

It is unlawful for any person acting under the exemption of this subdivision to represent or hold out to the public in any manner that he or she will perform or render any of the services exempted by this subdivision that are rendered or performed under the provisions of this chapter by a licensed dentist, including the construction, making, alteration or repairing of dental prosthetic or orthodontic appliances.

(f) The manufacture or sale of wholesale dental supplies.

(g) The practice of dentistry or dental hygiene by applicants during a licensing examination conducted in this state by the licensing agency of another state which does not have a dental school; provided, however, that the consent of the board to the conducting of the examination shall first have been obtained and that the examination shall be conducted in a dental college accredited by the board.

1 (h) The practice by personnel of the Air Force, Army, Coast Guard, or Navy
2 or employees of the United States Public Health Service, Veterans' Administration,
3 or Bureau of Indian Affairs when engaged in the discharge of official duties.

4 8. Section 1670 of the Code states:

5 Any licentiate may have his license revoked or suspended or be
6 reprimanded or be placed on probation by the board for unprofessional conduct,
7 or incompetence, or gross negligence, or repeated acts of negligence in his
8 profession, or for the issuance of a license by mistake, or for any other cause
9 applicable to the licentiate provided in this chapter.

10 9. Section 1680 of the Code states:

11 Unprofessional conduct by a person licensed under this chapter is defined as,
12 but is not limited to, any one of the following:

13

14 (c) The aiding or abetting of any unlicensed person to practice dentistry.

15

16 10. Section 1685 of the Code states:

17 In addition to other acts constituting unprofessional conduct under this
18 chapter, it is unprofessional conduct for a person licensed under this chapter to
19 require, either directly or through an office policy, or knowingly permit the
20 delivery of dental care that discourages necessary treatment or permits clearly
21 excessive treatment, incompetent treatment, grossly negligent treatment, repeated
22 negligent acts, or unnecessary treatment, as determined by the standard of practice
23 in the community.

24 11. Section 1718 of the Code states:

25 Except as otherwise provided in this chapter, an expired license may be
26 renewed at any time within five years after its expiration on filing of application
27 for renewal on a form prescribed by the board, and payment of all accrued renewal
28 and delinquency fees. If the license is renewed more than 30 days after its
expiration, the licensee, as a condition precedent to renewal, shall also pay the
delinquency fee prescribed by this chapter. Renewal under this section shall be
effective on the date on which the application is filed, on the date on which the
renewal fee is paid, or on the date on which the delinquency fee, if any, is paid,
whichever last occurs. If so renewed, the license shall continue in effect through
the expiration date provided in Section 1715 which next occurs after the effective
date of the renewal, when it shall expire if it is not again renewed.

29 COST RECOVERY

30 12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
31 administrative law judge to direct a licentiate found to have committed a violation or violations of

1 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
2 enforcement of the case.

3 13. Section 1672, subdivision (a), of the Code states:

4 When the board disciplines a licensee by placing him or her on probation,
5 the board may, in addition to the terms and conditions described in Section 1671,
6 require the licensee to pay the monetary costs associated with monitoring the
7 licensee's probation.

8 **PATIENT L.S.**

9 14. On or about December 17, 2007, Patient L.S. saw Respondent Hansen for the first
10 time at his dental practice, Comprehensive Dental Center Associates, for a consultation and
11 examination regarding a possible failed root canal procedure on tooth #14,¹ possible bone loss
12 and infection regarding teeth #'s 14 and 15, and possible sinus infection and penetration by tooth
13 #15. During his examination of Patient L.S., Respondent Hansen found that teeth #'s 14 and 15
14 had extensive bone loss, tooth #14 had a failed root canal, and there was periodontal pocketing on
15 teeth #'s 14 and 15, with bleeding on probing and pus exudate. Based on his examination and
16 findings, Respondent Hansen developed a treatment plan for Patient L.S., where he would re-treat
17 the root canal for tooth #14, perform "laser ozone disinfection" on the tooth, and then place a
18 temporary crown. Patient L.S. agreed with the treatment plan and was scheduled for another
19 appointment to begin the work.

20 15. At his next visit on January 2, 2008, Patient L.S. saw another dentist, Respondent
21 Yoon, who practiced with Respondent Hansen at Comprehensive Dental Center Associates. For
22 tooth #14, Respondent Yoon removed the permanent crown, re-treated the root canal, including
23 irrigating the canal with "oxygenated water", and placed a transitional (temporary) crown.
24 Respondent Yoon conducted a "mini bone aug" (bone augmentation/graft) on the distal root of
25 tooth #14. Respondent Yoon also performed "laser ozone disinfection" on the root canal, using a
26 laser and "ozonated water".

27 _____
28 ¹ Patient L.S. had a root canal procedure done in 2005 by another dentist.

1 16. On January 8, 2008, Patient L.S. again saw Respondent Yoon. Patient L.S.
2 complained to Respondent Yoon that tooth #14 had pain to hot and cold temperature. Upon
3 examination, Respondent Yoon found that tooth #15 had recession and bone loss. A
4 desensitizing agent was placed on tooth #15 and Patient L.S. was scheduled for a follow-up visit.

5 17. On January 16, 2008, Patient L.S. again saw Respondent Yoon. Respondent Yoon
6 performed a "NRG massage" on Patient L.S., as he was experiencing pain on the upper left side
7 of his mouth. Respondent Yoon also gave Traumeel Cream (pain reliever/anti-inflammatory) to
8 Patient L.S. to put on his face. Respondent Yoon recommended a Neti pot (a ceramic pot used
9 for nasal irrigation with a saline solution) to Patient L.S. for his sinus complaints, showed him
10 how to use it, and Patient L.S. then purchased the Neti pot at Comprehensive Dental Center
11 Associates.

12 18. On January 22, 2008, Patient L.S. saw both Respondents Hansen and Yoon at
13 Comprehensive Dental Center Associates. Respondent Hansen consulted with Patient L.S.
14 regarding teeth #'s 14 and 15. As to the pain he was still experiencing on the upper left side of
15 his mouth, Respondent Hansen told Patient L.S. that it will "take time to help with the
16 discomfort." Respondent Yoon recommended to Patient L.S. finishing the root canal on tooth
17 #14, prepping tooth #14 for a crown, and splinting teeth #'s 13 and 15 due to bone loss.

18 19. On February 15, 2008, Patient L.S. saw Respondent Yoon to finish the root canal
19 treatment for tooth #14. Respondent Yoon removed the temporary crown, irrigated canals with
20 "oxygenated water", filed and used a laser on canals, dried the canals with medium paper points,
21 and filled the tooth with MTA (mineral trioxide aggregate)² and dexamethasone³. Respondent
22 Yoon then placed three small fiber posts. Tooth #14 was prepped for a crown restoration,
23 including the making of an impression, and a temporary crown placed. Respondent Yoon also
24 performed another "NRG massage" on Patient L.S.

25
26
27 ² Mineral trioxide aggregate is a biocompatible material used to fill the root canals of teeth
as part of root canal treatment.

28 ³ Dexamethasone is a synthetic steroid commonly prescribed for anti-inflammatory effect.

1 20. On February 29, 2008, Patient L.S. saw Respondent Yoon to finish the crown on
2 tooth #14. A new permanent crown was fused on tooth #14. Respondent Yoon then splinted the
3 new crown to the tooth immediately in front of and behind the new crown.

4 21. On March 24, 2008, Patient L.S. went to Comprehensive Dental Center Associates
5 for prophylaxis (cleaning).

6 22. On June 20, 2008, Patient L.S. went to Comprehensive Dental Center Associates and
7 had prophylaxis with spot probing. Patient L.S. complained that his tooth #15 distal area was
8 sensitive to hot, cold, and touch. A Panorex (panoramic) x-ray was taken of the mouth and
9 reviewed by Respondent Hansen.

10 23. On November 12, 2008, Patient L.S. returned to Comprehensive Dental Center
11 Associates and consulted with both Respondents Hansen and Yoon. Patient L.S. indicated that
12 his upper left side hadn't healed yet and he thought there was still infection present. Patient L.S.
13 stated that he felt weaker this year compared to last year. Patient L.S. also mentioned that a week
14 ago, the splinting came off. After looking at his x-rays, Respondent Hansen told Patient L.S. that
15 he could see more bone fill, more cloudiness, which was a "good thing." Patient L.S. was told it
16 will take years to heal and both Respondents recommended bone augmentation to add calcium in
17 the area and re-splinting teeth #'s 14 and 15.

18 24. On November 19, 2008, Patient L.S. returned to Comprehensive Dental Center
19 Associates and new x-rays for teeth #'s 14 and 15 were taken. Patient L.S. was then scheduled
20 for a subsequent visit to see Respondent Hansen to consult regarding the new x-rays and
21 treatment for teeth #'s 14 and 15.

22 25. On December 2, 2008, Patient L.S. saw Respondent Hansen. Patient L.S. told
23 Respondent Hansen that he thought there was significant bone lost for teeth #'s 14 and 15, and
24 they looked worse. Respondent Hansen explained that for tooth #15, there was bone lost to the
25 tip of the root and that bone did not appear to have adequately regenerated, but for tooth #14, half
26 of the support tissue looked good.

27 26. On or about April 2, 2009, Patient L.S. presented to the Loma Linda University
28 School of Dentistry for a periodontal consultation. It was discovered that Patient L.S. had

1 periodontal pocket depths between 2-10 mm, with localized bleeding on probing and suppuration
2 (pus) on teeth #'s 24, 14, and 15. Teeth #'s 14 and 15 were described as "hopeless," with an
3 indication for extraction. The teeth were extracted without complication on or about May 27,
4 2009. Patient L.S. was also referred to an ENT (ear, nose and throat) physician for maxillary
5 sinus evaluation. The ENT physician found that Patient L.S. had chronic sinusitis and
6 Patient L.S. underwent sinus surgery for correction of the problem.

7 **FIRST CAUSE FOR DISCIPLINE**

8 **(Gross Negligence)**

9 27. Respondent Hansen is subject to disciplinary action under Code section 1670 in that
10 he was grossly negligent in his profession with respect to his care and treatment of Patient L.S., as
11 set forth above in paragraphs 14 to 26, which are incorporated herein by reference, in that:

12 a. Respondent Hansen failed to monitor and perform complete probings of the
13 periodontal pocket depths of Patient L.S.'s mouth, including those related to teeth #'s 14 and 15.

14 b. Respondent Hansen failed to treat obvious isolated and severe periodontal disease.

15 **SECOND CAUSE FOR DISCIPLINE**

16 **(Repeated Acts of Negligence)**

17 28. Respondent Hansen is subject to disciplinary action under Code section 1670 for
18 repeatedly negligent acts in his profession with respect to his care and treatment of Patient L.S.,
19 as set forth above in paragraphs 14 to 26, which are incorporated herein by reference, in that:

20 a. Respondent Hansen failed to obtain informed consent from Patient L.S. before
21 treatment was initiated. Patient L.S. was not informed about the guarded prognosis and
22 probability of success for the planned treatment of teeth #'s 14 and 15, and that "laser ozone
23 disinfection" was experimental.

24 b. Respondent Hansen failed to monitor and perform complete probings of the
25 periodontal pocket depths of Patient L.S.'s mouth, including those related to teeth #'s 14 and 15.

26 c. Respondent Hansen failed to diagnose obvious isolated and severe periodontal
27 disease.

28 d. Respondent Hansen failed to treat obvious isolated and severe periodontal disease.

1 e. Respondent Hansen failed to refer Patient L.S. for an evaluation by an ENT physician
2 (ear, nose and throat) for his continued sinus problems.

3 **THIRD CAUSE FOR DISCIPLINE**

4 **(Knowingly Permitting Gross or Repeated Negligence)**

5 29. Respondent Hansen is subject to disciplinary action under Code section 1685 in that
6 he knowingly permitted the delivery of dental care by Respondent Yoon that was grossly
7 negligent and/or repeatedly negligent, as alleged in the Fourth and Fifth Causes for Discipline,
8 which are incorporated herein by reference.

9 **FOURTH CAUSE FOR DISCIPLINE**

10 **(Gross Negligence)**

11 30. Respondent Yoon is subject to disciplinary action under Code section 1670 in that he
12 was grossly negligent in his profession with respect to his care and treatment of Patient L.S., as
13 set forth above in paragraphs 14 to 26, which are incorporated herein by reference, in that:

14 a. Respondent Yoon failed to monitor and perform complete probings of the periodontal
15 pocket depths of Patient L.S.'s mouth, including those related to teeth #'s 14 and 15.

16 b. Respondent Yoon failed to treat obvious isolated and severe periodontal disease.

17 **FIFTH CAUSE FOR DISCIPLINE**

18 **(Repeated Acts of Negligence)**

19 31. Respondent Yoon is subject to disciplinary action under Code section 1670 for
20 repeatedly negligent acts in his profession with respect to his care and treatment of Patient L.S.,
21 as set forth above in paragraphs 14 to 26, which are incorporated herein by reference, in that:

22 a. Respondent Yoon failed to obtain informed consent from Patient L.S. before
23 treatment was initiated. Patient L.S. was not informed about the guarded prognosis and
24 probability of success for the planned treatment of teeth #'s 14 and 15, and that "laser ozone
25 disinfection" was experimental.

26 b. Respondent Yoon failed to monitor and perform complete probings of the periodontal
27 pocket depths of Patient L.S.'s mouth, including those related to teeth #'s 14 and 15.

28 c. Respondent Yoon failed to diagnose obvious isolated and severe periodontal disease.

- 1 d. Respondent Yoon failed to treat obvious isolated and severe periodontal disease.
- 2 e. Respondent Yoon failed to refer Patient L.S. for an evaluation by an ENT physician
- 3 for his continued sinus problems.
- 4 f. Respondent Yoon failed to follow manufacturer's directions for MTA root canal
- 5 filling material in allowing it to adequately set for tooth #14.

6 **SIXTH CAUSE FOR DISCIPLINE**

7 **(Knowingly Permitting Gross or Repeated Negligence)**

8 32. Respondent Yoon is subject to disciplinary action under Code section 1685 in that he

9 knowingly permitted the delivery of dental care by Respondent Hansen that was grossly negligent

10 and/or repeatedly negligent, as alleged in the First and Second Causes for Discipline, which are

11 incorporated herein by reference.

12 **PATIENT S.B.**

13 33. On or about April 16, 2009, Patient S.B. saw Respondent Hansen for the first time at

14 his dental practice, Comprehensive Dental Center Associates, for a consultation and examination

15 regarding numerous decaying teeth. At this initial visit, full mouth and panoramic x-rays were

16 taken, Respondent Hansen conducted a dental exam, and he provided a consultation to Patient

17 S.B. regarding her teeth. Based on his examination and findings, Respondent Hansen developed

18 a treatment plan for Patient S.B., wherein, among other things, he would place porcelain veneers

19 on teeth #'s 4 through 12, 27, and 28, he would place onlays on teeth #'s 2, 4, 18, and 19, he

20 would place inlays on teeth #'s 13, 14, 15, 20, 21, and 32,⁴ perform "laser nerve treatment" on

21 teeth #'s 2, 4, and 19,⁵ perform a "laser restoration" on teeth #'s 16, 29 and 30,⁶ perform osseous

22

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24 ⁴ An inlay is a type of dental restoration (filling) which is fixed to a cavity of a damaged

25 or decayed tooth. An onlay is the same as an inlay, except that it extends to one or more cusps

(points) of the tooth.

26 ⁵ According to Respondent Hansen, "laser nerve treatment" uses a laser to disinfect and

remove decay from the nerve area of a tooth.

27 ⁶ According to Respondent Hansen, "laser restoration" uses a laser instead of a drill to

28 prepare the tooth for a dental restoration, such as an inlay or crown.

1 surgery on tooth #17,⁷ perform a root canal on tooth #18, and perform a root canal and place a
2 crown on tooth #31. The estimated cost for the treatment plan was \$29,205.00.

3 34. On April 17, 2009, Patient S.B. went to Comprehensive Dental Center Associates to
4 start the treatment plan. Respondent Hansen prepared teeth #'s 4 through 12 for their veneers,
5 and prepared teeth #'s 2, 4, and 12 for their onlays. In addition, Respondent Hansen performed
6 "laser nerve treatment" on teeth #'s 2 and 4. A full mouth debridement (gross removal of plaque
7 and calculus on teeth) was also done on Patient S.B.

8 35. On April 21, 2009, Patient S.B. went to Comprehensive Dental Center Associates to
9 continue the treatment plan. For tooth #29, Respondent Hansen performed a "laser restoration."
10 Respondent Hansen prepared teeth #'s 30, 31, and 32 for their respective dental restorations. For
11 tooth #31, Respondent Hansen started the root canal, including filing the canals, irrigating the
12 canals with "oxygenated water" and Peridex, filling them with dexamethasone, flagyl (antibiotic)
13 and tetracycline (antibiotic), and then placing a temporary crown. A partial mouth debridement
14 was also done on Patient S.B. at this time.

15 36. On April 23, 2009, Patient S.B. went to Comprehensive Dental Center Associates and
16 had her lower teeth laser bleached.

17 37. On April 29, 2009, Patient S.B. went to Comprehensive Dental Center Associates to
18 continue her dental work. Respondent Hansen placed/bonded the veneers on teeth #'s 4 through
19 12, and the onlays on teeth #'s 4 and 12.

20 38. On May 26, 2009, Patient S.B. went to Comprehensive Dental Center Associates to
21 continue her dental work. For tooth #30, Respondent Hansen prepared for a 2-surface (distal
22 occlusal) inlay and the inlay was then placed/bonded on the tooth. Respondent Hansen finished
23 the root canal for tooth #31, including irrigating the canals with Peridex or ozonated water, filing
24 the canals, cleaning infection, and filling them with dexamethasone, "Synthovial Seven"
25 (hyaluronic acid), MTA (mineral trioxide aggregate) and "Capset" (calcium sulfate). Respondent
26 Hansen also did final preparation on tooth #31 for a crown restoration (an impression was taken

27 ⁷ Osseous surgery is a type of dental surgery that reshapes the bone that holds one or more
28 teeth in place.

1 and sent to a dental lab for manufacture) and a temporary crown was placed on the tooth.

2 Respondent Hansen prepared tooth #32 for its inlay.

3 39. On June 2, 2009, Patient S.B. returned to Comprehensive Dental Center Associates
4 and saw Respondent Hansen. On this date, Respondent Hansen started the root canal on tooth
5 #18, including removing decay, filing the canals, irrigating the canals with "oxygenated water",
6 filling with dexamethasone, flagyl and tetracycline, and then placing a temporary crown.

7 40. On July 28, 2009, Patient S.B. returned to Comprehensive Dental Center Associates
8 and saw Respondent Hansen. At that time, Patient S.B. reported that her temporary crown had
9 come off from tooth #18. Respondent Hansen finished the root canal on tooth #18, including
10 irrigating the canals with Peridex and "ozonated water", filing the canals, removing decay, and
11 filling with dexamethasone, "Synthovial Seven", MTA and "Capset". Respondent Hansen then
12 did the final preparation on tooth #18 for its onlay restoration (an impression was taken and sent
13 to a dental lab for manufacture) and a temporary crown was placed. For tooth #19, Respondent
14 Hansen removed decay, used a laser for tooth sterilization, and prepared the tooth for its onlay.

15 41. On September 2, 2009, Patient S.B. returned to Comprehensive Dental Center
16 Associates and saw Respondent Yoon. Respondent Yoon placed/bonded the onlays on teeth #'s
17 2 and 31, and the inlay on tooth #32.

18 42. On July 21, 2010, Patient S.B. returned to Comprehensive Dental Center Associates
19 and saw Respondent Yoon. The veneer on tooth #7 had come off. In addition, the temporary
20 restorations for teeth #'s 17 through 21 had also come off. Respondent Yoon re-bonded the
21 veneer on tooth #7. Respondent Yoon reevaluated and took panoramic x-rays of Patient S.B.'s
22 teeth. For teeth #'s 31 and 32, the panoramic x-rays demonstrated periapical radiolucencies. For
23 teeth #'s 18 and 19, the panoramic x-rays showed large decay. Based on his evaluation,
24 Respondent Yoon determined that infection had set in to tooth #17, there was too much bone loss,
25 and therefore recommended extracting tooth #17.

26 43. On August 3, 2010, Patient S.B. returned to Comprehensive Dental Center Associates
27 and saw Respondent Yoon. Patient S.B. again presented with the veneer off tooth #7.
28 Respondent Yoon re-bonded the veneer on tooth #7.

1 44. On September 8, 2010, Patient S.B. returned to Comprehensive Dental Center
2 Associates and saw Respondent Yoon. For tooth #19, Respondent Yoon performed a root canal,
3 including irrigating the canals, using a laser for disinfection, filling with dexamethasone and
4 MTA, and placing a temporary crown. For tooth #18, Respondent Yoon prepared the tooth for its
5 onlay restoration, including post build up.

6 45. On September 28, 2010, Patient S.B. returned to Comprehensive Dental Center
7 Associates and saw Respondent Yoon. Respondent Yoon took the final impressions for the
8 restorations for teeth #'s 18 and 19. For teeth #'s 20 and 21, Respondent Yoon prepared those
9 teeth for their respective onlays. For tooth #19, he noted that this tooth had very deep decay.

10 46. On October 5, 2010, Patient S.B. returned to Comprehensive Dental Center
11 Associates and saw Respondent Yoon. Patient S.B. told Respondent Yoon that she had been
12 having pain in the lower left that woke her up in the middle of the night, coming from the area of
13 tooth #17. Patient S.B. reported that she also had tenderness when pushing on the gums in the
14 area of tooth #19. On this date, Respondent Yoon finally extracted tooth #17. In addition, the
15 temporaries for teeth #'s 18 through 21 had come off. Respondent Yoon re-cemented temporaries
16 for these teeth.

17 47. On October 27, 2010, Patient S.B. was seen by Timothy Kelley, M.D., regarding a
18 developing abscess that was on her right mid jawline. Patient S.B. was diagnosed by Dr. Kelley
19 as having a facial neoplasm. On November 3, 2010, an operation to have the abscess excised was
20 performed by Dr. Kelley. During the excision, it was found that there was a tract that led down to
21 Patient S.B.'s right mandibular molars. In particular, the tract appeared to lead towards teeth #'s
22 30 and 31. Dr. Kelley removed this tract.

23 48. On November 16, 2010, Dr. Timothy Kelly sent copy of his operation report and his
24 findings to Respondent Yoon.

25 49. On November 29, 2010, Patient S.B. returned to Comprehensive Dental Center
26 Associates and saw Respondent Hansen for an evaluation regarding the discovered tract by Dr.
27 Kelley and teeth #'s 30 and 31. Respondent Hansen opened into teeth #'s 30 and 31, without
28 anesthetic, but he did not see signs of infection. However, according to Respondent Hansen,

1 x-rays showed a radiolusency at the apex of tooth #31. Respondent Hansen believed the
2 radiolusency to be an invasive cyst or granuloma (an area of inflammation in tissue).
3 Respondent Hansen treated tooth #31 with antibiotics, ozone gas and "laser stimulation". Based
4 on his examination and findings, rather than extracting tooth #31, Respondent Hansen
5 recommended continued treatment of the tooth through the open canals into the bone, with ozone
6 gas, laser and file stimulation, and placement of antibiotics and bone induction calcium. Tooth
7 #31 would be observed for possible extraction in the future.

8 50. On November 30, 2010, Patient S.B. returned to Comprehensive Dental Center
9 Associates and saw Respondent Hansen. For tooth #31, Respondent Hansen cut off the crown,
10 accessed the distal root to the bone, rinsed with "oxygenated water", sterilized with a laser, and
11 spiraled in dexamethasone, flagyl and tetracycline. When asked if this would help, Respondent
12 Hansen told Patient S.B.'s mother, who was present at the time, that he was not quite sure.

13 Respondent Hansen stated that the things that are going on with Patient S.B.'s facial tissue could
14 be coming from tooth #31, but it was not abscessed. Respondent Hansen then placed a temporary
15 crown on tooth #31.

16 51. On December 3, 2010, Patient S.B. returned to Comprehensive Dental Center
17 Associates and saw Respondents Hansen and Yoon. Respondent Yoon bonded restorations on
18 teeth #'s 2, 18, 19, 20 and 21. Respondent Hansen then consulted with Patient S.B. regarding
19 tooth #31 and planned to continue treatment on it.

20 52. On December 6, 2010, Patient S.B. returned to Comprehensive Dental Center
21 Associates and saw Respondent Hansen. Patient S.B. reported that she still had swelling to the
22 right side of her face. Respondent Hansen re-opened tooth # 31, without anesthetic, instrumented
23 the canal, irrigated with "ozonated water", and placed "triple mix" (flagyl, tetracycline and
24 neomycin (antibiotic), plus dexamethasone) into the distal canal. Respondent Hansen then placed
25 a temporary on tooth #31. For Patient S.B.'s next visit, Respondent Hansen planned to continue
26 treatment on tooth #31.

27 53. On December 9, 2010, Patient S.B. consulted Lawrence Lorenzi, D.D.S., regarding
28 her teeth and the continued swelling and discomfort to the right side of her face. Panoramic

1 x-rays of Patient S.B.'s teeth were taken. Dr. Lorenzi determined that teeth #'s 31 and 32 were
2 both infected and were in need of extraction. The next day, on December 10, 2010, teeth #'s 31
3 and 32 were extracted by Dr. Lorenzi without complication. On December 28, 2010, Dr. Lorenzi
4 had to extract teeth #'s 18 and 19 as well.

5 **SEVENTH CAUSE FOR DISCIPLINE**

6 **(Gross Negligence)**

7 54. Respondent Hansen is subject to disciplinary action under Code section 1670 in that
8 he was grossly negligent in his profession with respect to his care and treatment of Patient S.B.,
9 as set forth above in paragraphs 33 to 53, which are incorporated herein by reference, in that:

10 a. Given Patient S.B.'s numerous decaying teeth, Respondent Hansen failed to provide a
11 treatment plan on April 16, 2009, which properly prioritized treatment, starting with stabilizing
12 the patient, including the immediate extraction of teeth that were not savable and decay removal,
13 ~~rather than aesthetic care, such as veneers and laser bleaching.~~

14 b. Respondent Hansen failed to extract tooth #17 at the inception of dental treatment
15 despite the fact that it could not be restored and was the source of an active infection.

16 c. Respondent Hansen failed to remove dental caries from teeth #'s 14 and 15.

17 d. On April 16, 2009, Respondent Hansen failed to adequately test and assess
18 teeth #'s 2, 4, 15, 17, 18, 19, 31 and 32, to palpation, percussion, biting, cold, and electric pulp
19 test (EPT) to determine their pulpal status, as these teeth all showed significant decay that could
20 involve the pulp.

21 e. On April 16, 2009, and November 29, 2010, Respondent Hansen failed to perform
22 probings of the periodontal pocket depths of Patient S.B.'s mouth, or document any such
23 probings.

24 **EIGHTH CAUSE FOR DISCIPLINE**

25 **(Repeated Acts of Negligence)**

26 55. Respondent Hansen is subject to disciplinary action under Code section 1670 for
27 repeatedly negligent acts in his profession with respect to his care and treatment of Patient S.B.,
28 as set forth above in paragraphs 33 to 53, which are incorporated herein by reference, in that:

- 1 a. Respondent Hansen placed dental restorations that had defective open margins and
2 were over contoured for teeth #'s 4 through 12, and 30.
- 3 b. Respondent Hansen failed to recognize that the prognosis of tooth #31 was guarded.
- 4 c. Respondent Hansen failed to inform Patient S.B. that the prognosis of tooth #31 was
5 guarded.
- 6 d. Respondent Hansen failed to follow manufacturer's directions for MTA root canal
7 filling material in allowing it to adequately set for tooth #31.
- 8 e. Respondent Hansen failed to document the pulpal findings, and make a final pulpal
9 diagnosis, for teeth #'s 18 and 31.
- 10 f. Respondent Hansen failed to use a rubber dam, or document its use, during his root
11 canal procedures on teeth #'s 18 and 31.
- 12 g. Respondent Hansen committed negligent acts as specified in paragraph 54 above,
13 subdivisions (a) through (e), which are incorporated herein by reference.

14 **NINTH CAUSE FOR DISCIPLINE**

15 **(Incompetence)**

16 56. Respondent Hansen is subject to disciplinary action under Code section 1670 for
17 incompetence in his profession with respect to his care and treatment of Patient S.B., as set forth
18 above in paragraphs 33 to 53, which are incorporated herein by reference, in that:

- 19 a. Respondent Hansen failed to appropriately clean, shape and seal the root canals on
20 teeth #'s 18 and 31.
- 21 b. Respondent Hansen failed to refer Patient S.B. to an endodontist on or about
22 November 29, 2010, when issues persisted with the draining fistula (abscess) on the lower right
23 side of Patient S.B.'s face tracking toward tooth #31.
- 24 c. When issues persisted with the draining fistula (abscess) on the right side of Patient
25 S.B.'s face, Respondent Hansen continued to attempt treatment on tooth #31 that was not
26 productive, and unreasonable, resulting in not extracting tooth #31 in a timely manner.
- 27 d. Respondent Hansen failed to recognize the odontogenic (tooth related) cause of the
28 draining fistula (abscess) on the lower right side of Patient S.B.'s face.

1 **TENTH CAUSE FOR DISCIPLINE**

2 **(Knowingly Permitting Gross or Repeated Negligence or Incompetence)**

3 57. Respondent Hansen is subject to disciplinary action under Code section 1685 in that
4 he knowingly permitted the delivery of dental care by Respondent Yoon that was grossly
5 negligent, repeatedly negligent and/or incompetent, as alleged in the Eleventh, Twelfth and
6 Thirteenth Causes for Discipline below, which are incorporated herein by reference.

7 **ELEVENTH CAUSE FOR DISCIPLINE**

8 **(Gross Negligence)**

9 58. Respondent Yoon is subject to disciplinary action under Code section 1670 in that he
10 was grossly negligent in his profession with respect to his care and treatment of Patient S.B., as
11 set forth above in paragraphs 33 to 53, which are incorporated herein by reference, in that:

12 a. Respondent Yoon failed to recognize and correct the issue of coronal leakage
13 (bacteria seeping back into and re-contaminating a tooth that has had a root canal) for tooth #18.

14 b. Given the worsened condition of her teeth, Respondent Yoon failed to provide a new
15 treatment plan for Patient S.B. when she returned to Comprehensive Dental Center Associates on
16 July 21, 2010, after being away for ten months, which properly prioritized treatment, starting with
17 stabilizing the patient, including the immediate extraction of teeth that were not savable and
18 decay removal, rather than aesthetic care, such as veneers.

19 c. On July 21, 2010, Respondent Yoon failed to adequately test and assess teeth #'s 2, 4,
20 15, 18, 19, 31 and 32, to palpation, percussion, biting, cold, and electric pulp test (EPT) to
21 determine their pulpal status, as these teeth all showed significant decay that could involve the
22 pulp.

23 d. On July 21, 2010, and October 5, 2010, Respondent Yoon failed to perform probings
24 of the periodontal pocket depths of Patient S.B.'s mouth, or document any such probings.

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1 **TWELFTH CAUSE FOR DISCIPLINE**

2 **(Repeated Acts of Negligence)**

3 59. Respondent Yoon is subject to disciplinary action under Code section 1670 for
4 repeatedly negligent acts in his profession with respect to his care and treatment of Patient S.B.,
5 as set forth above in paragraphs 33 to 53, which are incorporated herein by reference, in that:

6 a. Respondent Yoon failed to follow manufacturer's directions for MTA root canal
7 filling material in allowing it to adequately set for tooth #19.

8 b. Respondent Yoon failed to use a rubber dam, or document its use, during his root
9 canal procedures on tooth #19.

10 c. Respondent Yoon failed to document the pulpal findings, and make a final pulpal
11 diagnosis, for tooth #19.

12 d. Respondent Yoon failed to recognize that the prognosis of tooth #18 was guarded.

13 e. Respondent Yoon failed to inform Patient S.B. that the prognosis of tooth #18 was
14 guarded.

15 f. Respondent Yoon placed dental restorations that had defective open margins and
16 were over contoured for teeth #'s 2, 7, 18, and 19.

17 g. Respondent Yoon committed negligent acts as specified in paragraph 58 above,
18 subdivisions (a) through (d), which are incorporated herein by reference.

19 **THIRTEENTH CAUSE FOR DISCIPLINE**

20 **(Incompetence)**

21 60. Respondent Yoon is subject to disciplinary action under Code section 1670 for
22 incompetence in his profession with respect to his care and treatment of Patient S.B., as set forth
23 above in paragraphs 33 to 53, which are incorporated herein by reference, in that Respondent
24 Yoon failed to appropriately clean, shape and seal the root canals on tooth #19.

25 **FOURTEENTH CAUSE FOR DISCIPLINE**

26 **(Knowingly Permitting Gross or Repeated Negligence or Incompetence)**

27 61. Respondent Yoon is subject to disciplinary action under Code section 1685 in that he
28 knowingly permitted the delivery of dental care by Respondent Hansen that was grossly

1 negligent, repeatedly negligent, and/or incompetent as alleged in the Seventh, Eighth and Ninth
2 Causes for Discipline above, which are incorporated herein by reference.

3 **FIFTEENTH CAUSE FOR DISCIPLINE**

4 **(Aiding and Abetting Unlicensed Practice of Dentistry)**

5 62. Respondent Hansen is subject to disciplinary action under Code sections 1670 and
6 1680, subdivision (c), in conjunction with Section 1625, subdivisions (c), (d) and (e), and Section
7 1626, for unprofessional conduct in aiding and abetting "Comprehensive Health Association" in
8 the unlicensed practice of dentistry. The circumstances are as follows:

9 a. When Patient S.B. went to Comprehensive Dental Center Associates on or about
10 April 16, 2009, for the dental work on her teeth, she was told by office staff that she first needed
11 to join the "Comprehensive Health Association." Comprehensive Health Association was an
12 unincorporated, "nonprofit association" that provided dental services, run by its President, who
13 ~~was not a dentist. In fact, Comprehensive Health Association was not licensed by the Dental~~
14 Board of California, nor was it a professional dental corporation authorized to provide dental
15 services in California under the Moscone-Knox Professional Corporation Act. Despite this, the
16 association offered to and provided dental work to California consumers who joined the
17 association, through its agents and/or servants Respondents Hansen and Yoon. Patients of
18 Respondents Hansen and Yoon were first charged by, and made their payment for dental services
19 directly to, Comprehensive Health Association. The charges billed by the association were based
20 on an "Estimated Treatment Plan" that the association itself provided to the patient. The
21 association then contracted with and paid Respondents Hansen and Yoon for the dental services
22 they provided to the patients, who had become members of the association. In addition to paying
23 the dentists, Comprehensive Health Association managed and controlled the dental practice of
24 Respondents Hansen and Yoon by paying for their office expenses, including their office space,
25 paying or renting their office equipment, and providing office staff. Respondents Hansen and
26 Yoon belonged to Comprehensive Health Association as "provider members" in order to provide
27 dental services to "patient members" such as Patient S.B. When patients joined Comprehensive
28 Health Association, according to the association's by-laws, they gave up their right to sue

1 provider members such as Respondents Hansen and Yoon for malpractice, and instead, had to
2 submit to an internal grievance process and procedures administered by the association, followed
3 by commercial arbitration.

4 **SIXTEENTH CAUSE FOR DISCIPLINE**

5 **(Aiding and Abetting Unlicensed Practice of Dentistry)**

6 63. Respondent Yoon is subject to disciplinary action under Code sections 1670 and
7 1680, subdivision (c), in conjunction with Section 1625, subdivisions (c), (d) and (e), and Section
8 1626, for unprofessional conduct in aiding and abetting "Comprehensive Health Association" in
9 the unlicensed practice of dentistry, as alleged in paragraph 62 above, which is incorporated
10 herein by reference.

11 **DISCIPLINE CONSIDERATIONS**

12 64. To determine the degree of discipline, if any, to be imposed on Respondent Hansen,
13 Complainant alleges that on or about March 23, 1994, the Dental Board of California issued
14 Citation Number 02-93-1052 for a violation of former Health and Safety Code section 1795.12
15 (failure to provide patient records) and fined Respondent \$250.00. That Citation is now final and
16 the fine has been paid.

17 **PRAYER**

18 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
19 and that following the hearing, the Dental Board of California issue a decision:

- 20 1. Revoking or suspending Dental License Number 26070 issued to Richard Thomas
21 Hansen, Jr.;
- 22 2. Revoking or suspending Dental License Number 42717 issued to Andy Sang Yoon;
- 23 3. Ordering Richard Thomas Hansen, Jr., and Andy Sang Yoon to pay the Dental Board
24 of California the reasonable costs of the investigation and enforcement of this case, and, if placed
25 on probation, the costs of probation monitoring;

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4. Taking such other and further action as deemed necessary and proper.

DATED: 4/16/14

Karen Fischer
KAREN FISCHER
Executive Officer
Dental Board of California
Department of Consumer Affairs
State of California
Complainant

SD2012703476