IN THE MATTER OF	*	**BEFORE THE MARYLAND**
CHERYL R. TERRELL, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 13546	*	**Case Number: 2020-047**

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE DENTISTRY

The Maryland State Board of Dental Examiners (the "Board") hereby **SUMMARILY SUSPENDS** the license of **CHERYL R. TERRELL, D.D.S.** (the "Respondent"), License Number 13546, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under Md. Code Ann., State Gov't ("State Gov't") § 10-226(c) (2014 Repl. Vol.), finding that the public health, safety, or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

The Board bases its action on the following findings: [1]

I. LICENSING BACKGROUND

1. At all times relevant, the Respondent was and is licensed to practice dentistry in the State of Maryland. The Respondent was originally licensed to practice dentistry in Maryland on November 16, 2004, under License Number 13546. The Respondent's license is current through June 30, 2020.

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[1] The statements regarding the Respondent's conduct are intended to provide the Respondent with notice of the basis of the suspension. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

2. At all times relevant, the Respondent was the owner of a dental practice (the "Dental Office") located in Mitchellville, Maryland. The Respondent employed at least one other staff dentist ("Dentist A") at the Dental Office.

II. COMPLAINT

3. On or about July 15, 2019, the Board received a complaint from a patient (the "Complainant"), who alleged that on July 3, 2018, while waiting to receive dental treatment at the Dental Office, she observed an employee flossing his teeth in the operatory. When the Respondent came into the operatory to begin dental treatment, the Complainant, who was a registered nurse, declined to be treated.

4. Based on the complaint, the Board initiated an investigation of the Respondent's dental practices.

III. INFECTION CONTROL INSPECTION

5. Due to allegations of potential infection control issues at the Dental Office, on or about August 7, 2019, a Board-contracted infection control expert (the "Board Inspector"), along with a Board investigator, visited the Dental Office and conducted an infection control inspection.

6. Present during the inspection were the Respondent, Dentist A, a dental hygienist, three dental radiation technologists/assistants, the office manager, the receptionist, the insurance coordinator and the financial coordinator.

7. As part of the inspection, the Board Inspector utilized the Centers for Disease Control and Prevention ("CDC") Infection Prevention Checklist for Dental Settings.

8. During the inspection, the Board Inspector was able to directly observe patient treatment by

9. Based on the inspection, the Board Inspector found the following CDC violations:

Section I: Policies and Practices

a. **Administrative Measures** – The Respondent failed to maintain any: written infection control policies and procedures specific to the Dental Office; annual reassessments of those policies and procedures; assignment of a trained employee to coordinate the infection prevention program; utility gloves in the sterilization area; and a system for early detection and management of potentially infectious persons at initial points of patient encounter.

b. **Infection Prevention Education and Training** – The Respondent failed to maintain a training log of personnel training (upon hire, annually and new tasks or procedure) on infection prevention and bloodborne pathogens standards. Two days after the inspection, the Respondent provided the Board a sign-in sheet for a bloodborne pathogens training that occurred in September 2016. At least five employees presently working at the Dental Office failed to attend this training.

c. **Dental Health Care Personnel Safety** – The Respondent failed to maintain required documentation on: exposure control plan specific

to the Dental Office; employee training on OSHA Bloodborne Pathogens Standard (upon hire and at least annually); current CDC recommendations and office-specific policies on immunization, evaluation and follow-up; availability of Hepatitis B vaccination (two days after the inspection, the Respondent provided the Board documentation that two employees received Hepatitis B vaccination in 2004 and 2016); post-vaccination screening of Hepatitis B surface antibody; availability of annual influenza vaccination; baseline tuberculosis screening for all dental health care personnel; a log of needlesticks, sharps injuries and other exposure events; referral arrangements to qualified health care professionals; post-exposure evaluation and follow-up; and well-defined policies concerning contact of personnel with potentially transmittable conditions with patients.

d. **Program Evaluation** – The Respondent failed to maintain required documentation on policies and procedures on routine monitoring and evaluation of infection prevention and control program, and adherence to certain practices such as immunization, hand hygiene, sterilization monitoring and proper use of Personal Protective Equipment.

e. **Hand Hygiene** – The Respondent failed to maintain documentation on dental personnel training regarding appropriate indications for

hand hygiene including handwashing, hand antisepsis and surgical hand antisepsis.

f. **Personal Protective Equipment (PPE)** – The Respondent failed to maintain documentation that dental personnel received training on proper selection and use of PPE.

g. **Respiratory Hygiene/Cough Etiquette** – The Respondent failed to maintain documentation on policies/procedures and personnel training logs on containing respiratory secretion in people with signs and symptoms of respiratory infection. The Respondent also failed to post precautionary instructions for patients with symptoms of respiratory infection; provide tissues; offer face masks; and provide separate space for persons with respiratory symptoms.

h. **Sharps Safety** – The Respondent failed to maintain documentation on policies, procedures and guidelines for exposure prevention and post-exposure management. The Respondent failed to maintain documentation on identifying, evaluating and selecting devices with engineered safety features at least annually or as they become available in the market.

i. **Safe Injection Practices** – The Respondent failed to maintain documentation on policies, procedures and guidelines for safe-injection preparation and practices.

j. **Sterilization and Disinfection of Patient-Care Items and Devices** – The Respondent failed to maintain documentation, policies or procedures regarding: appropriate cleaning and processing of reusable instruments and devices; manufacturer's reprocessing instructions; upon hire and annual personnel training log on reprocessing of reusable instruments and devices; personnel training logs on appropriate use of PPE; maintenance logs on sterilization equipment; and responses in the event of a reprocessing error/failure. The Respondent failed to maintain documentation on spore testing on site. Test results later provided by biological monitoring services showed that the Respondent often failed to provide sufficient information for proper testing.

k. **Environmental Infection Prevention and Control** – The Respondent failed to maintain documentation, policies and procedures on: routine cleaning and disinfection of environmental surfaces; upon hire and annual personnel training about infection prevention and control management of clinical contact and housekeeping surfaces; personnel training logs on appropriate use of PPE; periodic monitoring and evaluations of use of surface barriers; and decontamination of spills or blood or other body fluid.

l. **Dental Unit Water Quality** – The Respondent failed to maintain documentation, policies and procedures for: maintaining dental unit

water quality; using sterile water as a coolant/irrigant when performing surgical procedures; and responding to a community boil-water advisory.

Section II: Direct Observation of Personnel and Patient-Care Practices

m. **Performance of Hand Hygiene** – The Respondent failed to perform handwashing before putting on gloves and after removing gloves between treating patients.

n. **Use of Personal Protective Equipment (PPE)** – The Respondent failed to perform handwashing before removing PPE. The Respondent also failed to remove her PPE before leaving the work area.

o. **Respiratory Hygiene/Cough Etiquette** – The Respondent failed to: post precautionary instructions (Cover Your Cough Poster) around the entrance area; provide tissues; offer face masks; and provide separate space for persons with respiratory symptoms.

p. **Sharps Safety** – The Respondent failed to place sharps containers in readily accessible areas of the operatories.

q. **Sterilization and Disinfection of Patient-Care Items and Devices** – The Respondent failed to: have available puncture and chemical resistant utility gloves for manual cleaning; use a chemical indicator inside each sterilization package; label sterilization packages with sterilizer used, the cycle or load number, and the date of sterilization;

and maintain logs for each sterilization cycle. The Respondent failed to maintain documentation on spore testing on site. Test results later provided by biological monitoring services showed that the Respondent often failed to provide sufficient information for proper testing.

r. **Environmental Infection Prevention and Control** – The Respondent failed to consistently barrier-protect clinical contact surfaces. The Respondent failed to use surface barriers for the computer keyboard and mouse. The Board Inspector observed an uncovered and dirty portable oxygen/nitrous oxide cart in the corner that was not suitable for patient use. Unopened sterile packs were placed on the same tray as used instruments. The Board Inspector also did not see an eye-wash station or an emergency medical kit.

s. **Dental Unit Water Quality** – The Respondent failed to perform waterline testing and treatment to monitor dental water unit quality.

12. Based on the lack of required documentation and his direct observations, the Board Inspector determined that the Respondent, as the owner of and a practicing dentist at the Dental Office, failed to comply with CDC Guidelines as set forth above, which posed a direct risk to patient safety.

CONCLUSIONS OF LAW

Based on the foregoing investigative findings, the Board concludes as a matter of law that there is a substantial likelihood that the Respondent's failure to comply with CDC

Guidelines poses a risk of harm to the public health, safety and welfare, which imperatively requires the immediate suspension of her license, pursuant to State Gov't § 10-226(c)(2) (2014 Repl. Vol.).

ORDER

Based on the foregoing investigative findings, it is, by a majority of the Board considering this case, pursuant to authority granted to the Board by State Gov't § 10-226(c)(2) (2014 Repl. Vol.):

ORDERED that the Respondent's license to practice dentistry in the State of Maryland, License Number 9990, is hereby **SUMMARILY SUSPENDED**; and it is further

ORDERED that upon the Board's receipt of a written request from the Respondent, a Show Cause Hearing shall be scheduled at the Board's next regularly scheduled meeting but not to exceed thirty (30) days from the date of the Respondent's request, at which the Respondent will be given an opportunity to be heard as to why the Order for Summary Suspension should not continue; and it is further

ORDERED that if the Respondent fails to request a Show Cause Hearing or files a written request for a Show Cause Hearing and fails to appear, the Board shall uphold and continue the Summary Suspension of his license; and it is further

ORDERED that upon service of this Order for Summary Suspension, the Respondent shall immediately surrender to the Board all indicia of licensure to practice dentistry issued by the Board that are in her possession, including but not limited to his original license, renewal certificates and wallet size license; and it is further

ORDERED that this document constitutes an order of the Board and is therefore a public document for purposes of public disclosure, as required by Md. Code Ann., Gen. Provisions §§ 4-101 *et seq.* (2014).

11/13/2019
Date

Francis X. McLaughlin, Jr.
Executive Director
Maryland State Board of Dental Examiners

NOTICE OF HEARING

Upon the Board's receipt of a written request from the Respondent, a Show Cause Hearing will be held at the offices of the Maryland State Board of Dental Examiners, Spring Grove Hospital Center, Benjamin Rush Building, 55 Wade Avenue, Catonsville, Maryland 21228. The Show Cause Hearing will be scheduled for the Board's next regularly scheduled meeting but not to exceed thirty (30) days from the Board's receipt of a written request for a hearing filed by the Respondent.

At the conclusion of the Show Cause Hearing held before the Board, the Respondent, if dissatisfied with the result of the hearing, may, within ten (10) days, file a written request for an evidentiary hearing. Unless otherwise agreed to by the parties, the Board shall provide a hearing within forty-five (45) days of the Respondent's written request. The Board shall conduct an evidentiary hearing under the contested case provisions of State Gov't §§ 10-201 *et seq.* (2014 Repl. Vol.).