IN THE MATTER OF	*	BEFORE THE MARYLAND
MARGARET N. KROMAH, D.D.S.	*	STATE BOARD OF
Respondent	*	DENTAL EXAMINERS
License Number: 7439	*	Case Number: 2013-005

* * * * * * * * * * * * *

CONSENT ORDER

On November 20, 2013, the Maryland State Board of Dental Examiners (the "Board") charged **MARGARET N. KROMAH, D.D.S** ("Respondent"), License Number 7439, under the Maryland Dentistry Act, Md. Code Ann. Health Occ. ("H.O.") §§ 4-101 *et seq.* (2009 Repl. Vol & 2012 Supp.) pursuant to H.O. § 4-315(a). The pertinent provisions of H.O. § 4-315(a), and those under which these charges are brought, are as follows:

> (a) *License to practice dentistry.* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may deny a general license to practice dentistry...reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the ... licensee:
>
> (18) Violates any rule or regulation adopted by the Board;
>
> (20) Willfully makes or files a false report in the practice of dentistry;
>
> (28) Except in an emergency life-threatening situation where it is not feasible or practicable, fails to comply with the Centers for Disease Control's ["CDC"] guidelines on universal precautions...[.]

The Board further charges the Respondent with violating Md. Code Regs. 10.44.22.04(B) which provides:

> **.04 Requirements**
>
> ...

B. A licensee seeking renewal shall complete not less than 30 full hours of continuing education, including 2 hours of infection control.

On February 19, 2014 the Respondent appeared before a Case Resolution Conference Committee ("CRC") to discuss the pending charges and a potential resolution of the charges. Following the CRC, the parties agreed to enter into this Consent Order as a means of resolving this matter.

FINDINGS OF FACT

1. At all times relevant hereto, the Respondent was and is a dentist licensed to practice dentistry in the State of Maryland. The Respondent initially was licensed on February 20, 1981. Her license will expire on June 30, 2015.

2. At all times relevant hereto, the Respondent maintained an office for the private practice of dentistry located in Baltimore, Maryland.

I. Procedural History

3. On or about August 25, 2008, the Board received a complaint from a patient of the Respondent and her former partner regarding the unsanitary condition of the dental office (Case Number 2009-056). The office about which the patient complained is same as the Respondent's current office.

4. Thereafter, Board staff conducted an unannounced inspection of the dental office.

5. Board staff found numerous CDC violations including but not limited to the following: incomplete spore testing records; lack of a hazardous waste removal contract; unclean and grimy instruments and lamp; open sterilization packs containing instruments, some with no dates; lack of an instrument processing area; unsterilized burs; leaking suction and

air hose; uncapped syringes lying on counter; overflowing sharps container and general lack of cleanliness.

6. On January 5, 2009, the Board issued to the Respondent an Advisory Letter in which she was advised of the observed CDC violations and noting that the office was "in total disarray." The Respondent was further advised that the Board's case would not be closed until a follow-up inspection was satisfactory.

7. By letter dated May 1, 2009, the Board advised the Respondent that the follow-up inspection had been satisfactory and that the Board considered the case closed, but reserved the right to re-examine it if necessary.

II. Current Complaint

8. On or about June 28, 2012, the Board received a complaint from an individual ("Complainant") who had made an appointment with the Respondent but who left before being treated because she was so concerned about the unsanitary condition of the Respondent's office. Specifically, the Complainant alleged *inter alia* that there was dust along the floorboards, exposed pipes, rust stains on the floor, multiple holes in the wall of the treatment room, yellow rubber cleaning gloves stuffed into sink pipes and that the light above the dental chair was chipped and rusty.

9. Based on the complaint, the Board initiated an investigation that included referral to an outside consultant with expertise in infection control. The results of that investigation are set forth *infra*.

II. Office Inspection

10. On December 19, 2012, an independent Board consultant ("Board expert") conducted an unannounced inspection of the Respondent's office. During her inspection,

the Board expert interviewed the Respondent. She also inspected the office, reviewed written protocols, and observed patient care provided by the Respondent. The Board expert also provided the Respondent with the opportunity to submit supplemental documents to address various deficiencies noted during the inspection.

11. Although the Board expert began by investigating the allegations in the complaint, she also conducted a thorough and comprehensive infection control inspection of the Respondent's office to determine whether the Respondent was complying with the Act and the CDC Guidelines for Infection Control in Dental Health Care Settings ("CDCICDHS"). Based on that inspection, the Board expert substantiated the allegations in the Complaint set forth in ¶8 and also found numerous additional violations of CDC[1] guidelines, as delineated herein.

III. <u>Complaint allegations</u>

12. Inspection revealed a lack of routine cleaning throughout the office and worn carpeting, water and rust stains on the linoleum tile, exposed wires and pipe in the clinical area. The Respondent stated that maintenance services were not included in her lease, but that she would address the issue when negotiating the next lease. The Board expert's findings regarding the overall maintenance of the Respondent's office constitute violations of CDC guidelines.

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[1] The Centers for Disease Control and Prevention ("CDC") is a federal agency dedicated to designing protocols to prevent the spread of disease. The CDC has issued guidelines for dental offices which detail the procedures deemed necessary to minimize the chance of transmitting infection both from one patient to another and from the dentist, dental hygienist and dental staff to and from the patients. These guidelines include some very basic precautions, such as washing one's hands prior to and after treating a patient, and also sets forth more involved standards for infection control.

IV. Additional violations

13. The Board expert observed that the Respondent failed to use protective equipment in the form of utility gloves while she was preparing instruments for sterilization. This finding constitutes a violation of CDC guidelines.

14. The Respondent did not have an eyewash station or a protocol for handling eye injuries. This finding constitutes a violation of CDC guidelines.

15. The Respondent failed to perform consistent weekly autoclave spore testing. Although documented spore testing results were negative, the number of tests were insufficient to cover weekly testing. In her supplemental response, the Respondent provided documentation of dates during 2012 that she did not see any patients. Spore testing, however, was not performed from October 22, 2012 through December 31, 2012 during which period the Respondent saw patients except for December 10 through 16, 2012. This finding constitutes a violation of CDC guidelines.

16. The Respondent failed to perform consistent, verifiable sterilization of all re-usable intra-oral instruments including hand pieces, burs and hand instruments. The Board expert observed that the Respondent left a high speed dental hand piece on the dental unit in a treatment room throughout the visit. In addition, the Respondent stored loose instruments in drawers with instruments in sealed sterilization bags and improperly stored reusable devices in torn sterilization bags. The Board expert also observed bulk storage of instruments in plastic bins and a tin can in the sterilization area. This finding constitutes a violation of CDC guidelines.

17. The Respondent failed to establish a dental unit waterline maintenance policy. This finding constitutes a violation of CDC guidelines.

18. The Respondent failed to maintain a laboratory protocol for case disinfection and isolation, the purpose of which is to prevent cross infection. Countertops in an operatory were cluttered with equipment, stone casts and even a telephone book. One sink is used for both instrument cleaning and lab work, setting up a potential cross-contamination risk. This finding constitutes a violation of CDC guidelines.

19. The Respondent failed to provide for timely removal of medical waste and failed to maintain manifests documenting regular medical waste removal for the required three year period. This finding constitutes a violation of CDC guidelines.

20. The Respondent failed to have a CPR resuscitator mask available. This finding constitutes a violation of CDC guidelines.

21. The Respondent's medical emergency supplies contained multiple expired items. This finding constitutes a violation of CDC guidelines.

22. The Respondent failed to maintain documentation of annual safety evaluations and Hepatitis B vaccination records. These findings constitute violations of CDC guidelines.

23. In furtherance of the Board's investigation, Board staff requested the Respondent to provide verification that she had completed a two-hour course in infection control as she had indicated on her 2011 renewal application. The Respondent was unable to provide to Board staff verification that she had taken the infection control course. This finding constitutes a violation of Board regulations, specifically Md. Code Regs. 10.44.22.04B.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent failed to comply with Centers for Disease Control's guidelines on universal precautions, in violation of H.O. § 4-315(a)(28); willfully made or filed a false

report in the practice of dentistry, in violation of H.O. § 4-315(a)((20) and/or violated any rule or regulation adopted by the Board, in violation of H.O. § 4-315(a)(18).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 7th day of May, 2014, by a majority of the quorum of the Board, hereby

ORDERED that the Respondent is **Reprimanded**; and it is further

ORDERED that the Respondent shall be placed on **Probation** for a minimum period of two (2) years from the date of the execution of this Consent Order and until the Respondent fully and satisfactorily complies with the following terms and conditions:

1. Within three (3) months from the date of this Order, the Respondent shall retain a Board-approved consultant who shall conduct an unannounced inspection to evaluate her current dental office for compliance with CDC guidelines and shall train the Respondent and her office staff in the proper implementation of CDC guidelines. The consultant shall be provided with copies of the Board file, this Consent Order, all prior inspections and any and all documentation deemed relevant by the Board;

2. The Respondent shall be subject to a minimum of two (2) additional unannounced inspections by the Board approved consultant, during her two (2) year probationary period. The second inspection shall be conducted not later than one (1) year after the execution of this Order. The third inspection shall be conducted no later than twenty-three (23) months after the execution of this Order. Based upon the results of these inspections, the Board, in its discretion, may order additional inspections or may extend the probationary period;

3. The Respondent shall request that the consultant provide reports to the Board, within ten (10) days of the date of each inspection. The consultant may consult with the Board regarding the findings of the inspections;

4. All inspections shall be unannounced and shall be conducted during a full day of patient care and shall be designed to ensure that the Respondent and all office staff, is complying with the CDC guidelines and the Act;

5. Respondent shall, at all times, comply with CDC guidelines, including Occupational Safety and Health Administration's ("OSHA") for dental healthcare settings;

6. At any time during the period of probation, if the Board makes a finding that Respondent is not in compliance with CDC guidelines or the Act, the Respondent shall have the opportunity to correct the infractions within seven (7) days and shall be subject to a repeat inspection within thirty (30) days; and it is further

ORDERED that the Respondent shall successfully complete at her own expense a Board-approved infection control course no later than six (6) months from the date of the Consent Order. The course shall be applied to her required continuing education credits required for continued licensure; and it is further

ORDERED that after a minimum of two (2) years of probation, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board. The Board may grant termination if Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

ORDERED that if the Respondent closes or sells her practice, she may petition to the Board to alter the terms of her probation; and it is further

ORDERED that the Respondent shall at all times cooperate with the Board, any of its agents or employees, and with her consultant, in the monitoring, supervision and investigation of the Respondent's compliance with the terms and conditions of this Consent Order; and it is further

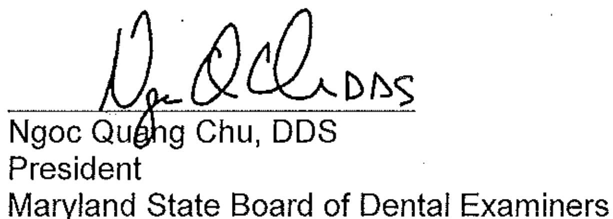
ORDERED that the Respondent shall be responsible for all costs incurred under this Consent Order; and it is further

ORDERED that if the Respondent violates any of the terms or conditions of this Consent Order, the Board, in its discretion, after notice and an opportunity for a show

cause hearing before the Board, or opportunity for an evidentiary hearing before an Administrative Law Judge at the Office of Administrative Hearings if there is a genuine dispute as to the underlying material facts, may impose any sanction which the Board may have imposed in this case under §§ 4-315 and 4-317 of the Maryland Dental Practice Act, including an additional probationary term and conditions of probation, reprimand, suspension, revocation and/or a monetary penalty, said violation being proved by a preponderance of the evidence; and it is further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-601 *et seq.* (2009 Repl. Vol. & 2013 Supp.)

5/7/2014
Date



Ngoc Quang Chu, DDS
President
Maryland State Board of Dental Examiners

CONSENT

I, Margaret N. Kromah, DDS, acknowledge that I am represented by counsel and have consulted with counsel before entering this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

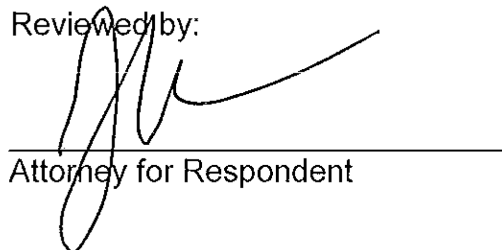
I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that I might have filed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

5-02-2014
Date

Margaret N. Kromah, DDS.
Respondent

Reviewed by:

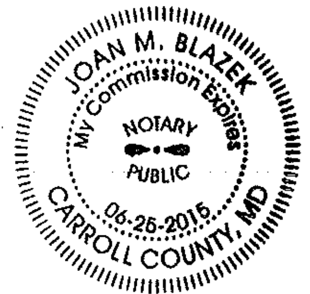

Attorney for Respondent

STATE OF Maryland

CITY/COUNTY OF Carroll

I HEREBY CERTIFY that on this 2nd day of May 2014, before me, a Notary Public of the foregoing State and City/County, Margaret N. Kromah, DDS personally appeared , and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed.

AS WITNESSETH my hand and notarial seal.



Joan M. Blazek
Notary Public

My Commission expires: 06-25-2015