IN THE MATTER OF	*	**BEFORE THE MARYLAND**
TONGELA WILLIAMS, D.D.S.	*	**STATE BOARD OF**
RESPONDENT	*	**DENTAL EXAMINERS**
License Number: 13680	*	**Case Number: 2018-027**

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

CONSENT ORDER

On or about September 6, 2017, the Maryland State Board of Dental Examiners (the "Board") issued and served on **Tongela Williams, D.D.S.** (the "Respondent"), License Number 13680: **CHARGES** under the Maryland Dentistry Act, codified at Md. Code Ann., Health Occ. I ("Health Occ.") §§ 4-101 *et seq.* (2014) (the "Act"); and an **ORDER FOR SUMMARY SUSPENSION,** by which it summarily suspended the Respondent's license to practice dentistry in the State of Maryland. The Board took such action pursuant to its authority under Md. Code Ann., State Gov't § 10-226(c) (2014 Repl. Vol.), concluding that the public health, safety and welfare imperatively required emergency action.

Specifically, the Board charges the Respondent with violating the following provisions of the Act:

Health Occ. § 4-315

> (a) *License to practice dentistry.* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may ... reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the ... licensee:
>
> (16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession;
>
> (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...;

On September 20, 2017, a joint Show Cause Hearing and Case Resolution Conference ("CRC") was held at the Board's office. As a resolution of this case, the Respondent agreed to enter into this public Consent Order consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGSOF FACT

The Board finds the following:

1. At all times relevant hereto, the Respondent was licensed to practice dentistry in the State of Maryland. The Respondent was initially licensed on April 23, 2006. Her license is current through June 30, 2018.

2. At all times relevant hereto, the Respondent, a sole practitioner, maintained an office for the private practice of dentistry located at 9001 Stuart Lane, Clinton, Maryland 20735 (the "Office").

Complaint

3. On or about August 9, 2017, the Board received a complaint (the "Complaint") from an individual (the "Complainant") who identified herself as a dental assistant employed at the Office.

4. In the Complaint, the Complainant indicated that the Respondent was experiencing turmoil in her personal life that was causing her professional performance to become "erratic."

5. In particular, the Complaint alleges that the Respondent is disregarding important sanitation protocols designed to prevent the spread of infection, and "using dirty faulty equipment." Specifically, the Complaint states the Respondent is using: an autoclave that fails to properly sterilize instruments; an air compressor that fails to

properly perform suction and disposal of fluids from patients' mouths; an X-ray machine that is dated and "out of code."

6. Based on the Complaint, the Board initiated an investigation regarding the Respondent's compliance with CDC guidelines. [1]

7. In furtherance of the investigation, the Board assigned an expert in infection control protocols (the "CDC Expert") to conduct an inspection of the Office.

Expert Report

8. On or about August 16, 2017, the CDC Expert conducted an inspection of the Office to determine whether the Respondent was complying with the CDC guidelines.

9. Following the inspection, the CDC Expert completed a report (the "Expert Report") regarding the Respondent's compliance with CDC Guidelines at the Office.

10. In the Expert Report, the CDC Expert noted serious deficiencies in the Respondent's compliance with CDC Guidelines. Based on these deficiencies, the CDC Expert opined that "a risk to patient and staff safety exists."

11. The CDC expert wrote in his Expert Report that, "There were no written policies of any kind available for review at the time of the inspection." The Respondent also stated that she was unaware of the obligation to keep spore testing logs and maintenance logs for equipment.

12. The CDC Expert noted deficiencies in a wide range of areas, including: failure to document infection control training, failure to maintain employee training

[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 (the "CDC 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. Under the Act, all dentists are required to comply with the CDC guidelines, which incorporate by reference Occupational Safety and Health Administration's ("OSHA") final rule on Occupational Exposure to Bloodborne Pathogens (29 CFR 1910.1030). The only exception to this rule arises in an emergency which is life-threatening *and* where it is not feasible or practicable to comply with the guidelines.

records, failure to document exposure management programs, failure to maintain updated infection control reference materials, deficient sterilization verification, maintenance, and documentation, inconsistent barrier protection practices, deficient waterline maintenance documentation, deficient autoclave maintenance documentation.

13. In summary, the specific violations noted by the CDC Expert included the following:

1. Failed spore test results for multiple dates, with no indication of remediation action to address the failures;
2. Inconsistent time periods between spore tests, with multiple gaps of approximately two weeks or more between tests and no log to address discrepancies;
3. No spore test log maintained;[2]
4. No equipment maintenance log for autoclave (sterilizer) maintained;
5. No equipment maintenance log for dental waterlines maintained;
6. No staff training manual maintained for infection control practices;
7. No staff training log for infection control practices;
8. Multiple examples of unverifiable sterilization of dental devices, including burs, bur blocks, XCP (radiographic film) equipment, and other items;
9. Storage of expired materials and medications;
10. Storage of broken and unused equipment in close proximity to usable equipment;
11. Inconsistent barrier protection in operatories.

14. After the inspection, the Respondent sent the Board's investigator several documents, such as an infection control training manual, log of work-related injuries, injury report forms; disinfection checklists; a spore testing log; waterline maintenance

[2] Although the Respondent failed to maintain a spore testing log in the Office, the CDC Expert was able to analyze the Respondent's performance of spore testing because after the inspection, the Respondent sent the CDC Expert printouts from the spore testing company's website, which displayed spore testing results for her autoclave.

log; staff training log forms; privacy training acknowledgement forms. However, these materials were all simply blank forms that had apparently never been used.

CONCLUSIONS OF LAW

The Board concludes as a matter of law that the Respondent's conduct as described above, including failing to comply with the CDC Guidelines, as described above, constitutes: behaving dishonorably or unprofessionally, or violating a professional code of ethics pertaining to the dentistry profession, in violation of Health Occ. § 4-315(a)(16); and failing to comply with Centers for Disease Control's guidelines on universal precautions in violation of Health Occ. § 4-315(a)(28).

ORDER

Based on the foregoing findings, it is, by a majority of a quorum of the Board, hereby:

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

ORDERED that upon the Board's receipt of verified documentation that the Respondent has formally retained the services of a qualified Board-approved infection control consultant and that the consultant has issued a favorable report substantiating that the Respondent and her office staff are in substantial compliance with CDC Infection Control Guidelines, the Board shall issue an **Order for Reinstatement** lifting the summary suspension issued on September 6, 2017; and it is further

ORDERED that from the date of the Board's the Order for Reinstatement, the Respondent shall be placed on **PROBATION** for a period of **TWO (2) YEARS** under the following terms and conditions:

1. A Board-assigned inspector shall conduct an unannounced inspection within ten (10) business days after the Respondent's license is reinstated in order to evaluate the Respondent and her staff regarding compliance with the Act and infection control

guidelines. The Board-assigned inspector shall be provided with copies of the Board file, the Consent Order, and any other documentation deemed relevant by the Board;

2. The Respondent shall provide to the Board-assigned inspector a schedule of her office's regular weekly hours of practice and promptly apprise the consultant of any changes;

3. During the two (2) year probationary period, the Respondent shall be subject to quarterly unannounced onsite inspections by a Board-assigned inspector;

4. The Board-assigned inspector shall provide reports to the Board within ten (10) business days of the date of each inspection and may consult with the Board regarding the findings of the inspections;

5. The Respondent shall, at all times, practice dentistry in accordance with the Act, related regulations, and shall comply with CDC and Occupational Safety and Health Administration's ("OSHA") guidelines on infection control for dental healthcare settings; and

6. At any time during the period of probation, if the Board makes a finding that the Respondent is not in compliance with CDC and OSHA 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 seven (7) days to confirm that the violation has been remedied.

7. Within six (6) months of the Order for Reinstatement, the Respondent shall successfully complete a Board-approved course equivalent to at least six (6) hours of continuing education (CE) credit in infection control protocols. And

IT IS FURTHER ORDERED that no part of the training or education that the Respondent receives in order to comply with this Consent Order may be applied to her required continuing education credits, and it is further

ORDERED that the Respondent shall at all times cooperate with the Board, any of its agents or employees, and with the Board-assigned inspector, 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 after a minimum of two (2) years from the effective date of the Order for Reinstatement, 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. In addition, the Respondent shall have the right to petition the Board for termination of probation upon the sale of her ownership interest in her Office. The Board shall grant termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending investigations or outstanding complaints related to the findings of fact in this Consent Order; and it is further

ORDERED that if the Respondent allegedly fails to comply with any term or condition of probation or this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be an evidentiary hearing before the Board. If there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before the Board; and it is further

ORDERED that after the appropriate hearing, if the Board determines that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice dentistry in Maryland. The Board may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent;

ORDERED that this Consent Order is a public document pursuant to Md. Code Ann., Md. Code Ann., Gen. Prov. §§ 4-101 et seq. (2014).

9/20/12
Date

Arthur C. Jee, D.M.D.
President
Maryland State Board of Dental Examiners

CONSENT

By this Consent, I, Tongela WIlliams, D.D.S., agree and accept to be bound by this Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact and Conclusions of Law.

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 as provided by law. I acknowledge the legal authority and the jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I also affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing.

I sign this Consent Order after having consulted with counsel, and I fully understand and comprehend the language, meaning and terms of this Consent Order. I voluntarily sign this Order, and understand its effect.

9/20/17
Date

Tongela Williams, DDS
Tongela Williams, D.D.S.
Respondent

NOTARY

STATE OF MARYLAND

CITY/COUNTY OF: BALTIMORE

I HEREBY CERTIFY that on this 20TH day of SEPTEMBER 2017, before me, a Notary Public of the State and County aforesaid, personally appeared Tongela Williams, D.D.S., and gave oath in due form of law that the foregoing Consent Order was her voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Sharon Oliver
Notary Public

My commission expires: 7/19/2021