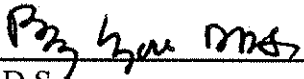


IN THE MATTER OF * BEFORE THE MARYLAND
ROCHELLE RENWICK-CURTIS, D.D.S. * STATE BOARD OF
Respondent * DENTAL EXAMINERS
License Number 7179 * Case Number 2002-292

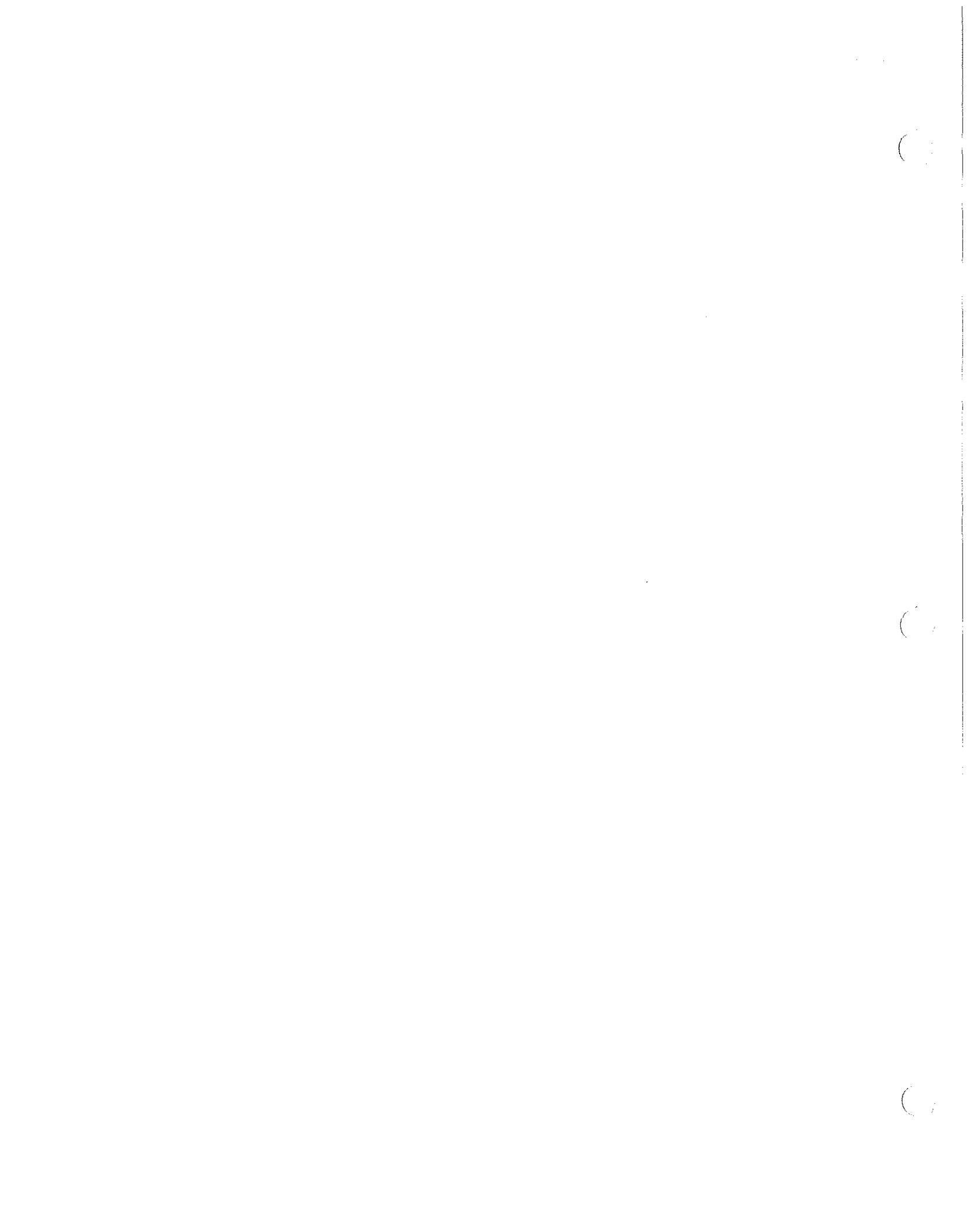
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**ORDER OF TERMINATION
OF PROBATION**

The Maryland State Board of Dental Examiners hereby acknowledges that Rochelle Renwick-Curtis, D.D.S., License Number 7179, has fully completed the requirements of the Consent Order dated August 3, 2005. Effective July 18, 2007, Dr. Renwick-Curtis' license to practice dentistry in the State of Maryland is restored without restrictions or conditions.



Barry D. Lyon, D.D.S.
Secretary-Treasurer
Maryland State Board of Dental Examiners



IN THE MATTER OF	*	BEFORE THE MARYLAND
ROCHELLE RENWICK-CURTIS, D.D.S.	*	STATE BOARD OF
Respondent	*	DENTAL EXAMINERS
License Number: 7179	*	Case No.: 2002-292
	*	OAG Case No.: 04-BP-220

* * * * *

CONSENT ORDER

The Maryland State Board of Dental Examiners (the "Board") on May 4, 2005 voted to offer Rochelle Renwick-Curtis, D.D.S. ("Respondent"), License No. 7179, a Pre-Charge Consent Order in lieu of issuing Charges for violations of the Maryland Dentistry Act (the "Act"), Md. Health Occ. Code Ann. ("Health Occ.") § 4-101 *et seq.* (2000 Repl. Vol. & Supp. 2004).

The pertinent provisions of the Act provide:

Health Occ. §4-315. Denials, reprimands, probations, suspensions and revocations – Grounds.

(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 applicant or licensee:

(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 guidelines on universal precautions; and

(31) Fails to comply with any Board order.

The Board and the Respondent agree to enter into this Consent Order consisting of Procedural Background, Findings of Fact, Conclusions of Law, and Order.

PROCEDURAL BACKGROUND

The Board Summarily Suspended the Respondent’s license on June 18, 2003 under the Maryland Dentistry Act (the "Act"), Md. Health Occ. ("H.O.") Code Ann. §§ 4-101 *et seq.* (2000).

The Respondent appeared before the Board at a Show Cause hearing on July 2, 2003 regarding the Summary Suspension. Thereafter, the Board issued a Final Decision and Order on August 7, 2003 which suspended the Respondent's license for six (6) months, with all six (6) months stayed, and placed the Respondent's license on probation for one (1) year subject to the following conditions.

1. Respondent's practice of dentistry will be subject to four unannounced monitoring inspections by Christine Wisnom, R.N. during the probationary period to assure her ongoing compliance with CDC infection control practices;
2. Ms. Wisnom shall report to the Board, in writing, when the office is in full compliance with the CDC guidelines and when Respondent evidences a working knowledge and understanding of the CDC guidelines and implementation thereof.
3. Respondent's practice will also be subject to unannounced inspections by Board personnel during the probationary period at a frequency as determined by the Board to ensure compliance with the CDC guidelines. A finding by the Board or Ms. Wisnom indicating that the Respondent or her practice is not in compliance with the CDC guidelines shall constitute a violation of this Order and may, in the Board's discretion, be grounds for suspending the Respondent's license. In the event that Respondent's license is suspended under this provision, she shall be afforded a Show Cause Hearing before the Board to show cause as to why her license should not be suspended or should not have been suspended;

During the Probationary period, the CDC Consultant, Christine Wisnom, R.N., conducted four (4) unannounced CDC inspections of the Respondent's office which included observation of patient care. In addition, the Board's Dental Compliance Officer, Frederick Magaziner, D.D.S., conducted an unannounced CDC inspection of the Respondent's dental office with observation of patient care on May 23, 2004. Based on the observations by the CDC Consultant and the Dental Compliance Officer during their inspections, which are set-forth below, the Board and the Respondent agree to enter into this Consent Order.

FINDINGS OF FACT

1. On or around August 21, 2003, Christine Wisnom, R.N. CDC Consultant, conducted an unannounced CDC Infection Control/OSHA inspection of the Respondent's office located at 3331 Toledo Terrace, Suite #106, Hyattsville, MD 20872. During the August 21, 2003 inspection, Ms. Wisnom noted the following areas that were violations of the CDC guidelines:

- a. The button on the x-ray machine was not wiped or covered with a barrier and touched repeatedly with contaminated gloves.
 - b. A contaminated lead apron was placed next to a clean apron thereby contaminating the clean apron.
2. On or around December 19, 2003, Ms. Wisnom conducted a second unannounced CDC inspection of the Respondent's office. During the December 19, 2003 inspection, Ms. Wisnom noted the following areas that were violations of the CDC guidelines:
 - a. The handle of the Cavitron was not covered with a barrier, nor was it disinfected after patient use.
 - b. The burs were mounted in an uncovered bur block which contained multiple (approximately 20) burs. They were not sterilized or covered in any fashion to protect them from contamination. Ms. Wisnom informed the Respondent that reaching into a bur block with gloves to remove an appropriate bur contaminates all of the adjacent burs that are contacted by the operator's gloves.
3. On or around March 19, 2004, Ms. Wisnom conducted a third unannounced CDC inspection of the Respondent's office. During the March 19, 2004 inspection, Ms. Wisnom noted the following areas that were violations of the CDC guidelines:
 - a. A recently hired employee had not received formal OSHA training.
 - b. The coatroom contains dental supplies and prosthetics which are stacked on top of one another, in random order on the floor. In addition, prosthetic cases are mounted on articulators with no protective coverings. Impression trays and numerous prosthetic devices in various states of development for various patients are stacked on top of one another, with no indication that they have been disinfected.

- c. The Respondent was not observed to disinfect her protective eyewear throughout the morning.
 - d. The Respondent was observed repeatedly recapping contaminated needles with a two-handed manual recapping technique, even after Ms. Wisnom discussed the dangers of this practice.
 - e. An error in infection control occurred when the Respondent placed Dycal and base from the two (2) tubes onto a mixing pad while wearing contaminated examination gloves. The Respondent touched those same two tubes with contaminated gloves during treatment of a later patient thereby causing cross contamination from patient to patient.
 - f. Ms. Wisnom observed the Respondent fail to flush the water line following the use of the high-speed handpiece on one patient and then, after seating the next patient, place a sterilized handpiece on the high-speed line and flush the line. This practice potentially caused patient fluids that may have been retracted in the line from the previous patient to be expelled through the sterile handpiece which was then to be used on the new patient.
 - g. The Respondent did not respond appropriately when her sterilizer failed the spore test dated March 6, 2004. Ms. Wisnom states that the autoclave should have been taken out of service immediately and a loaner obtained from a dental supply company. The autoclave should have been retested before it was placed back in service to assure its efficacy.
4. In her March 25, 2004 report to the Board, Ms. Wisnom states that, "while much progress has occurred, I feel that [the Respondent] would benefit from additional support from an infection control consultant to reinforce the CDC Protocols for Infection Control in Dentistry."
5. On or around April 23, 2004, the Board's Dental Compliance Officer, Frederick Magaziner, D.D.S., conducted an unannounced CDC Infection Control inspection of the Respondent's

dental office. During the inspection, the Dental Compliance Officer observed the following violations of the CDC Guidelines:

- a. The water lines were not flushed for the recommended 2-3 minutes prior to commencement of patient care and for the recommended 30 seconds between patients.
6. On or around August 16, 2004, Ms. Wisnom conducted a fourth unannounced CDC inspection of the Respondent's office. During the August 16, 2004 inspection, Ms. Wisnom noted the following areas that were violations of the CDC guidelines:
- a. A recently hired chairside assistant had not been added to the "Exposure Determination" section of the Exposure Control Plan (ECP).
 - b. Evidence of the assistant's second Hepatitis B vaccination was not available during the inspection and was not provided subsequent to the inspection.
 - c. Many incidents of cross contamination were observed in the clinical areas including the following:
 - i. A half consumed bottle of water was stored in a refrigerator marked "Dental Materials Only."
 - ii. Clinical eyewear with side shields was resting next to the coffee pot.
 - iii. In the sterilization/cleaning area a red bag containing contaminated items was lying next to a bag with sterilized items.
 - iv. Contaminated bite wings were observed lying on a paper towel next to a prescription bottle.
 - v. Instrument trays waiting to receive sterilized instruments were resting against sharps containers.
 - vi. Metal amalgam wells were not sterilized and were contaminated by contact with amalgam carriers which had been used intraorally.

- vii. The cold sterilizing containers were very dirty in appearance.
 - viii. Disposable single use items such as evacuator tips, prophylactic angles and cups were sterilized and stored in bags in an operatory drawer.
 - ix. Spore testing results for the autoclave were only available through April 2004 and no records for spore testing from April through August 2004 were submitted to Ms. Wisnom.
 - x. Prosthetic devices were thrown into a box which also contained clinical supplies on the floor of the closet. This situation remained uncorrected since the last inspection.
7. In her August 24, 2004 report to the Board, Ms. Wisnom states that “[b]ased on these findings, it is [her] recommendation that the Consent Order for [the Respondent] be extended for an extra year and [the Respondent] continue to work with an Infection Control consultant.”

CONCLUSIONS OF LAW

The Board finds that the Respondent violated Md. Health Occ. Code Ann. § 4-315 (28) which requires compliance with the CDC’s guidelines on universal precautions except in life threatening circumstances and that she has not completed the requirements set-forth in the probationary terms of the Board’s August 7, 2003 Order which constitutes a violation of Health Occ. § 4-315(31) which requires compliance with any Board order. Specifically, the Respondent has not completed the probationary requirement that Ms. Wisnom submit a report to the Board, in writing, indicating that the Respondent’s office is in full compliance with the CDC guidelines and that the Respondent evidences a working knowledge and understanding of the CDC guidelines and implementation thereof.

ORDER

Based on the Board's Findings of Fact and Conclusions of Law set-forth above, it is hereby:

ORDERED that the **PROBATION** of Respondent's license shall be continued for two (2) years from the date of this Consent Order; and it is further

ORDERED that the terms and conditions imposed in the Board's Final Order issued on August 7, 2003 are incorporated in their entirety herein; and it is further

ORDERED that the Respondent shall permit a Board-approved CDC Consultant to perform at least quarterly CDC inspections/consultations at the Respondent's office during the probationary period. The CDC Consultant will submit reports to the Board regarding the Respondent's compliance with the CDC Infection Control Guidelines on universal precautions; and it is further

ORDERED that the cost of the CDC Consultant will be paid by the Respondent; and it is further

ORDERED that Respondent will permit her practice to be subject to unannounced inspections by Board personnel during the probationary period at a frequency as determined by the Board to ensure compliance with the CDC guidelines; and it is further

ORDERED that the Respondent may petition for termination of the probation after one (1) year (four quarterly inspections) if the Board-approved CDC Consultant submits a favorable report to the Board with respect to the Respondent's compliance with the CDC Infection Control Guidelines. In any case, the Respondent may not apply for termination until at least four (4) inspections by the Board-approved CDC Consultant have been completed. Termination of the probationary period prior to two (2) years from the date of this Consent Order is entirely at the Board's discretion; and it is further

ORDERED that if the Respondent violates any of the terms or conditions of this Consent Order, including the probationary terms or conditions as set forth herein, then the Board, after a

determination of violation and notice, and an opportunity for Show Cause hearing, may impose any other disciplinary sanctions it deems appropriate, including suspension or revocation, said violation being proved by a preponderance of evidence; and it is further

ORDERED that, except as otherwise provided herein, at the conclusion of the two (2) years of probation, the Respondent may petition, in writing, for termination of her probationary status without further conditions or restrictions provided the Respondent has satisfactorily complied with all of the conditions of the Consent Order, including the terms of the Probation, and it is further

ORDERED that the Respondent shall practice dentistry in accordance with the Maryland Dentistry Act; and it is further

ORDERED that in the event the Board finds for any reason that the Respondent has violated any provision of Md. Health Occ. Code Ann. §§ 4-101, *et seq.* or the regulations thereunder, the Board, after notification to the Respondent, and an opportunity for a Show Cause hearing, may take immediate action and may impose any lawful disciplinary sanction it deems appropriate, including but not limited to revocation or suspension of the Respondent's license to practice dentistry; and it is further


ORDERED that for purposes of public disclosure, and as permitted by Md. State Gov't. Code Ann. § 10-617(h) (2004), this document consists of the contents of the foregoing Procedural Background, Findings of Fact, Conclusions of Law and Order, and that the Board may also disclose to any national reporting bank or other entity to whom the Board is mandated to report; and it is further

ORDERED that any costs associated with this Consent Order shall be paid by the Respondent; and it is further

ORDERED that the conditions of this Consent Order be, and the same is hereby, effective as of the date of this Order; and it is further

ORDERED that this is a **FINAL ORDER** and, as such, is a public document pursuant to Md. State Gov't. Code Ann. §§ 10-611 *et seq.* (2004).

IT IS SO ORDERED THIS 3rd **DAY OF** August, 2005.


Eric A. Katkow, D.D.S, President-Elect
Maryland Board of Dental Examiners

CONSENT OF ROCHELLE RENWICK-CURTIS, D.D.S.

I, Rochelle Renwick-Curtis, D.D.S., License No. 7179, by affixing my signature hereto, acknowledge that:

1. I have had the opportunity to consult with counsel before signing this document.
2. I am aware that I am entitled to a formal evidentiary hearing before the Board, pursuant to Md. Health Occ. Code Ann. § 4-318 (2004) and, Md. State Gov't. Code Ann. §§10-201 *et seq.* (2004)
3. I acknowledge the validity of this Consent Order as if entered after 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 law.
4. I voluntarily enter into and consent to the foregoing Findings of Fact, Conclusions of Law and Order, provided that the Board adopts the foregoing Consent Order in its entirety. I waive any right to contest the Findings of Fact and Conclusions of Law, and I waive my right to a full evidentiary hearing, as set forth above, and any right to appeal this Consent Order or as set forth in § 4-318 of the Act and Md. State Gov't. Code Ann. §§ 10-201 *et seq.* (2004).

5. I acknowledge that by failing to abide by the conditions set forth in this Consent Order, and, following proper procedures, I may suffer disciplinary action, which may include revocation of my license to practice dentistry in the State of Maryland.

6. I sign this Consent Order without reservation as my voluntary act and deed. I acknowledge that I fully understand and comprehend the language, meaning, and terms of this Consent Order.

4/13/05
Date

Rochelle Renwick-Curtis, D.D.S.
Rochelle Renwick-Curtis, D.D.S.

[Signature]
Respondent's Counsel

NOTARY

STATE OF MARYLAND

CITY/COUNTY OF MONTGOMERY

I HEREBY CERTIFY THAT on this 13 day of JULY, 2005, before me, a Notary Public for the State of Maryland and the City/County aforesaid, personally appeared **Rochelle Renwick-Curtis, D.D.S.**, and made oath in due form of law that the foregoing Consent Order was her voluntary act and deed.

AS WITNESS my hand and Notarial Seal.

[Signature]
Notary Public

My Commission Expires: 11/01/06

CHARLES F. MURRAY
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires November 1, 2006