IN THE MATTER OF	*	**BEFORE THE**
CAROL M. ORLANDO, D.D.S.	*	**MARYLAND STATE BOARD**
Respondent	*	**OF DENTAL EXAMINERS**
License Number: 8804	*	**Case Number: 2015-015 & 016**

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

CONSENT ORDER

On November 16, 2016, the Maryland State Board of Dental Examiners (the "Board") charged **CAROL M. ORLANDO, D.D.S.,** (the "Respondent"), License Number 8804, with violating the Maryland Dentistry Act (the "Act"), Md. Code Ann., Health Occ. I ("Health Occ. I") §§ 4-101 *et seq.* (2014 Repl. Vol.).

Specifically, the Board charged the Respondent with violating the following provisions of the Act under Health Occ. I § 4-315 and Md. Code Regs. ("COMAR") 10.44 *et seq.*:

> **Health Occ. I § 4-315. Denials, reprimand, probations, suspension, and revocations— Grounds.**
>
> (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:
>
> (6) Practices dentistry in a professionally incompetent manner or in a grossly incompetent manner;
>
> (16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession; [and]
>
> (20) Violates any rule or regulation adopted by the Board[.]

COMAR 10.44.23.01 Unprofessional or Dishonorable Conduct

B. A dentist . . . may not engage in unprofessional or dishonorable conduct.

C. The following shall constitute unprofessional or dishonorable conduct in the practice of dentistry . . .:

(2) Engaging in conduct which is unbecoming a member of the dental profession; [and]

(8) Committing any other unprofessional or dishonorable act or omission in the practice of dentistry . . .[.]

COMAR 10.44.30.02 General Provisions for Handwritten, Typed and Electronic Health Records.

K. Dental records shall:

(2) Be detailed; [and]

(3) Be legible[.]

On January 18, 2017, a Case Resolution Conference was held before a committee of the Board, during which the Respondent disputed the Board's allegations that she practiced dentistry in a grossly or professionally incompetent manner. As a resolution of this matter, the Respondent agreed to enter into this public Consent Order consisting of the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Board makes the following Findings of Fact:

I. BACKGROUND

1. At all times relevant, the Respondent was licensed to practice dentistry in the State of Maryland. The Respondent was initially licensed to practice dentistry in Maryland on or about October 26, 1984, under License Number 8804.

2. At all times relevant, the Respondent practiced pediatric dentistry at a dental practice (the "Practice")[1] in Bethesda, Maryland.

3. On or about July 28, 2014, the Board initiated an investigation of the Respondent after reviewing information from the Maryland Healthcare Alternative Dispute Resolution Office regarding a dental malpractice claim a patient ("Patient A") filed against the Respondent. The claim alleged that the Respondent provided dental care to Patient A from in or around 2003 to 2011, during which time the Respondent failed to apply sealants and perform competent cleanings on Patient A's teeth, causing extensive decay in 21 teeth.

4. In reviewing the National Practitioner Data Bank, a Board investigator discovered that in or around September 2009, the Respondent's insurance company settled two dental malpractice claims against the Respondent in which two of the Respondent's patients alleged that she failed to diagnose and treat their extensive tooth decay and dental caries, and failed to perform sealant therapy and annual x-rays, which resulted in the worsening of their tooth caries and decay.

II. BOARD INVESTIGATION

5. In the course of its investigation, the Board subpoenaed Patient A's dental record and additional patient dental records from the Respondent and submitted them to a licensed dentist (the "Board Expert") who specialized in pediatric dentistry for a practice review. Based on his review, the Board Expert determined that the Respondent exhibited a pattern of incompetency in her care and treatment of a number the patients and failed to keep adequate records.

[1] To protect confidentiality, the name of the Complainant, patients, other dentists or dental practices will not be identified by name in this document.

A. Summary of Deficiencies

6. The Respondent's care and treatment of Patients A through F were deficient for reasons including:

a. Failing to perform to perform basic diagnostic techniques to assess for caries;

b. Failing to take radiographs where appropriate during routine recall visits;

c. Inconsistent placement of dental sealants on permanent molars to prevent pit and fissure caries;

d. Failing to diagnose and treat new and recurrent caries identifiable on radiographs;

e. Failing to diagnose and treat abscesses identifiable on radiographs; and

f. Failing to document detailed and legible notes to include information as such:

(i) Type of isolation used during restorative treatment;

(ii) Whether local anesthetic was used and the amount used;

(iii) Radiographs taken;

(iv) Radiographic and examination findings;

(v) Patient's weight and amount and strength of antibiotics prescribed; and

(vi) Update of patients' medical history.

B. Patient-Specific Allegations

Patient A

7. Patient A, then eight years old, initially presented to the Respondent on or about September 22, 2003, for a comprehensive oral examination, dental prophylaxis

and fluoride treatment. The Respondent noted that Patient A's parents were to forward to him Patient A's prior radiographs, though there were no prior radiographs in Patient A's chart. The Respondent did not note any caries in Patient A's chart during this visit.

8. The Respondent provided periodic oral examinations, dental prophylaxis and fluoride treatments to Patient A generally once every six months from approximately September 22, 2003, to February 2, 2011. During the treatment period, the Respondent noted that Patient A had poor oral hygiene.

9. On or about August 10, 2004, Patient A presented with complaints of upper left sided pain. The Respondent took a periapical radiograph, which showed decay on the distal surface of Tooth # I.[2] Patient A's chart failed to contain any notes as to what, if any, treatment the Respondent provided.

10. In or around 2009, the Respondent referred Patient A to an orthodontist, who later placed Patient A in an orthodontic fixed appliance.

11. Patient A's financial ledger indicated that the Respondent placed a sealant on Patient A's Tooth # 14 on or about December 23, 2009. The Respondent, however, failed to document this visit in Patient A's chart.

12. On or about September 30, 2010, an orthodontist debanded Patient A from her orthodontic fixed appliance. The Respondent noted in Patient A's chart that there was decalcification but failed to document which tooth or area had decalcified. The Respondent took a periapical radiograph of Patient A's Tooth # 14 and noted a fracture on the mesial-buccal sides, which she treated with a liner and filling.

[2] Throughout this document, the following abbreviations will be used to reference certain tooth surfaces: buccal (B), distal (D), facial (F), lingual (L), mesial (M) and occlusal (O).

13. The Respondent saw Patient A on or about January 17, 2011, for a routine follow-up visit. At this visit the Respondent took bitewing radiographs of Patient A's teeth and diagnosed the following caries: #19(M), #20(D), #29(D) and #30(M). On or about January 26, 2011, the Respondent performed composite restorations to the following teeth: #19(MO), #29(DO) and #30(MO). Patient A's chart did not contain any documentation as to the use of anesthesia.

14. On or about August 11, 2011, Patient A sought care from another dentist ("Dentist A"). After examining Patient A, Dentist A diagnosed "rampant and extensive" decay in 21 of Patient A's teeth (Tooth # 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 18, 19, 20, 22, 27, 28, 29, 30 and 31).

15. During Patient A's approximately seven and one-half year treatment period, the Respondent took bitewing radiographs on only one occasion, which occurred on or about January 17, 2011.

16. The Respondent's care and treatment of Patient A were deficient for reasons including:

a. Failing to perform basic diagnostic techniques to assess for caries;

b. Failing to take radiographs where appropriate during routine recall visits;

c. Failing to counsel Patient A on nutrition and prevention during recall visits;

d. Failing to place Patient A on home fluoride therapy;

e. Failing to treat Patient A's posterior teeth with sealants to protect them from pit and fissure caries;

f. Failing to perform proper dental restorations, which resulted in recurrent decay; and

g. Failing to keep detailed and legible dental records.

Patient B

17. Patient B, then five years old, initially presented to the Respondent on or about September 22, 2003, for a comprehensive oral examination, dental prophylaxis and fluoride treatment. The Respondent noted that Patient B's parents were to forward to him Patient B's prior radiographs, though there were no prior radiographs in Patient B's chart. The Respondent did not note any caries in Patient B's chart during this visit.

18. The Respondent provided periodic oral examinations, dental prophylaxis and fluoride treatments to Patient B generally once every six months from approximately September 22, 2003, to January 17, 2011. During the treatment period, the Respondent noted that Patient B had poor oral hygiene.

19. On or about April 8, 2004, the Respondent saw Patient B for an oral examination, dental prophylaxis and fluoride treatment. Patient B's financial ledger noted that she took a periapical radiograph. The radiograph in Patient B's chart clearly demonstrated an abscess on Tooth # S. The Respondent, however, failed to document taking a periapical radiograph and failed to diagnose and note an abscess on Tooth # S in Patient B's chart.

20. Patient B returned to the Respondent on or about November 9, 2004, for an oral examination, dental prophylaxis and fluoride treatment. The Respondent took two bitewing radiographs and noted that Patient B had signs of infection on Tooth # L. Patient B's radiographs demonstrated that the Respondent misdiagnosed Patient B as having an abscess on Tooth # L, when the abscess was on Tooth # S. The

Respondent further failed to formulate a treatment plan to address the source of the infection.

21. Patient B's financial ledger noted that on December 7, 2004, the Respondent took one occlusal and one periapical radiograph. The Respondent failed to document in Patient B's chart that she saw Patient B on December 7, 2004, and took two radiographs.

22. On or about October 3, 2005, Patient B presented with complaints of pain in the lower left quadrant. The Respondent noted that Patient B's December 2004 radiograph showed root resorption on Tooth # L. She recommended that if the pain persisted, a periapical radiograph should be taken and Tooth # L should be extracted. The Respondent failed to recognize that Patient B's December 2004 radiograph was of the lower right quadrant.

23. Patient B appeared for an emergency visit on or about May 22, 2006, with complaints of pain. The Respondent took a periapical radiograph, which demonstrated an abscess on Tooth # L. The Respondent noted that Tooth # L was being impacted with food and recommended evaluation for extraction or restoration. Patient B returned on or about May 30, 2006, during which time the Respondent noted swelling in the lower left quadrant and recommended an evaluation for extraction. Patient B returned on or about June 7, 2006, at which time the Respondent noted no resolution of the swelling and referred Patient B to an oral surgeon for extraction of Tooth # L. Patient B's financial ledger on this date indicated that the Respondent took a periapical radiograph, which she failed to document in Patient B's chart. The Respondent should have treatment-planned Patient B's Tooth # L for extraction on May 22, 2006, instead of

waiting until two visits later. The Respondent also failed to diagnose and document decay on Patient B's Tooth # K-MO from the radiograph.

24. Patient B's financial ledger indicated that the Respondent took a periapical radiograph on January 18, 2007. The radiograph demonstrated an abscess in the area of Tooth # B with significant decay and a lesion on Tooth # A. The Respondent failed to document, diagnose and treatment-plan the abscess/decay on Tooth # B and the lesion on Tooth # A based on this periapical radiograph.

25. On or about August 28, 2007, the Respondent saw Patient B for an oral examination, dental prophylaxis and fluoride treatment. The Respondent took a panoramic radiograph of Patient B but did not document any findings. The radiograph clearly demonstrated an abscess on Tooth # S. The Respondent failed to diagnose and treatment-plan the abscess on Patient B's Tooth # S.

26. The Respondent continued to provide periodic oral examinations, dental prophylaxis and fluoride treatments to Patient B until January 17, 2011. On or about December 14, 2009, the Respondent noted Patient B had in place an orthodontic fixed appliance. On or about May 11, 2010, the Respondent extracted Tooth # T.

27. On or about August 11, 2011, Patient B sought care from Dentist A. After examining Patient B, Dentist A diagnosed "rampant and extensive" decay in eight of Patient B's teeth (Tooth # 2, 5, 12, 15, 18, 19, 30 and 31).

28. A review of Patient B's chart revealed that the Respondent took two periapical radiographs that she did not date or reference in her notes. The lower left periapical radiograph showed caries on Tooth # K - MO, and the upper right periapical radiograph showed over retained root tip from Tooth # B and decay on Tooth # A - MO.

The Respondent failed to diagnose and formulate treatment plans to address these teeth.

29. The Respondent's care and treatment of Patient B were deficient for reasons including:

a. Failing to perform basic diagnostic techniques to assess for caries;

b. Failing to take radiographs where appropriate during routine recall visits;

c. Failing to address multiple dental abscesses during routine recall visits;

d. Failing to counsel Patient B on nutrition and prevention during recall visits;

e. Failing to place Patient B on home fluoride therapy;

f. Failing to treat Patient B's posterior teeth with sealants to protect them from pit and fissure caries;

g. Failing to document Patient B's weight and dosage of antibiotics prescribed on November 9, 2004, and April 26, 2011; and

h. Failing to keep detailed and legible dental records.

Patient C

30. Patient C, then five years old, initially saw the Respondent on or about November 21, 2012, for a comprehensive oral examination, dental prophylaxis and fluoride treatment. The Respondent did not take radiographs of Patient C's teeth during this visit.

31. The Respondent provided periodic oral examinations, dental prophylaxis and fluoride treatments to Patient C, generally once every seven-to-eight months,

beginning around November 21, 2012, to June 7, 2015. During this treatment period, the Respondent did not take any radiographs of Patient C's teeth.

32. The first time the Respondent took a radiograph of Patient C was a panoramic radiograph on or about June 7, 2015, after having seen Patient C on four prior visits.

33. The Respondent's care and treatment of Patient C were deficient in that she failed to take bitewing radiographs of Patient C during earlier visits to rule out interproximal decay.

Patient D

34. Patient D, then three years old, initially presented to the Respondent on or about December 18, 2001, for a comprehensive oral examination, dental prophylaxis and fluoride treatment. The Respondent noted dental decay on the follow teeth: # B - O, # K - O, # L - O and # T - O. The Respondent provided restoration of Patient D's teeth with composite resin on or about January 31, 2002, and March 6, 2002.

35. The Respondent provided periodic oral examinations, dental prophylaxis and fluoride treatments to Patient D, generally once every six months, from approximately December 18, 2001, until February 18, 2014. During the treatment period, the Respondent noted that Patient D had poor oral hygiene.

36. On or about April 15, 2004, Patient D presented with pain in the lower right quadrant. The Respondent only documented performing a limited oral examination and taking a bitewing radiograph but otherwise failed to document his examination findings. The Respondent failed to diagnose the source of Patient D's pain and to formulate a

treatment plan to address the pain. The bitewing radiograph showed a large area of decay under the existing composite restoration on Tooth # T.

37. The Respondent saw Patient D on or about September 2, 2004, for restoration of Tooth # T with "pellet" and Intermediate Restorative Material ("IRM"). The Respondent prescribed Amoxicillin but failed to document Patient D's weight or the dosage prescribed. Patient D later lost the filling, which the Respondent replaced with glass ionomer.

38. Patient D's financial ledger indicated that the Respondent took an occlusal radiograph of Patient D on or about May 25, 2005. The Respondent, however, failed to document taking a radiograph on or about May 25, 2005, in Patient D's chart.

39. On or about August 17, 2006, the Respondent saw Patient D for an oral examination, dental prophylaxis and fluoride treatment. The Respondent documented taking a bitewing radiograph but failed to note any findings. The bitewing radiograph showed pathology in the furcation of Tooth # T. The Respondent failed to diagnose the pathology on Tooth # T and failed to formulate a treatment plan to address the pathology.

40. The Respondent took a panoramic radiograph of Patient D on or about October 11, 2006. In Patient D's chart, the Respondent noted that he placed sealant on Tooth # 3, 14, 19 and 30. The panoramic radiograph revealed that Patient D had abscesses on Tooth # K and T. The Respondent failed to diagnose and document this pathology, and failed to formulate a treatment plan to address this pathology.

41. The Respondent continued to provide periodic oral examinations, dental prophylaxis and fluoride treatments to Patient D until February 18, 2015. During this

time period, the Respondent referred Patient D to an orthodontist, who placed him in an orthodontic fixed appliance. The Respondent consistently noted in Patient D's chart that Patient D had poor oral hygiene.

42. The Respondent's care and treatment of Patient D were deficient for reasons including:

a. Failing to document the amount or type of anesthesia she used to treat Patient D;

b. Failing to document her clinical examination findings and failing to diagnose and treatment-plan the source of Patient D's pain during Patient D's April 15, 2004, visit;

c. Failing to document Patient D's weight or the dosage of Amoxicillin prescribed during Patient D's September 2, 2004, visit;

d. Failing to diagnose, treatment-plan and document Patient D's furcataion of Tooth # T during Patient D's August 17, 2006, visit;

e. Failing to diagnose, treatment-plan and document abscesses on Patient D's Tooth # K and T during Patient D's October 11, 2006, visit;

f. Failing to take radiographs where appropriate during routine recall visits; and

g. Failing to keep detailed and legible dental records.

Patient E

43. Patient E, then four years old, initially saw the Respondent on or about August 14, 2003, for a comprehensive oral examination, dental prophylaxis and fluoride treatment.

44. The Respondent provided periodic oral examinations, dental prophylaxis and fluoride treatments to Patient E, generally once every six months, from approximately August 14, 2003, to May 18, 2015.

45. On or about February 12, 2009, Patient E presented to the Respondent with complaints of pain in the lower left quadrant. The Respondent took a periapical radiograph and noted that everything appeared fine. The Respondent noted that she smoothed down the restoration and prescribed Amoxicillin. The Respondent, however, failed to document Patient E's weight or the dosage of Amoxicillin prescribed.

46. The Respondent's treatment of Patient E was deficient in that she failed to document Patient E's weight or the dosage of Amoxicillin prescribed on or about February 12, 2009.

Patient F

47. Patient F, then six years old, initially saw the Respondent on or about October 7, 2009, for a comprehensive oral examination. The Respondent noted that Patient F's parents were to forward to him Patient F's prior radiographs.

48. The Respondent provided periodic oral examinations, dental prophylaxis and fluoride treatments to Patient F, generally once every six months, beginning around October 7, 2009, to June 24, 2015.

49. On or about October 29, 2009, the Respondent provided restorative treatment to Patient F's Tooth # 19 with facial composite. The Respondent, however, failed to document the type of isolation employed or whether she used any local anesthetic.

50. The Respondent saw Patient F on or about March 12, 2013, for an oral examination, dental prophylaxis and fluoride treatment. The Respondent took a bitewing radiograph of Patient F. The radiograph demonstrated caries on Tooth # A and J, which the Respondent failed to diagnose, treatment-plan and document.

51. On or about May 21, 2015, the Respondent provided restorative treatment to Patient F's Tooth # 18 and 31 with surface composite. The Respondent, however, failed to document the type of isolation employed or whether she used any local anesthetic.

52. The Respondent's care and treatment of Patient F were deficient for reasons including:

a. Failing to document the type of isolation employed or whether she used any local anesthetic during restorative treatment on Patient F; and

b. Failing to diagnose, treatment-plan and document noticeable caries on Patient F's Tooth # A and J noted on the bitewing radiographs taken on or about March 12, 2013.

Additional Patient Charts

53. In addition to those patients set forth above, the Board's Expert reviewed a number of additional patient charts in which no deficiencies in the care and treatment were noted.

54. The Board's investigation did not reveal any deficiencies in the Respondent's care and treatment of patients within the last three (3) years.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that while the Respondent's actions, as set forth above, do not constitute gross incompetence, the recordkeeping concerns constitute violations of Health Occ. I §§ 4-315(a) (16) and (20), and COMAR 10.44.23.01B, C(2) and (8), and COMAR 10.44.30.02K(2) and (3).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 26th day of May, 2017, by a majority of the Board considering this case:

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

ORDERED that the Respondent is placed on **PROBATION** for a minimum period of **EIGHTEEN (18) MONTHS**. During the probationary period, the Respondent must comply with the following terms and conditions:

1. The Respondent shall successfully complete the following Board-approved courses: 1) a six (6) credit hour equivalent course in dental record keeping; 2) a four (4) credit hour equivalent course in diagnosis, treatment planning and radiography; and 3) a two (2) credit hour equivalent course in ethics. The Respondent shall be responsible for submitting written documentation to the Board of her successful completion of these courses. The Respondent understands and agrees that she may not use this coursework to fulfill any requirements mandated for licensure renewal. The Respondent shall be solely responsible for furnishing the Board with adequate written verification that she has completed the courses according to the terms set forth herein.

2. The Respondent is subject chart reviews by the Board. The Board will conduct at least two office visits for the purpose of chart review to ensure that the Respondent is in compliance with record keeping standards.

3. The Respondent is fined in the amount of **One Thousand dollars ($1,000)**, which shall be stayed if the Respondent complies with all of the terms and conditions of her probation.

4. The Respondent shall comply with the Maryland Dentistry Act and all laws, statutes and regulations pertaining thereof.

AND IT IS FURTHER ORDERED that after the conclusion of **EIGHTEEN (18) MONTHS** from the date of this Consent Order, 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, or a designated Board committee. The Board, or designated Board committee, may grant the termination if the 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 violates any of the terms and conditions of this Consent Order, the Board, in its discretion, after notice and an opportunity for an evidentiary hearing if there is a genuine dispute as to the underlying material facts, or an opportunity for a show cause hearing before the Board otherwise, may impose any sanction which the Board may have imposed in this case, including additional probationary terms and conditions, a reprimand, suspension, revocation and/or a monetary penalty; and it is further

ORDERED that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Provisions, §§ 4-101 *et seq.* (2014 Repl. Vol.).

Ronald F. Moser DDS

Ronald F. Moser, D.D.S.
Board President
State Board of Dental Examiners

CONSENT

I, Carol M. Orlando, D.D.S., acknowledge that I am represented by counsel and have consulted with counsel before entering into 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 might have followed 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 this Consent Order.

5/25/17
Date

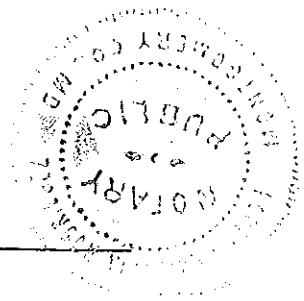
Carol M. Orlando, D.D.S.

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Montgomery County

I HEREBY CERTIFY that on this 25th day of May, 2017, before me, a Notary Public of the foregoing State and City/County personally appear Carol M. Orlando, D.D.S., 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 notary seal.



Notary Public

My commission expires:

LORENA CRISTINA RODRIGUEZ
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires March 3, 2020

4837-3812-6913, v. 1