

IN THE MATTER OF	*	BEFORE THE MARYLAND
TAUNYA L. JENKINS, D.D.S.	*	STATE BOARD OF
RESPONDENT	*	DENTAL EXAMINERS
License Number: 13537	*	Case Numbers: 2014-236

* * * * *

CONSENT ORDER

On or about September 21, 2016, the Maryland State Board of Dental Examiners (the "Board") charged **TAUNYA L. JENKINS, D.D.S., License Number 13537** (the "Respondent"), with violations of the Maryland Dentistry Act (the "Act"), Md. Code Ann., Health Occ. I §§ 4-101 *et seq.* (2014 Repl. Vol.) and the regulations adopted by the Board, Md. Code Regs. ("COMAR") §§ 10.44.01 *et seq.*

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

§ 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;
- (20) Violates any rule or regulation adopted by the Board;

The Board charges the Respondent with violating the following regulations adopted by the Board:

COMAR § 10.44.23.01 Unprofessional or Dishonorable Conduct

C. The following shall constitute unprofessional or dishonorable conduct in the practice of dentistry, dental hygiene, or dental radiation technology:

- (6) Performing a dental procedure without first obtaining informed consent from the patient or the patient's legal representative;
- (8) Committing any other unprofessional or dishonorable act or omission in the practice of dentistry, dental hygiene, or dental radiation technology [.]

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

B. Dental records shall include:

- (1) A patient's clinical chart as described in Regulation .03 of this chapter;

...

K. Dental records shall:

- (1) Be accurate;
- (2) Be detailed;
- (3) Be legible;
- (4) Be well organized; and
- (5) Document all data in the dentist's possession pertaining to the patient's dental health status;

COMAR § 10.44.30.03 Clinical Charts.

A. Each patient's clinical chart shall include at a minimum the following:

- (3) Treatment plans that are signed and dated by both the treating dentist and the patient;
- (5) Diagnosis and treatment notes;
- (10) Identification of medications prescribed, administered, dispensed, quantity, and directions for use;
- (12) Radiographs of diagnostic quality;

- (13) Periodontal charting;
- (14) Laboratory work authorization forms and correspondence to and from laboratories;
- (15) Informed consent;
- (18) Details regarding referrals and consultations;

COMAR § 10.44.30.05 Violations

- A. Failure to comply with this chapter constitutes unprofessional conduct and may constitute other violations of law.

On December 7, 2016, a Case Resolution Conference (“CRC”) was held at the Board’s offices. Following the CRC, the Respondent and the Board agreed to enter into this Consent Order.

FINDINGS OF FACT

The Board finds the following facts.

Background

1. At all times relevant to the charges herein, 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 December 8, 2003, under License Number 13537 and limiting drug dispensing permit number DR13537. The Respondent's license is renewed through July 30, 2017.

2. At all times relevant to these charges, the Respondent operated a dental practice at 6525 Belcrest Road, Suite 201, Hyattsville, Maryland 20782.

Complaint

3. On or about April 29, 2014, a former patient ("Patient A")¹ of the Respondent filed a claim with the Health Care Alternative Dispute Resolution Office ("HCADRO").

4. On or about May 9, 2014, the Board received the claim form from the HCADRO against the Respondent (the "Complaint").

5. According to the Complaint, Patient A was under the Respondent's care from January 2007 through January 2011. The Complaint alleged *inter alia* that the Respondent provided substandard care in that she failed to prevent extensive tooth decay, and ultimately caused Patient A's teeth to become unsalvageable.

6. Based on the Complaint, the Board initiated an investigation of the Respondent.

Investigation

7. In furtherance of its investigation, the Board requested from the Respondent Patient A's treatment records and a narrative response to the Complaint.

8. Subsequently, the Board obtained the treatment records of five additional patients (Patients B, C, D, E, & F).

9. The Board referred the treatment records of Patients A through F to an expert in general dentistry (the "Expert") for a review of the Respondent's care.

Expert Report

10. On or about June 30, 2015, the Expert issued a report (the "Expert Report") of his findings. The Expert Report revealed the following.

Patient A

¹ To ensure confidentiality, the names of patients or other individuals will not be disclosed in this charging document. The Respondent may obtain the identity of any patient or individual referenced herein by contacting the assigned administrative prosecutor.

11. Patient A was under the Respondent's care from approximately January 2007 until January 2011. During this period, the Respondent performed extensive and varied treatments on multiple teeth, including: prophylaxis, root canal therapies, crowns and subsequent recementing and lengthening procedures, extractions.

12. The Expert Report documents the following deficiencies in the Respondent's care of Patient A and the Respondent's documentation:

- (a) Mistaken billing of insurance for crowns made of porcelain fused to high noble metal when actually fabricating crowns of less costly semi-precious metal;
- (b) Failure to perform a comprehensive treatment plan;
- (c) Failure to perform tooth charting;
- (d) Failure to perform periodontal charting;
- (e) Failure to document procedures performed with appropriate clinical detail;
- (f) Failure to obtain and/or document informed consent for treatment;
- (g) Failure to document medical history;
- (h) Failure to document the quantity of epinephrine in local anesthetics;
- (i) Failure to document the quantity, dosage, and medical necessity of drugs prescribed;
- (j) Improper fabrication of crowns, causing failure of the crowns multiple times;
- (k) Failure to timely recognize and address crowns fabricated with open margins; and

- (l) Performance of orthodontics prior to the completion of restorative treatment.

13. Based on his review, the Expert concluded that the Respondent's care of Patient A was professionally or grossly incompetent.

Patient B

14. Patient B was under the Respondent's care from approximately February 2010 until January 2015. During this period, the Respondent performed extensive and varied treatments on multiple teeth, including: crown recementing and replacements and restoration.

15. The Expert Report documents the following deficiencies in the Respondent's care of Patient B and the Respondent's documentation:

- (a) Failure to perform a comprehensive treatment plan;
- (b) Failure to perform tooth charting;
- (c) Failure to perform periodontal charting;
- (d) Failure to document medical history;
- (e) Failure to document referral to specialist or a reason therefore;
- (f) Failure to document a tooth number for procedures performed;
- (g) Failure to document procedures performed with appropriate clinical detail;
- (h) Failure to document materials used;
- (i) Failure to document the quantity of epinephrine in local anesthetics;
- (j) Failure to document medical necessity of procedures; and
- (k) Placement of an amalgam restoration with distal overhanging margin.

16. Based on his review, the Expert concluded that the Respondent's care of Patient B was professionally or grossly incompetent.

Patient C

17. Patient C was under the Respondent's care from approximately August 2011 until February 2015. During this period, the Respondent performed various treatments on multiple teeth, including: restorations, and scaling and root planing.

18. The Expert Report documents the following deficiencies in the Respondent's care of Patient C and the Respondent's documentation:

- (a) Failure to document medical history; and
- (b) Failure to document the quantity of epinephrine in local anesthetics.

19. Based on his review, the Expert concluded that the Respondent's care of Patient C was professionally or grossly incompetent.

Patient D

20. Patient D was under the Respondent's care for many years. The Expert limited his review to those treatments the Respondent performed beginning in June 2005 until November 2014. During this period, the Respondent performed extensive and varied treatments on multiple teeth, including: crown recementing, prophylaxis, replacement of a fractured crown, delivery of a crown, and buildup and preparation for crown.

21. The Expert Report documents the following deficiencies in the Respondent's care of Patient D and the Respondent's documentation:

- (a) Failure to document medical history;
- (b) Failure to document the quantity of epinephrine in local anesthetics;
- (c) Failure to document materials used;

- (d) Failure to document procedures performed with appropriate clinical detail; and
- (e) Failure to diagnose, inform, and treat advanced periodontal disease.

22. Based on his review, the Expert concluded that the Respondent's care of Patient D was professionally or grossly incompetent.

Patient E

23. Patient E was under the Respondent's care for many years. The Expert limited his review to those treatments the Respondent during and after October 2006. During this period, the Respondent performed extensive and varied treatments on multiple teeth, including: amalgam restorations, replacement of lost restorations and amalgams, extractions, and delivery of a bridge.

24. The Expert Report documents the following deficiencies in the Respondent's care of Patient E and the Respondent's documentation:

- (a) Failure to document medical history;
- (b) Failure to document the quantity of epinephrine in local anesthetics;
- (c) Failure to document medical necessity of procedures;
- (d) Failure to retain x-rays;
- (e) Failure to perform a comprehensive treatment plan;
- (f) Failure to diagnose and treat severe periodontal disease; and
- (g) Fabrication of an unsuitable resin-bonded bridge on hopeless teeth.

25. Based on his review, the Expert concluded that the Respondent's care of Patient E was professionally or grossly incompetent.

Patient F

26. Patient F was under the Respondent's care for many years, during which there appears to have been a gap of approximately five years, from 2006 to 2011 during which period Patient F did not present for treatment. The Expert limited his review to those treatments the Respondent during and after October 2005. During this period, the Respondent performed extensive and varied treatments on multiple teeth, including: buildup and crowns, root canal therapies, a filling, crown recementing, cleaning, prophylaxis, amalgam, placement of composites.

27. The Expert Report documents the following deficiencies in the Respondent's care of Patient F and the Respondent's documentation:

- (a) Failure to document medical history;
- (b) Failure to document medical necessity of procedures;
- (c) Failure to obtain and document Patient F's informed consent for treatment;
- (d) Failure to document procedures performed with appropriate clinical detail;
- (e) Failure to document the quantity and dosage of drugs prescribed;
- (f) Failure to document premedications related to a knee replacement;
- (g) Failure to document materials used;
- (h) Failure to document procedures performed;
- (i) Failure to document the local anesthetics used;
- (j) Failure to document a tooth number for procedures performed;
- (k) Failure to retain x-rays;
- (l) Failure to retain laboratory authorizations; and

- (m) Performing treatment and diagnoses in the absence of appropriate x-rays.

28. Based on his review, the Expert concluded that the Respondent's care of Patient F was professionally or grossly incompetent.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's conduct, as described above, constitutes violations of the following provisions of the Act: Health Occ. I § 4-315(a)(6) Practices dentistry in a professionally incompetent manner or in a grossly incompetent manner; (16) Behaves unprofessionally in the practice of dentistry; and (20) Violates any rule or regulation adopted by the Board; and the regulations adopted by the Board, as cited above.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, by the Board, hereby:

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

ORDERED that the Respondent is fined in the amount of **\$2000 (TWO THOUSAND DOLLARS)**, of which \$1000 (ONE-THOUSAND DOLLARS) is due within sixty (60) days, and \$1000 (ONE-THOUSAND DOLLARS) is immediately **STAYED**. In addition to any other sanctions imposed, the stayed portion of the fine shall be due within 60 (sixty) days upon a finding by the Board that the Respondent has violated the terms of this Consent Order. The stayed portion of the fine shall be cancelled upon a finding by the Board that the Respondent has fully and satisfactorily complied with all the probationary terms and conditions set forth herein; and it is further

ORDERED that the Respondent shall be placed on **PROBATION** for a minimum period of **THIRTY-SIX (36) MONTHS**, commencing on the effective date of the Consent Order, and continuing until the Respondent successfully completes the following conditions:

1. Within six (6) months of the effective date of the consent order the Respondent shall, at her own expense, enroll in an intensive, hands-on course of remedial training, approved by the Board in advance, equivalent to between 12 and 20 credit hours (to be determined by the providers of the course based on their evaluation of the Respondent's needs) focusing on: treatment planning, restorative treatment, including bridge and crown work, and periodontal diagnosis and treatment. The Respondent shall provide the provider of the course with the Board's Consent Order in advance. The Respondent shall successfully complete the course as scheduled, and shall submit written verification that satisfies the Board of her successful completion within 30 days of completion of the course;
2. Within six (6) months of the effective date of the consent order, the Respondent shall, at her own expense, successfully complete a course, approved by the Board in advance, equivalent to at least four continuing education (C.E.) credits, focusing on dental recordkeeping. The Respondent shall successfully complete the course as scheduled, and shall submit written verification that satisfies the Board of her successful completion within 30 days of completion of the course;
3. At its discretion, during the probationary period, the Board may conduct up to three (3) record reviews of the Respondent's patient records. Each record review shall be conducted by a Board-designated expert who shall review the records of a selection of patients whom the Respondent has treated **after** completing the recordkeeping course mentioned above in probationary condition (2). The Board designee shall personally select the records of the patients on site at the Respondent's practice, and may do so at either a scheduled or unannounced visit. In order to facilitate the Board designee's ability to access the Respondent's patient records, the Respondent shall provide, after completing the recordkeeping course mentioned above in probationary condition (2), on the **first** of each month, a copy of her appointment book. If the Respondent will not be present at

the office during these appointment times, she shall notify the Board beforehand, unless she is unable to do so by reason of a documented emergency or illness.

4. The Respondent shall comply with the Maryland Dentistry Act.

And it is further

ORDERED that no part of the training or education that the Respondent receives in connection 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, and any of its agents or employees, 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 thirty-six (36) months from the effective date of the Consent Order, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, 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, outstanding complaints related to the charges, or violations of this Consent Order; and it is further

ORDERED that if the Respondent violates any of the terms or conditions of the Consent Order, the Board, in its discretion, after notice and an opportunity for a show cause hearing before the Board, or an evidentiary hearing if there is a genuine dispute of fact, may impose an additional probationary term and conditions of probation, reprimand, suspension, revocation and/or a monetary penalty; and it is further

ORDERED that this Consent Order is a Final Order of the Board and a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov. §§ 4-101 et seq. (2014).

11/18/17
Date

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

CONSENT

By this Consent, I, Taunya Jenkins, D.D.S., acknowledge that I have consulted with legal counsel at all stages of this matter. I understand that this Consent Order will resolve the Charges against me and forfeit my right to a formal evidentiary hearing on the Charges. By this Consent, I agree to be bound by the terms of this Consent Order. I acknowledge that for all purposes, the Findings of Fact and Conclusions of Law will be treated as if proven in 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 Findings of Fact and Conclusions of Law. 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 waive my right to any appeal in this matter. I affirm that I have asked and received satisfactory answers to all my questions regarding the language, meaning, and terms of this Consent Order. I sign this Consent Order voluntarily and without reservation, and I fully understand and comprehend the language, meaning, and terms of this Consent Order.

Dec. 30, 2017

Taunya Jenkins

Date

Tauny Jenkins, D.D.S.
Respondent

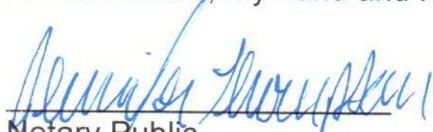
NOTARY

STATE OF District of Columbia

CITY/COUNTY OF: —

I HEREBY CERTIFY that on this 30th day of December, 2016, before me, a Notary Public of the State and County aforesaid, personally appeared Taunya Jenkins, 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.


Notary Public

My commission expires: 01/14/2017

