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**

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE DENTISTRY

The Maryland State Board of Dental Examiners (the "Board") hereby **SUMMARILY SUSPENDS** the license of **TONGELA WILLIAMS, D.D.S.** (the "Respondent"), License Number 13680, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under: Md. Code Regs. ("COMAR") § 10.44.07.22, determining that there is a substantial likelihood that the Respondent poses a risk of harm to the public health, safety, or welfare; and Md. Code Ann., State Gov't § 10-226(c)(2) (2014 Repl. Vol.), concluding that the public health, safety and welfare imperatively require emergency action.

INVESTIGATIVE FINDINGS

The Board bases its action on the following findings:[1]

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.

[1] The statements describing the Respondent's conduct are intended to provide the Respondent with notice of the basis of the summary suspension. They are not intended as, and do not necessarily represent a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

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. [2]

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.

[2] 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.

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 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;[3]

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 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

Based on the foregoing Investigative Findings, and pursuant to its authority under Md. Code Ann., State Gov't § 10-226(c)(2) (2014 Repl. Vol.), the Board concludes that the public health, safety, and welfare imperatively require this emergency action of summary suspension. In addition, pursuant to COMAR § 10.44.07.22, the Board concludes that

[3] 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.

there is a substantial likelihood that the Respondent poses a risk of harm to the public health, safety, or welfare.

ORDER

Based on the foregoing, it is this 6th day of September 2017, by the Board hereby:

ORDERED that the Respondent's license to practice dentistry in the State of Maryland, under License Number 13680, is hereby **SUMMARILY SUSPENDED**; and it is further

ORDERED that upon the Board's receipt of a written request from the Respondent, a Show Cause Hearing shall be scheduled at the Board's next regularly scheduled meeting, not to exceed thirty (30) days from the Board's receipt, at which the Respondent will be given an opportunity to be heard as to why the Order the Summary Suspension should not continue; and it is further

ORDERED that if the Respondent fails to request a Show Cause Hearing or files a written request for a Show Cause Hearing and fails to appear, the Board shall uphold and continue the Summary Suspension; and it is further

ORDERED that upon service of this Order for Summary Suspension, the Respondent shall immediately surrender to the Board all indicia of licensure to practice dentistry issued by the Board that are in her possession, including but not limited to her original license, renewal certificates, and wallet size license; and it is further

ORDERED that this document constitutes an Order of the Board and is therefore a public document for purposes of public disclosure, as required by Md. Code Ann., General Provisions §§ 4-101 through 4-601 (Repl. Vol. 2014).

NOTICE OF HEARING

Following the Board's receipt of a written request for hearing filed by the Respondent, a Show Cause Hearing will be held at the offices of the Maryland Board of Dental Examiners, Spring Grove Hospital Center, Benjamin Rush Building, 55 Wade Avenue/Tulip Drive, Catonsville, Maryland 21228. The Show Cause Hearing will be scheduled for the Board's next regularly scheduled meeting, not to exceed thirty (30) days.

At the conclusion of the Show Cause Hearing held before the Board, the Respondent, if dissatisfied with the result of the hearing, may, within ten (10) days, file a written request an evidentiary hearing. Unless otherwise agreed to by the parties, the Board shall provide a hearing within forty-five (45) days of the Respondent's written request. The Board shall conduct an evidentiary hearing under the contested case provisions of Md. Code Ann., State Gov't §§ 10-210 *et seq.*

09/06/2017
Date

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