IN THE MATTER OF	*	**BEFORE THE MARYLAND**
CHERYL R. TERRELL, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 13546	*	**Case Number: 2020-047**

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CONSENT ORDER

On November 13, 2019, the Maryland State Board of Dental Examiners (the "Board") summarily suspended the license of **CHERYL R. TERRELL, D.D.S.,** (the "Respondent"), License Number 13546, and charged her with violating the Maryland Dentistry Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 4-101 *et seq.* (2014 Repl. Vol. and 2019 Supp.).

Specifically, the Board charged the Respondent with violating the following provisions of the Act under Health Occ. I § 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; [and]
>
> (30) 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[.]

On December 4, 2019, a Case Resolution Conference was held before a committee of the Board. As a resolution of this matter, the Respondent agreed to enter this public Consent Order consisting of Findings of Fact, Conclusions of Law, Order and Consent.

FINDINGS OF FACT

The Board makes the following Findings of Fact:

I. LICENSING BACKGROUND

1. At all times relevant, the Respondent was and is licensed to practice dentistry in the State of Maryland. The Respondent was originally licensed to practice dentistry in Maryland on November 16, 2004, under License Number 13546. The Respondent's license is current through June 30, 2020.

2. At all times relevant, the Respondent co-owned a dental practice (the "Dental Office") with another dentist ("Dentist A") located in Mitchellville, Maryland.

II. COMPLAINT

3. On or about July 15, 2019, the Board received a complaint from a patient (the "Complainant"), who alleged that on July 3, 2018, while waiting to receive dental treatment at the Dental Office, she observed an employee flossing his teeth in the operatory. When the Respondent came into the operatory to begin dental treatment, the Complainant, who was a registered nurse, declined to be treated.

4. Based on the complaint, the Board initiated an investigation of the Respondent's dental practices.

III. INFECTION CONTROL INSPECTION

5. Due to allegations of potential infection control issues at the Dental Office, on or about August 7, 2019, a Board-contracted infection control expert (the "Board Inspector"), along with a Board investigator, visited the Dental Office and conducted an infection control inspection.

6. Present during the inspection were the Respondent, Dentist A, a dental hygienist, three dental radiation technologists/assistants, the office manager, the receptionist, the insurance coordinator and the financial coordinator.

7. As part of the inspection, the Board Inspector utilized the Centers for Disease Control and Prevention ("CDC") Infection Prevention Checklist for Dental Settings.

8. During the inspection, the Board Inspector was able to directly observe patient treatment by

9. Based on the inspection, the Board Inspector found the following CDC violations:

Section I: Policies and Practices

a. **Administrative Measures** – The Respondent failed to maintain any: written infection control policies and procedures specific to the Dental Office; annual reassessments of those policies and procedures; assignment of a trained employee to coordinate the infection prevention program; utility gloves in the sterilization area; and a system for early detection and management of potentially infectious persons at initial points of patient encounter.

b. **Infection Prevention Education and Training** – The Respondent failed to maintain a training log of personnel training (upon hire, annually and new tasks or procedure) on infection prevention and bloodborne pathogens standards. Two days after the inspection, the Respondent provided the Board a sign-in sheet for a bloodborne pathogens training that occurred in September 2016. At least five employees presently working at the Dental Office failed to attend this training.

c. **Dental Health Care Personnel Safety** – The Respondent failed to maintain required documentation on: exposure control plan specific to the Dental Office; employee training on OSHA Bloodborne Pathogens Standard (upon hire and at least annually); current CDC recommendations and office-specific policies on immunization, evaluation and follow-up; availability of Hepatitis B vaccination (two days after the inspection, the Respondent provided the Board documentation that two employees received Hepatitis B vaccination in 2004 and 2016); post-vaccination screening of Hepatitis B surface antibody; availability of annual influenza vaccination; baseline tuberculosis screening for all dental health care personnel; a log of needlesticks, sharps injuries and other exposure events; referral arrangements to qualified health care professionals; post-exposure evaluation and follow-up; and well-defined policies concerning

contact of personnel with potentially transmittable conditions with patients.

d. **Program Evaluation** – The Respondent failed to maintain required documentation on policies and procedures on routine monitoring and evaluation of infection prevention and control program, and adherence to certain practices such as immunization, hand hygiene, sterilization monitoring and proper use of Personal Protective Equipment.

e. **Hand Hygiene** – The Respondent failed to maintain documentation on dental personnel training regarding appropriate indications for hand hygiene including handwashing, hand antisepsis and surgical hand antisepsis.

f. **Personal Protective Equipment (PPE)** – The Respondent failed to maintain documentation that dental personnel received training on proper selection and use of PPE.

g. **Respiratory Hygiene/Cough Etiquette** – The Respondent failed to maintain documentation on policies/procedures and personnel training logs on containing respiratory secretion in people with signs and symptoms of respiratory infection. The Respondent also failed to post precautionary instructions for patients with symptoms of respiratory infection; provide tissues; offer face masks; and provide separate space for persons with respiratory symptoms.

h. **Sharps Safety** – The Respondent failed to maintain documentation on policies, procedures and guidelines for exposure prevention and post-exposure management. The Respondent failed to maintain documentation on identifying, evaluating and selecting devices with engineered safety features at least annually or as they become available in the market.

i. **Safe Injection Practices** – The Respondent failed to maintain documentation on policies, procedures and guidelines for safe-injection preparation and practices.

j. **Sterilization and Disinfection of Patient-Care Items and Devices** – The Respondent failed to maintain documentation, policies or procedures regarding: appropriate cleaning and processing of reusable instruments and devices; manufacturer's reprocessing instructions; upon hire and annual personnel training log on reprocessing of reusable instruments and devices; personnel training logs on appropriate use of PPE; maintenance logs on sterilization equipment; and responses in the event of a reprocessing error/failure. The Respondent failed to maintain documentation on spore testing on site. Test results later provided by biological monitoring services showed that the Respondent often failed to provide sufficient information for proper testing.

k. **Environmental Infection Prevention and Control** – The Respondent failed to maintain documentation, policies and procedures on: routine cleaning and disinfection of environmental surfaces; upon hire and annual personnel training about infection prevention and control management of clinical contact and housekeeping surfaces; personnel training logs on appropriate use of PPE; periodic monitoring and evaluations of use of surface barriers; and decontamination of spills or blood or other body fluid.

l. **Dental Unit Water Quality** – The Respondent failed to maintain documentation, policies and procedures for: maintaining dental unit water quality; using sterile water as a coolant/irrigant when performing surgical procedures; and responding to a community boil-water advisory.

Section II: Direct Observation of Personnel and Patient-Care Practices

m. **Performance of Hand Hygiene** – The Respondent failed to perform handwashing before putting on gloves and after removing gloves between treating patients.

n. **Use of Personal Protective Equipment (PPE)** – The Respondent failed to perform handwashing before removing PPE. The Respondent also failed to remove her PPE before leaving the work area.

o. **Respiratory Hygiene/Cough Etiquette** – The Respondent failed to: post precautionary instructions (Cover Your Cough Poster) around the entrance area; provide tissues; offer face masks; and provide separate space for persons with respiratory symptoms.

p. **Sharps Safety** – The Respondent failed to place sharps containers in readily accessible areas of the operatories.

q. **Sterilization and Disinfection of Patient-Care Items and Devices** – The Respondent failed to: have available puncture and chemical resistant utility gloves for manual cleaning; use a chemical indicator inside each sterilization package; label sterilization packages with sterilizer used, the cycle or load number, and the date of sterilization; and maintain logs for each sterilization cycle. The Respondent failed to maintain documentation on spore testing on site. Test results later provided by biological monitoring services showed that the Respondent often failed to provide sufficient information for proper testing.

r. **Environmental Infection Prevention and Control** – The Respondent failed to consistently barrier-protect clinical contact surfaces. The Respondent failed to use surface barriers for the computer keyboard and mouse. The Board Inspector observed an uncovered and dirty portable oxygen/nitrous oxide cart in the corner that was not suitable for patient use. Unopened sterile packs were

placed on the same tray as used instruments. The Board Inspector also did not see an eye-wash station or an emergency medical kit.

s. **Dental Unit Water Quality** – The Respondent failed to perform waterline testing and treatment to monitor dental water unit quality.

12. Based on the lack of required documentation and his direct observations, the Board Inspector determined that the Respondent, as the owner of and a practicing dentist at the Dental Office, failed to comply with CDC Guidelines as set forth above, which posed a direct risk to patient safety.

13. As a result of the Board Inspector's findings, the Respondent proactively retained an infection control consultant to assist her with CDC policies, procedures and compliance. The Respondent's consultant has provided the Board with a favorable report of the Respondent's compliance with CDC Guidelines.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's failure to comply with CDC Guidelines in her practice of dentistry at the Dental Office 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 except in an emergency life-threatening situation where it is not feasible or practicable, failing to comply with the Centers for Disease Control's guidelines on universal precautions, in violation of § 4-315(a)(30).

ORDER

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

ORDERED that the Board's *Order for Summary Suspension* of the Respondent's license to practice dentistry in the State of Maryland, issued on November 13, 2019, is hereby **TERMINATED**; and it is further

ORDERED that the Respondent is hereby **REPRIMANDED,** and it is further

ORDERED that the Respondent is placed on **PROBATION** for a period of **TWO (2) YEARS**, subject to the following terms and conditions:

1. A Board-assigned inspector shall conduct an unannounced inspection within ten (10) business days of the date of this Consent Order in order to evaluate the Respondent and his staff regarding compliance with the Act and infection control guidelines. The Board-assigned inspector shall be provided with copies of the Board's 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 inspector of any changes.

3. During the probationary period, the Respondent shall be subject to quarterly unannounced onsite inspections by a Board-assigned inspector.

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

6. Any non-compliance with the Maryland Dentistry Act, all related statutes and regulations, and CDC and OSHA guidelines shall constitute a violation of probation and of this Consent Order.

7. On or before the fifth day of each month, the Respondent shall provide to the Board a copy of her current patient appointment book for that month.

8. Within ninety (90) days, the Respondent shall pay a fine in the amount of **TWO THOUSAND FIVE-HUNDRED DOLLARS** ($2,500) of which **ONE THOUSAND DOLLARS ($1,000)** is **STAYED** by bank certified check or money order made payable to the Maryland Board of Dental Examiners.

9. Within six (6) months of the date of this Consent Order, the Respondent shall successfully complete a Board-approved in-person four (4) credit hour course(s) in infection control protocols and in-person or online one (1) credit hour course in ethics, which may not be applied toward her license renewal.

10. The Respondent may file a petition for early termination of her probation after one (1) year from the date of this Consent Order. After consideration of the petition, the Board, or a designated committee of the Board, may grant or deny such petition at its sole discretion.

AND IT IS FURTHER ORDERED that after the conclusion of the **TWO (2) YEAR** probationary period, 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 of similar nature; and it is further

ORDERED that if the Board has reason to believe that the Respondent has failed 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; 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 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).

12/4/2019
Date

Francis X. McLaughlin, Jr.
Executive Director

CONSENT

I, Cheryl R. Terrell, 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.

12-4-19
Date

Cheryl R. Terrell, D.D.S.
The Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF BALTIMORE COUNTY

I HEREBY CERTIFY that on this 4TH day of DECEMBER _____, 2019, before me, a Notary Public of the foregoing State and City/County personally appear Cheryl R. Terrell, 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: 10/10/2023