

BEFORE THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

IN THE MATTER OF:

Jean Woods, D.D.S.
(License Number 6102)

)
)
)
)

FINAL AGENCY DECISION

THIS MATTER was heard before the North Carolina State Board of Dental Examiners (Dental Board) on January 18, 2018, pursuant to N.C. Gen. Stat. §§ 90-41.1 and 150B-38 and 21 NCAC 16N .0504 of the Board's Rules. The Board's Hearing Panel consisted of Board members, Dr. Merlin W. Young, presiding; Dr. William M. Litaker, Jr.; Dr. Kenneth M. Sadler; Dr. Clifford O. Feingold; and Dr. Catherine A. Watkins. Board members Dr. Millard W. Wester, III, Ms. Nancy A. St. Onge, and Mr. Dominic Totman did not participate in the hearing, deliberation, or decision of this matter. Doug Brocker and Crystal Carlisle represented the Investigative Panel of the Dental Board. Fred Morelock represented the Dental Board's Hearing Panel. Jean Woods, D.D.S. (Respondent) was properly served with notice but did not attend the hearing.

Based upon the evidence admitted at the hearing, the Board enters the following:

FINDINGS OF FACT

1. The Dental Board is a body duly organized under the laws of North Carolina and is the proper party to bring this proceeding pursuant to the authority granted to it in Chapter 90 of the North Carolina General Statutes (the Dental Practice Act) and the Rules and Regulations of the Dental Board.

2. Respondent was licensed to practice dentistry on June 17, 1991 and has held license number 6102 at all times relevant hereto.

3. Respondent is subject to the Dental Practice Act and the Rules promulgated thereunder.

4. At all times relevant hereto, Respondent worked as a general dentist at Community Smiles in Chapel Hill, North Carolina.

Respondent's Treatment and Care of Patient Susan G.

5. Patient Susan G. presented to Respondent's office on February 8, 2016 with complaints of severe pain in the area of tooth number 14. Respondent advised Susan G. she could perform a root canal or an extraction. Susan G. elected to have tooth number 14 extracted, and the extraction was performed the same day.

6. Approximately one week later, on February 16, 2016, Susan G. returned to Respondent's office for what she believed was a pre-operative appointment for implant placement in the area of number 14. Respondent advised Susan G. she would place the implant that day and provided Susan G. with paperwork to complete.

7. Respondent did not give Susan G. adequate time for a full review of the procedure, including risks and complications, so that she could provide informed consent.

8. Respondent did not provide Susan G. adequate information regarding the risks of placing the implant, including sinus proximity to the extraction socket, potential need for sinus augmentation, or the risks of sinus augmentation.

9. When Respondent attempted to place the implant, the implant was pushed into Susan G.'s sinus. Respondent includes the following in her notes for the procedure performed on February 16, 2016: "implant placed to bone level depth, granular bone graft placed in socket, implant pushed into sinus while placing healing cap."

10. Respondent had a difficult time removing the implant from Susan G.'s sinus, but was eventually able to remove the implant.

11. Respondent then grafted the sinus area in what she describes as an attempt to increase bone density for future placement of an implant.

12. On February 20, 2016, Susan G.'s daughter, Jessi L., contacted Respondent's office via email stating that Susan G. was very bruised and swollen, had swollen glands, and was still in pain, including in her head and neck.

13. On February 22, 2016, Jessi L. reported to Respondent's office that Susan G. had buzzing in her ears, issues with breathing through her nose, swollen glands, facial swelling, sore neck, and fatigue. Jessi L. stated Susan G. was afraid to come back to get her sutures removed because she was very sore.

14. On February 25, 2016, Susan G. presented to Respondent for a post-operative appointment and removal of her sutures. Respondent's treatment notes state Susan G. was "healing well, all sutures dissolved, pt. c/o some sinus congestion – rec'd decongestants" and commented regarding decay under Susan G.'s bridge, around her abutments.

15. Respondent did not prescribe antibiotics to Susan G. or refer her to a physician regarding her symptoms.

16. On March 13, 2016, Susan G. emailed Respondent and reported continuing and increasing yellow mucus in her nasal cavities that was running down her throat as well as continued pain that was increasing near her nose, around her eyes, and in her jaw. Susan G. reported an odor coming from her left nostril.

17. In the same email, Susan G. advised Respondent that the cataract surgery on her left eye may be postponed due to sinus complications, and she needed Respondent to make a recommendation, so she could heal and be ready for cataract surgery. Neither Respondent nor her office responded to this email from Susan G.

18. Susan G. had a CT scan at UNC hospital on June 2, 2016 which showed left maxillary and ethmoid sinusitis.

19. Susan G. presented to an ear, nose and throat physician, Dr. Harold Pillsbury M.D., on June 6, 2016. In addition to the symptoms previously described, she also reported vertigo, tinnitus, and hearing loss.

20. Dr. HP invited rhinologist, Dr. Charles Ebert, M.D., to evaluate Susan G. Drs. Pillsbury and Ebert advised Susan G. that she would likely require surgery due to an infection in my left sinus.

21. On August 11, 2016, Susan G. reported to Dr. Jeffrey Jelic, D.M.D. for evaluation. She complained of postnasal drip and pressure in her left cheek area.

22. Dr. Jelic reviewed a CT scan from UNC which showed infection and foreign particles in Susan G.'s left sinus. He recommended surgery to remove the particles as well as exploration to see whether the bone grafting placed by Dr. Woods was still viable. Dr. Jelic advised Susan G. to have a prosthetic evaluation prior to initiating any dental implant restorations.

23. Susan G. continues to experience intermittent pain and dripping in her left sinus and has not had a planned surgery because of an allergic reaction to medication along with her age and the associated risks.

Standard of Care Evidence – Patient Susan G.

24. The Investigative Panel proffered the testimony of and a corroborating affidavit from its designated expert, Dr. Kenneth P. Rasenberger, D.M.D., concerning the standard of care and causation, based upon his review of Respondent's treatment records for Susan G. and the treatment records of subsequent medical and dental providers.

25. Dr. Rasenberger opined in his sworn testimony and corroborating affidavit that Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina listed in that she failed to:

- a. allow Susan G. adequate time to provide informed consent for the implant procedure;
- b. adequately inform Susan G. of the risks and complications that may result from the implant procedure, including those related to the proximity to her sinus;
- c. select an appropriate site placement for the implant to ensure stability;
- d. adequately manage complications arising during the implant procedure, including the sinus perforation by the implant; and
- e. recognize and adequately manage post-procedure symptoms and complications and recognize when to refer Susan G. for medical treatment.

26. The Hearing Panel found Dr. Rasenberger to have valuable expertise and his opinion and other testimony, including regarding Respondent's treatment of Susan G., to be credible.

27. Respondent failed to provide Susan G. with adequate time for review and consideration of the consent for treatment for placement of the implant.

28. Respondent failed to thoroughly inform Susan G. of many of the risks associated with placing an implant in close proximity to her sinus, allowing Susan G. to make an informed decision.

29. Respondent failed to select an appropriate site for implant placement.

30. Once the implant became lodged in Susan G.'s sinus, and Respondent had difficulty removing it, she failed to consult a specialist or refer Susan G. to a specialist to assist in recovering the lost implant.

31. Respondent failed to appropriately treat the sinus perforation by packing the site with bone rather than isolating the perforation with a sliding pedicle graft to allow for site healing.

32. After learning of Susan G.'s post-operative symptoms, Respondent failed to manage the symptoms herself or refer Susan G. to another physician to manage the symptoms.

33. Susan G. suffered injury and harm as a result of Respondent's treatment.

Respondent's Treatment and Care of Patient Vanessa M.

34. On or about June 13, 2016, Vanessa M. presented to Respondent for extraction of her remaining bottom teeth (numbers 29, 28, 27, 26, 25, 24, 23, 22, 21, 20 and 18).

35. Respondent's notes indicate Respondent prescribed Augmentin and Motrin post-procedure; however, Respondent provided Vanessa M. only with a prescription for Motrin.

36. Vanessa M. returned for a post-operative appointment on June 21, 2016. Respondent noted that the area was healing slowly, the gingiva was very red, and there was a lot of debris buildup on the anterior mandibular area. Respondent cleaned the area. Respondent did not prescribe any medications for Vanessa M. on the date of this first post-surgery appointment.

37. On June 27, 2016, Respondent examined Vanessa M. due to her complaint of pain on the lower right in the area of teeth 28 and 29. Respondent noted that the area was very inflamed. Respondent irrigated the area and "removed bone fragment." Dr. Woods did not prescribe any medications for Vanessa M. on the date of this second post-surgery appointment.

38. Respondent's treatment notes indicate she prescribed Augmentin and Tylenol 3 at the June 27, 2016 visit; however, the patient records she produced for Vanessa M. demonstrate that she did not prescribe Augmentin and Tylenol No. 3 until two (2) days later on June 29, 2016.

39. Vanessa M. continued to experience pain and swelling. On July 3, 2016, she presented to the emergency room at UNC Hospital with left facial swelling, gum swelling, trismus (lockjaw), and low-grade fever.

40. The physicians at UNC Hospital diagnosed Vanessa M. with an abscess and had to operate to drain the abscess involving the left pterygomandibular and left peritonsillar spaces.

41. The surgeons also removed a retained root tip from the area of #21, and placed drains to help drain the fluid from the abscess.

42. Respondent never advised Vanessa M. that she had left a root tip from the extractions on June 13, 2016.

43. Respondent also never advised Vanessa M. to seek medical treatment for the pain, infection, and other complications that developed after her extractions. Vanessa M. eventually went to the UNC emergency room eventually without any referral from Respondent

44. Vanessa M. spent five (5) days in the hospital before being discharged on July 8, 2016.

45. Vanessa M.'s mouth remains numb on one side and her lower dentures still do not fit correctly preventing her from eating properly.

46. Vanessa M. suffered injury and harm as a result of Respondent's treatment.

Standard of Care Evidence – Patient Vanessa M.

47. The Investigative Panel proffered the testimony of and a corroborating affidavit from its designated expert, Dr. Kenneth P. Rasenberger, D.M.D., concerning the standard of care and causation, based upon his review of Respondent's treatment records for Vanessa M. and the treatment records of subsequent medical providers.

48. Dr. Rasenberger opined in his sworn testimony and affidavit that Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina listed in that she failed to:

- a. recognize and inform Vanessa M. that a root tip had not been extracted;

- b. adequately recognize and manage complications that arose after the procedure, including a serious infection; and
- c. recognize when to refer Vanessa M. for medical treatment to address post-procedure complications.

49. The Hearing Panel found Dr. Rasenberger to have valuable expertise and his opinion and other testimony, including regarding Respondent's treatment of Vanessa M., to be credible.

50. Respondent failed to recognize that she did not extract the root tip of tooth #21 and failed to advise Vanessa M. about the retained root tip.

51. Respondent failed to adequately recognize Vanessa M.'s post-surgical symptoms and manage complications that arose after the procedure, including a serious infection.

52. Respondent failed to recognize when to refer Vanessa M. to a third-party physician for medical treatment upon learning of her post-surgical symptoms.

53. Respondent's failures resulted in significant issues for patient Vanessa M., including pain, infection, an emergency room visit, surgery, and a five-day hospital stay.

54. Vanessa M.'s mouth remains numb on one side and her lower dentures still do not fit correctly preventing her from eating properly.

55. Vanessa M. suffered injury and harm as a result of Respondent's treatment.

Failure to Respond

56. At the hearing, the Investigative Panel offered the following evidence through the testimony of Betty Sines, Investigations Coordinator for the North Carolina State Board of Dental Examiners:

57. The Investigative Panel filed a Notice of Hearing in this matter on October 2, 2017. The Notice of Hearing, along with a Pre-Hearing Management Scheduling Order and the IP's First Combined Interrogatories and Request for Production of Documents were served by hand delivery by a process server at 2:26 p.m. on October 4, 2017 at Respondent's office located at 1728 Fordham Blvd., Suite 125, Chapel Hill, North Carolina.

58. The Investigative Panel received no communication from Respondent in response to the service of the Notice of Hearing and accompanying documents, including to the discovery requests.

59. On October 18, 2018, the Investigative Panel filed and served on Respondent its Expert Witness Disclosure. Service was accomplished by Certified/Return Receipt and First-Class mail addressed to Respondent's office address. Ms. Sines received delivery confirmation dated October 23, 2017.

60. The Investigative Panel received no communication from Respondent in response to the service of the Expert Witness Disclosure.

61. On November 6, 2018, the Investigative Panel filed and served on Respondent its First Request for Admissions, requesting that Respondent admit or deny the allegations set forth in the Notice of Hearing. Service was by Certified/Return Receipt and by facsimile. Ms. Sines received confirmation of delivery by facsimile on November 6, 2018 and delivery confirmation of the mailed documents dated November 8, 2016.

62. Respondent did not respond to the First Request for Admissions.

63. On November 22, 2017, the Investigative Panel filed and served on Respondent its Second Request for Admissions, requesting Respondent attest to the

authenticity of medical and dental records. Service was accomplished by Certified/Return Receipt. Ms. Sines received delivery confirmation dated November 27, 2017.

64. Respondent did not respond to the Second Request for Admissions.

65. Ms. Sines testified that on January 11, 2018, she attempted to email to Respondent the Investigative Panel's Exhibit List, Witness List, Contested Issues List, and a link for her to access the Investigative Panel's exhibits for hearing. Ms. Sines used the email address provided by Respondent to the Board. The email was returned undeliverable. Ms. Sines faxed the lists to Respondent with a message to please contact the Board to arrange to receive the exhibits. Ms. Sines received a fax confirmation but no response.

66. The Investigative Panel served Respondent by process server with a Motion for Summary Judgment and attached exhibits on January 8.

67. Respondent served no response to the Motion for Summary Judgment or opposing affidavits.

68. Respondent did not appear at the Board's office at scheduled hearing time on January 18, 2018.

69. Respondent was notified by confirmed facsimile on January 18 that the contested case hearing would begin at 8:30 AM on January 20 due to inclement weather, and she failed to appear on that date and time.

Based upon the foregoing Findings of Fact and evidence admitted at the hearing, the Hearing Panel enters the following:

CONCLUSIONS OF LAW

1. The North Carolina State Board of Dental Examiners has jurisdiction over the subject matter of this action and over the person of the Respondent.
2. Respondent was properly served with the Notice of Hearing and failed to appear at the hearing.

Violations concerning Patient Susan G.

3. Based on the testimony and other evidence admitted and on the Hearing Panel members' collective experience, technical competence, and specialized knowledge, the Hearing Panel concludes that the standard of care for dentists licensed to practice dentistry in North Carolina, at the time Respondent treated Susan G., required dentists to:
 - a. Allow patients adequate time for review and consideration of the information provided to them regarding surgical procedures including Consent for Treatment forms;
 - b. Inform patients of risks and complications that may result from specific procedures;
 - c. Select an appropriate site for placement of implants;
 - d. Adequately manage complications that arise during procedures; and
 - e. Recognize and adequately manage post-procedure symptoms and recognize when to refer patients for additional medical treatment.
4. Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina, and thereby engaged in negligence in violation of G.S. § 90-41(a) (6) and (12) in her treatment of Susan G. by failing to:

- a. allow Susan G. adequate time to provide informed consent for the implant procedure;
- b. adequately inform Susan G. of the risks and complications that may result from the implant procedure, including those related to the proximity to her sinus;
- c. select an appropriate site placement for the implant to ensure stability;
- d. adequately manage complications arising during the implant procedure, including the sinus perforation by the implant; and
- e. recognize and adequately manage post-procedure symptoms and complications and recognize when to refer Susan G. for medical treatment.

5. Respondent's violations of the standard of care caused or contributed to Susan G.'s injury and harm.

Violations Concerning Patient Vanessa M.

6. Based on the testimony and other evidence presented and on the Hearing Panel members' collective experience, technical competence, and specialized knowledge, the Hearing Panel concludes that the standard of care for dentists licensed to practice dentistry in North Carolina, at the time Respondent treated Vanessa M., required dentists to:

- a. Recognize when a root tip has not been extracted and inform the patient.
- b. Adequately recognize and manage complications that arise post-procedure; and

- c. Recognize when to refer patients for additional medical treatment for post-procedure complications.

7. Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina, and thereby engaged in negligence in violation of G.S. § 90-41(a) (6) and (12) in her treatment of Vanessa M. by failing to:

- a. recognize and inform Vanessa M. that a root tip had not been extracted;
- b. adequately recognize and manage complications that arose after the procedure, including a serious infection; and
- c. recognize when to refer Vanessa M. for medical treatment to address post-procedure complications.

8. Respondent's violations of the standard of care caused or contributed to injury to Vanessa M.

Respondent's Admissions are an Independent Basis

9. Respondent was properly served with various documents from the Investigative Panel, including its first and second Requests for Admissions, and failed to respond.

10. Pursuant to Rule 36(a) of the North Carolina Rules of Civil Procedure, "[e]ach matter of which an admission is requested shall be separately set forth. The matter is admitted unless, within 30 days after service of the request . . . the party to whom the request is directed serves upon the party requesting the admission a written answer or objection addressed to the matter, signed by the party or by his attorney . . ."

11. Pursuant to North Carolina Rules of Civil Procedure Rule 36(b), "Any matter admitted under this rule is conclusively established unless the court on motion permits withdraw or amendment of the admission."

12. By operation of law, all the material facts in this matter have been conclusively established by Respondent's admissions and by her failure to request and receive permission to withdraw or amend her admissions.

13. The conclusive admissions of all the material facts in this matter establish the findings, conclusions, and violations set forth herein and warrant the discipline imposed, independent of the testimony, exhibits and other evidence admitted.

14. Respondent's violations, erratic behavior with patients, and her repeated failure to respond or participate in the formal hearing process, indicates a potential mental health or substance abuse problem that could be a threat to the public regarding her treatment of patients.

15. Respondent's violations in her treatment of Susan G. and Vanessa M. and the corresponding harm to her patients warrant an indefinite suspension of Respondent's dental license.

16. Only if Respondent complies fully with various terms and conditions as set forth herein, including full future compliance with the Dental Practice Act and the Board's Rules and Regulations, can the public be adequately protected by potentially provisionally restoring her license.

Based upon the foregoing Findings of Fact and Conclusions of Law, the Hearing Panel enters the following:

ORDER OF DISCIPLINE

1. License number 6102 issued to Respondent for the practice of dentistry in North Carolina is suspended indefinitely. Respondent's dental license potentially may be provisionally restored after sixty (60) days of active suspension, provided Respondent complies with all the following probationary terms and conditions for a period of five (5) years from the date of this Decision:

- a. Respondent shall violate no provisions of the Dental Practice Act or the Board's Rules and Regulations;
- b. Respondent shall neither permit nor direct any of her employees to violate any provision of the Dental Practice Act or the Board's Rules and Regulations;
- c. Respondent shall permit the Board and its agents to inspect and observe her office and patient records and interview employers, employees, and co-workers at any time during normal office hours;
- d. Respondent shall, within one (1) year from the date of this Decision, complete continuing education courses especially designed for her by the University of North Carolina School of Dentistry in conjunction with, and approved in advance by, the North Carolina State Board of Dental Examiners. These shall be comprehensive, remedial courses in: (i) patient screening and selection; (ii) diagnosis, treatment planning, and placement of implants; (iii) recordkeeping, including adequate informed consent; (iv) extractions including the removal of root tips; and (v) management of post-surgical symptoms and

conditions. This requirement shall be in addition to the continuing education required by the Board for renewal of Respondent's dental license. Respondent shall submit to the Board's Director of Investigations written proof of satisfactory completion of these courses before they will be accepted in satisfaction of this requirement. It is the Respondent's responsibility to make all arrangements for and bear the costs of these courses within the specified time;

- e. Respondent shall not perform extractions or place implants and refer any pending implant cases to another practitioner. Respondent may petition to resume performing extractions and placing implants once she has completed the continuing education courses especially designed for her by the University of North Carolina School of Dentistry set forth in paragraph 1(d) above and engaged an approved practice monitor set forth in paragraph 1(f) herein;
- f. Respondent shall engage a licensed North Carolina dentist approved by the Board's IP to serve as a practice monitor related to any practice Respondent owns or in which she engages in the practice of dentistry. Within sixty (60) days of the entry of this Order, Respondent shall submit a proposed practice monitor for review and potential approval by the Board's IP, at its discretion. The practice monitor shall meet with Respondent regularly and no less than quarterly and review example patient chart and billing records

selected by the monitor, not Respondent or her employees. During these meetings, the monitor shall examine example patient records to determine Respondent's compliance concerning (i) patient screening and selection; (ii) diagnosis, treatment planning and placement of implants; (iii) recordkeeping, including adequate informed consent; (iv) extractions involving the removal of root tips; and (v) management of post-surgical symptoms and conditions appropriate treatment of patients, Respondent shall ensure that the monitor prepares and submits to the Board quarterly reports with the findings concerning those issues for the quarter, including identifying the specific patient treatment and billing records reviewed. The IP reserves the right to review the charts that the monitor selects for his/her report, which records Respondent shall provide to the IP upon its request. The reports shall be due no later than April 1, July 1, October 1, and January 1 for the previous quarter in each year. Respondent is responsible for all payment of costs associated with this monitoring. If the monitor reports information to the Board indicating that Respondent may be engaging in a violation of the Board's statutes or regulations, Respondent understands that such findings may result in further disciplinary action by the Board, including potential activation of her indefinite suspension, following notice to Respondent and an opportunity to be heard. If the monitor timely submits quarterly reports indicating that Respondent has been

engaged in the practice of dentistry and has been in full compliance with the Board's statutes and regulations for two (2) consecutive years, Respondent may petition the Board Hearing Panel to reduce or eliminate this practice monitor requirement.

- g. During this term of suspension, Respondent may, with the Board's prior approval, lease her dental office and equipment. Any lease approved by the Board must be in writing and must disclose fully all material terms of the transaction. In no event, shall any such lease allow operation of a dental practice on behalf of or for the benefit of Respondent. Respondent may not receive any fees or funds generated as a result of the lease of his dental office or equipment, but may use the funds to pay a locum tenens, rent, staff salaries and other normal dental office expenses. As part of the Board-approved lease agreement, the locum tenens must agree to limit his/her services to the following procedures during the terms of the agreement: routine dental procedures, post-operative checks and emergency care. No implants are to be placed by a locum tenens. Respondent may not be in her dental office during business hours or while patient treatment is occurring during any period of active suspension.
- h. Respondent shall obtain an evaluation or assessment at a facility or by a provider approved by North Carolina Caring Dental Professionals (CDP). Respondent shall follow all recommendations of CDP and the

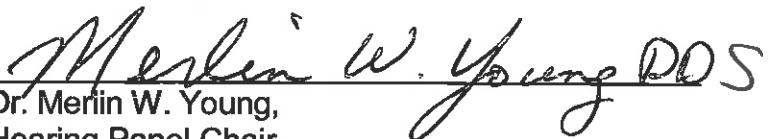
approved treatment facility or provider and participate in any in-patient, out-patient or after-care treatment plan recommended by the approved treatment facility or provider. If recommended by the assessment, Respondent shall enter into a contract with CDP. The terms of the contract are at the sole discretion of CDP after consideration of the assessment and Respondent's treatment providers. Respondent must comply with all provisions of that contract. Respondent shall sign a release with the Caring Dental Professionals permitting them to submit monthly reports to the Board regarding her progress in the program. If CDP recommends any period of in-patient treatment, such treatment shall be completed successfully before Respondent's license is restored.

2. The Board recognizes that the conditions, limitations, or requirements set forth in this Decision may present Respondent with certain practical difficulties. The Board concludes that each one is necessary to ensure public protection and it does not intend to modify or eliminate any of the conditions, limitations, or requirements set forth herein based on such potential difficulties.

3. If Respondent fails to comply with any provision of this Decision or breaches any term or condition thereof, including those in paragraph one (1), the Board shall promptly schedule a public Show Cause Hearing to allow Respondent an opportunity to show cause as to why Respondent's suspension shall not be activated for violating a valid order of the Board. If after the Show Cause Hearing, the Board is satisfied that Respondent failed to comply or breached any term or condition of this Decision, the Board shall activate the

indefinite suspension and also may enter such other discipline or conditions as the evidence warrants for proven violations of the Dental Practice Act or of the Board's Rules occurring after entry of this Decision.

This the 20th day of January, 2018.


Dr. Merlin W. Young,
Hearing Panel Chair

THE NORTH CAROLINA STATE
BOARD OF DENTAL EXAMINERS

