

BEFORE THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

In the Matter of)
)
Richard Ramon Rolle, Jr., DDS) **CONSENT ORDER**
(License No. 9406))
)

THIS MATTER is before the North Carolina State Board of Dental Examiners (the "Board") as authorized by G.S. § 90-41 for consideration of a Consent Order in lieu of a formal administrative hearing. Respondent, Richard Ramon Rolle, Jr., DDS ("Respondent") was represented by Kenneth L. Jones and Carrie E. Meigs. The Investigative Panel ("IP") was represented by Douglas J. Brocker and Crystal S. Carlisle. The parties freely and voluntarily consent to the following:

FINDINGS OF FACT

1. The 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, including the Dental Practice Act and the Rules and Regulations of the Board.
2. Respondent was licensed to practice dentistry in North Carolina in September 2012 and holds license number 9406. Respondent was issued and has held a general anesthesia permit since April 10, 2013.
3. At all times relevant hereto, Respondent was subject to the Dental Practice Act and the Board Rules and Regulations.

Patient Mary Jane H.

4. Patient Mary Jane H., a seventy-five (75) year-old woman weighing 105 pounds, presented to Respondent on July 6, 2016 for extractions of multiple teeth.

5. Patient Mary Jane H. self-reported the following medical history to Respondent: history of dehydration within the past five years, bilateral hip replacement, sinus trouble, asthma or hay fever, fainting spells or seizures, thyroid problems, arthritis or painful swollen joints including jaw joint (TMJ), history of blood transfusion, and epilepsy seizures. She also indicated she wanted to talk to Respondent privately about something.

6. Patient Mary Jane H. self-reported that she was taking numerous medications including a Spiriva Inhaler, Advair, and Forteo.

7. Respondent included an American Society of Anesthesiologists (ASA) physical status classification of 3 in his consultation notes for patient Mary Jane H.

8. Respondent did not elaborate upon or clarify any of the medical history, the patient's request to speak to him privately, or the medications that patient reported.

9. Respondent did not seek a medical consultation or request medical clearance for patient Mary Jane H. in order to proceed with administration of deep sedation or general anesthesia in an outpatient setting.

10. Respondent extracted teeth numbers 2, 5, 14, 15, 30, and 31 and the residual roots of teeth numbers 6, 7, 12, 23, and 28 from patient Mary Jane H. on July 19, 2016.

11. During the surgical procedure, Respondent administered 10 mg of Versed and 50 mg of Ketamine to patient Mary Jane H., but did not include the times these medications were administered in his patient treatment record.

12. Respondent failed to record the patient's baseline vital signs and vital signs throughout the procedure in the patient's treatment record for the July 19, 2016 procedure under general anesthesia.

13. On August 3, 2016, patient Mary Jane H. complained of intermittent residual pain and Respondent scheduled her for a surgical debridement which was performed under general anesthesia on August 10, 2016.

14. There is no anesthetic record in Respondent's patient's chart for the August 10, 2016 surgery. Therefore, there is no record of the medication administered during the surgical procedure or any of the patient's vital signs for the August 10, 2016 surgery.

15. On September 1, 2016, patient Mary Jane H. again returned to Respondent's office with complaints of intermittent residual pain. Respondent scheduled her for another surgical debridement, which was performed on September 7, 2016.

16. During the September 7, 2016 surgical procedure, Respondent administered 5 mg of Versed and 25 mg of Ketamine to patient Mary Jane H., but did not include the times these medications were administered in the treatment or anesthetic record.

17. Respondent failed to record the patient's baseline vital signs and vital signs throughout the procedure in her treatment or anesthetic record.

18. Patient Mary Jane H.'s final visit with Respondent was on September 12, 2016. She continued to complain of residual pain and swelling. Respondent's treatment notes indicate he would see her "PRN."

19. On September 15, 2016, patient Mary Jane H. was subsequently diagnosed by another provider with osteonecrosis of the jaw with exposed alveolar bone on the lower right, roughly 1.5 cm in length. The diagnosis was confirmed on October 12, 2016, and the necrotic bone was removed on November 2, 2016.

20. Patient Mary Jane H. was ultimately left with a lack of vestibular depth and an inability to wear a properly fitting denture.

21. The standard of care applicable to dentists licensed to practice in North Carolina requires dentists to elaborate upon or clarify a patient's medical history or medications reported.

22. The standard of care applicable to dentists licensed to practice in North Carolina requires dentists to seek a medical consultation or request medical clearance for medically compromised patients before proceeding with administration of deep sedation or general anesthesia in an outpatient setting.

23. At the time the procedures on Mary Jane H. were performed, the Board's rules and the standard of care required that a dentist with a general anesthesia permit include a sedation record, including baseline vital signs, periodic vital signs taken during the procedure, and the time drugs are administered. 21 NCAC 16Q .0202(a)(6)(B),(C) (effective November 1, 2013).

Patient Loretta W.

24. On March 18, 2014, Respondent extracted patient Loretta W.'s tooth number 17.

25. Patient Loretta W. began to experience pain in the left side of her mouth when eating certain foods. On October 18, 2017, she presented to her general dentist for a prophylaxis, and her dentist noticed a metal object in the area of tooth number 17. No further surgery was performed on Loretta W.'s tooth number 17 after March 18, 2014 and prior to October 18, 2017.

26. Patient Loretta W. was referred to an oral surgeon for evaluation of the object and for the extraction of two teeth.

27. On November 8, 2017, the oral surgeon removed from the area of tooth number 17 a metallic object, which was a broken tip of an elevator and is evident on a panoramic x-ray taken on the same date.

28. Respondent's treatment records on March 18, 2014 or thereafter do not indicate that an elevator tip was retained in the area of patient Loretta W.'s tooth number 17.

29. Respondent did not inform patient Loretta W. that the elevator tip was retained in the area of tooth number 17.

30. The standard of care applicable to dentists licensed in North Carolina requires dentists to inspect dental instruments both before and after use on patients to ensure they are functioning and intact.

31. The standard of care applicable to dentists licensed in North Carolina require dentists to advise patients if foreign objects remain in their oral cavity so the patient can make an informed decision about whether to have the object removed.

Patient Frankie T.

32. Patient Frankie T. presented to Respondent on May 30, 2018 for extraction of tooth number 14.

33. Patient Frankie T. self-reported the following medical history to Respondent: right and left hip replacements, shortness of breath after mild exercise, swollen left ankle, allergies, sinus trouble, and low blood pressure.

34. In Respondent's operative report for May 30, 2018, he listed under "Significant Medical Hx," bilateral hip replacement and obesity.

35. Respondent did not elaborate upon or clarify any of the medical history for patient Frankie T in his patient treatment record.

36. During the May 30, 2018 surgical procedure, Respondent administered 50 mcg Fentanyl, 10 mg of Versed and 50 mg of Ketamine to patient Frankie T. but failed to include the times these medications were administered.

37. Respondent also failed to record baseline vital signs or the procedure start and end times in the operative report or anesthetic record.

38. The day following the surgery, patient Frankie T. complained of intermittent residual pain and presented to both the emergency department and her general dentist with continued pain. She returned to Respondent's office on June 11, 2018 and was

scheduled for a debridement and alveoloplasty. Respondent's note states the extraction site was "healing well."

39. The following day, patient Frankie T. was again seen in the emergency department where yellow drainage was noted at sites of teeth 13, 14 and 16. She was subsequently diagnosed with an infection and mature fibrous dysplasia.

40. The standard of care applicable to dentists licensed to practice in North Carolina requires dentists to recognize and treat an infected extraction site or refer the patient to another clinician who can.

41. The standard of care applicable to dentists licensed to practice in North Carolina requires dentists to include the times all drugs are administered during surgical and anesthetic procedures.

42. At the time the procedure on Frankie T. was performed, the Board's rules and the standard of care required that a dentist with a general anesthesia permit include a sedation record, including baseline vital signs and procedure start and end times. 21 NCAC 16Q .0202(a)(5) (effective June 1, 2017).

Patient Wendy P.

43. On August 27, 2018, patient Wendy P. presented to Respondent for a consultation for a full mouth extraction.

44. Patient Wendy P. self-reported the following medical history to Respondent: mitral valve prolapse since birth, sinus trouble, asthma or hay fever, required a blood transfusion, smoked one pack of cigarettes per day, and psychiatric conditions.

45. Patient Wendy P. disclosed that she was under the care of an internal medicine physician and provided a list of medications she was currently taking.

46. Respondent did not elaborate upon or clarify any of the medical history or medications that patient reported.

47. On September 11, 2018, Respondent performed the full mouth extraction.

48. During the surgical procedure, Respondent administered 10 mg of Versed, 50 mcg of Fentanyl, 50 mg of Ketamine, and 20 mg of propofol to patient Wendy P., but failed to include the times any of these medications were administered.

49. Respondent failed to record baseline vital signs or procedure start and end times in the operative report or anesthetic record.

50. Approximately three (3) hours post-surgery, patient Wendy P. presented to her general dentist. It was noted that she had blood-soaked gauze in her mouth and blood was dripping onto her clothes. The general dentist had to replace the gauze four (4) times, and patient Wendy P. remained in the dental chair for two (2) hours while the bleeding subsided.

51. Subsequently, patient Wendy P. contacted Respondent's office with complaints of soreness under her eye. On September 19, 2018, she presented to the emergency room where she stated her left eye was almost swollen shut that morning. She was given IV antibiotics.

52. On October 5, 2018, patient Wendy P. returned to Respondent's office for an alveoloplasty.

53. During the surgical procedure, Respondent administered 90 mg of propofol, 50 mcg Fentanyl, 10 mg Versed, and 12.5 mg of Ketamine to patient Wendy P., but failed to include the times any of these medications were administered.

54. Respondent failed to record baseline vital signs or procedure start and end times in the operative report or anesthetic record and no blood pressure was recorded until twelve (12) minutes into the surgical procedure.

55. The patient's husband called Respondent's office after the procedure to complain that the patient's lip and chin were cut, the bone was still sharp, and her dentures did not fit due to the way her mouth was stitched together.

56. Patient Wendy P. was subsequently seen at the emergency room and by her general dentist. Her general dentist noted that her sutures were attached to the lower inside area of her lip; the extraction sites were open, inflamed, and red; and she could not wear her dentures.

57. On November 21, 2018, Wendy P. was evaluated by another oral surgeon who noted: there is significant irregular bone across the anterior maxilla specifically in the central area where there is a sharp protuberance of alveolar bone; irregularity of the mandibular alveolus, near obliteration of the right posterior mandibular vestibule, and loss of the vestibule anteriorly and on the left posterior. As a result, Wendy P. was unable to wear her dentures.

58. The standard of care applicable to dentists licensed to practice in North Carolina requires dentists to elaborate upon or clarify a patient's medical history or medications reported prior to administering general anesthesia or performing surgery.

59. The standard of care applicable to dentists licensed to practice in North Carolina requires dentists to inform patients of any cut or injury to their face or mouth during a dental or surgical procedure.

60. The standard of care applicable to dentists licensed to practice in North Carolina requires dentists to include the times all drugs are administered during surgical or anesthetic procedures.

61. At the time the procedures were performed on patient Wendy P., the Board's rules and the standard of care required that a dentist with a general anesthesia permit include a sedation record, including baseline vital signs and procedure start and stop times. 21 NCAC 16Q .0202(a)(4)(D), (a)(5) (effective August 1, 2018).

Patient Penelope L.

62. On March 6, 2017, patient Penelope L. presented to Dr. Rolle for extraction of one or more lower teeth including tooth number 28.

63. Initially, the patient's general dentist referred her to Respondent to have her remaining teeth extracted, including teeth numbers 6-11. However, upon discovering that Medicaid would not pay for a full upper denture for the patient, the general dentist revised and sent Respondent a new referral requesting only the extraction of the lower teeth.

64. The general dentist states that Respondent's office called on or near the date of the extractions to confirm that only teeth numbers 21, 27, and 28 would be removed.

65. Respondent, however, extracted teeth numbers 6-11, as well as teeth 21, 27, and 28. The day following the extractions, the patient contacted her general dentist upset that her upper teeth had been extracted.

66. Although Respondent had the patient sign a Consent Form which included teeth numbers 6-11, the patient was not aware Respondent would be extracting her upper teeth as evidenced by the telephone call she made to her general dentist the day following the surgery.

67. The standard of care applicable to dentists licensed to practice in North Carolina requires dentists to obtain a patient's informed consent regarding which teeth will be extracted before performing extractions.

General Anesthesia Inspection and Records

68. A general anesthesia re-inspection was conducted of Respondent's office by an Investigator for the Board on February 27, 2019.

69. Respondent failed the unannounced re-inspection in the following areas:

a. Required Drugs – A majority of the emergency medications required by Board rules were either missing or expired including: epinephrine, atropine, an anti-arrhythmic, an antihistamine, a corticosteroid, an antiemetic, and a bronchodilator. Reversal agents were drawn up in syringes and placed in a bucket without any labels or expiration dates.

b. Equipment – The backup suction and thermometer were not operational as required by Board rules.

c. **Emergency Drills** – There was no documentation that emergency drills had been performed with the staff.

d. **Required Documentation** - One of the two patient anesthesia records selected did not have all the required information.

70. The Board Investigator also requested that Respondent provide required documentation that was not immediately available upon the Investigator's request, such as a sedation location permit and proof of required continuing education.

71. A subsequent inspection was performed by a Board Inspector on March 7, 2019.

72. At this inspection, it was noted that Respondent did not have an opioid reversal agent, had an insufficient amount of anti-arrhythmic, and his AED was not operational with batteries that had expired in 2012.

73. A third inspection was performed by a Board Investigator on May 15, 2019 and revealed two additional issues: Respondent did not have pediatric pads for the AED and needed to acquire a duplicate original general anesthesia permit. Respondent subsequently corrected those last two remaining issues.

74. The standard of care applicable to dentists licensed to practice in North Carolina and Board Rule 21 NCAC 16Q .0202(a) requires dentist with a general anesthesia permit to possess the necessary drugs and equipment to perform surgery under general anesthesia, including possessing all the necessary drugs to address potential medical emergencies; perform and document emergency drills; follow sterilization procedures, include all necessary information in patient anesthetic records, and possess all necessary documentation to present upon inspection.

Based upon the foregoing Findings of Fact and with the consent of the parties hereto, the Hearing Panel enters the following:

CONCLUSIONS OF LAW

1. The Board has jurisdiction over the subject matter of this action and over Respondent.
2. Respondent was properly notified of this matter and has consented to the entry of this Consent Order.
3. Respondent violated N.C. Gen. Stat. § 90-41(a)(6) and (12) and 21 NCAC 16Q .0202(a) in his care and treatment of patients Mary Jane H., Loretta W., Frankie T., Wendy P., and Penelope L. as set forth in Findings of Fact paragraphs 4 through 67 above.
4. Respondent violated NCAC 16Q .0202(a) as set forth in paragraphs 68-74 above.

Based upon the foregoing Findings of Fact and Conclusions of Law and with the consent of the parties hereto, it is ORDERED as follows:

ORDER OF DISCIPLINE

1. License 9406 issued to Respondent for the practice of dentistry in North Carolina is suspended for a period of six (6) months. The suspension shall be immediately stayed, and Respondent's license shall remain active, provided that for five

(5) years from the effective date of this Order, Respondent adheres to the following probationary terms and conditions:

- a. Respondent shall violate no provision of the Dental Practice Act or the Dental Board rules.**
- b. Respondent shall neither direct or permit any of his employees to violate any provision of the Dental Practice Act or the Board's rules.**
- c. Respondent shall permit the Board or its agents to inspect and observe his office, conduct a random review of patient chart records, and interview employers, employees, and coworkers at any time during normal office hours.**

2. Within 90 days from the date of this Order, Respondent shall complete the following continuing education courses especially designed for him 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, including a comprehensive, remedial course covering: (1) Clinical and sedation recordkeeping; (2) Sedation protocol, including dosages and titration with respect to individual patients and discharge criterion and assessment; (3) Emergency drugs, protocols, and equipment; (4) Surgical protocol and technique including clinical observations by approved instructor; and (5) Postoperative follow-up protocol. 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

3. Respondent shall engage a licensed North Carolina dentist to serve as a practice monitor which practice monitor Respondent shall submit for review and obtain approval by the Board's IP, at its discretion. The practice monitor shall meet with Respondent regularly and no less than quarterly to review example patient charts selected by the monitor, not by Respondent or employees at the office(s) where he practices. During these meetings, the monitor shall examine example patient records to determine Respondent's compliance concerning: (i) recordkeeping, including documentation of all required elements of patient treatment and sedation records; and (ii) any other issues identified by the monitor related to Respondent's compliance with the Dental Practice Act and the Board's rules and regulations. 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 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 any and 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 or this Order, Respondent understands that such findings may result in further disciplinary action by the Board, including potential activation of his suspension, following notice to Respondent and an opportunity to be heard. If the monitor's reports and the Board's

inspections demonstrate no violations of the Dental Practice Act or the Board rules for two (2) consecutive years, then Respondent may petition the Board to eliminate this requirement for the remaining probationary period.

5. Within thirty (30) days of the date of this Order, Respondent shall reimburse the Board for the costs associated with the investigation of this matter in the amount of \$3,000.00.

6. Respondent recognizes that the conditions, limitations, or requirements set forth in this Consent Order may present him 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.

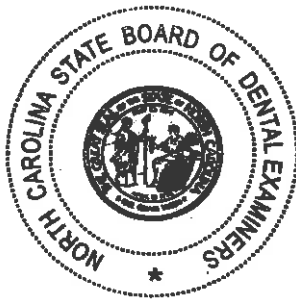
7. If Respondent fails to comply with any provision of this Decision or breaches any term or condition thereof, including those in paragraphs one (1) through five (5), the Board shall promptly schedule a public Show Cause Hearing to allow Respondent an opportunity to show cause as to why Respondent's 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 suspension and 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 14th day of January, 2020

THE NORTH CAROLINA STATE
BOARD OF DENTAL EXAMINERS

By: *Merlin W. Young DDS*

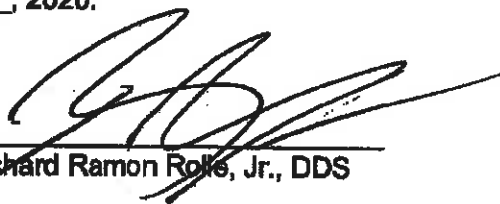
Merlin W. Young, D.D.S.



STATEMENT OF CONSENT

I, Richard Ramon Rolle, Jr., DDS, do hereby certify that I have read the foregoing Consent Order in its entirety. I assent to its terms and conditions set out herein. I freely and voluntarily acknowledge that there is sufficient evidence to form a factual basis for the findings of fact herein, that the findings of fact support the conclusions of law, that I will not contest the findings of fact, the conclusions of law, or the order in any future proceedings before or involving the Dental Board, including if future disciplinary proceedings or action is warranted in this matter. I knowingly waive any right to appeal or otherwise later challenge this Consent Order once entered. I understand that the Board will report the contents of this Consent Order to the National Practitioner Data Bank and that this Consent Order will become part of the Board's permanent public record. I further acknowledge that this required reporting may have adverse consequences in other contexts and any potential effects will not be the basis for a reconsideration of this Consent Order. I have consulted with counsel before signing this Consent Order.

This the 10 day of January, 2020.


Richard Ramon Rolle, Jr., DDS