

IN THE MATTER OF
CLETUS FONMEDIG, D.D.S.

Respondent

License Number: 14798

*** BEFORE THE MARYLAND**
*** STATE BOARD OF**
*** DENTAL EXAMINERS**

*** Case Number: 2021-007**

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CONSENT ORDER

In or around July 2020, the Maryland State Board of Dental Examiners (the “Board”) opened an investigation of **CLETUS FONMEDIG, D.D.S.** (the “Respondent”), License Number 14798. Based on its investigation, the Board determined that it has grounds to charge the Respondent with violating the Maryland Dentistry Act (the “Act”), Md. Code Ann., Health Occ. (“Health Occ.”) §§ 16-101 *et seq.* (2014 Repl. Vol. & 2020 Supp.).

The pertinent provisions of the Act provide:

Health Occ. § 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;

(28) Except in an emergency life-threatening situation where it is not feasible or practicable, fails to comply with the Centers for Disease Control’s [“CDC”] guidelines on universal precautions...;

Prior to the Board issuing disciplinary charges, the Respondent agreed to enter this public Consent Order consisting of Findings of Fact, Conclusions of Law, and Order.

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 December 8, 2010, under License Number 14798. The Respondent's license is current through June 30, 2022.

2. At all times relevant, the Respondent practiced dentistry at a dental practice he owns in Rosedale, Maryland (the "Office").

II. COMPLAINT

3. On or about July 20, 2020, the Board received a complaint from a patient (the "Complainant") at the Respondent alleging, among other things, that there were substandard infection control practices at the Office.

4. Based on the complaint, the Board initiated an investigation of the Office's compliance with CDC guidelines.¹

¹ 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

III. INFECTION CONTROL INSPECTION

5. Due to allegations of potential infection control issues at the Office, on or about January 25, 2021, a Board-contracted infection control inspector (the "Board Inspector"), along with a Board investigator, visited the Office and conducted an infection control inspection.

6. The Respondent was present during the inspection. Also present were a receptionist and two clinical staff members (Dental Healthcare Personnel, or "DHCP").

7. During the inspection, the Board Inspector was able to directly observe patient treatment by DHCP employed at the Office and by the Respondent.

8. As part of the inspection, the Board Inspector utilized the publicly available Centers for Disease Control and Prevention ("CDC") Infection Prevention Checklist for Dental Settings to contemporaneously record his observations.

9. On or about February 27, 2021, based on a review of the Board Inspector's records and observations, a Board-assigned expert in CDC Guidelines completed a report (the "Expert's Report") in which she identified specific CDC Guidelines with which the Respondent failed to comply. The pertinent conclusions of the Expert's Report are summarized below, following the format of the Infection Prevention Checklist.

Section I: Policies and Practices

I.1 ADMINISTRATIVE MEASURES

emergency which is life-threatening *and* where it is not feasible or practicable to comply with the guidelines.

Infection Control policies and practices specific to the practice were not available. No documentation exists that employees completed training. There is no documentation that policies and procedures are reassessed at least annually or according to state and federal requirements and updated when appropriate.

There were no bonnets and no N95 respirators, but there was a small box of KN 95 respirators. Sufficient supply of gloves was noted but an extremely limited supply of gowns and only two face shields were found in the entire practice.

There was no documentation that a system for early detection and management of potentially infectious persons was being utilized. No signs were available in the reception area with regards to infection prevention. No facemasks were offered or available at the front desk.

I.2 INFECTION PREVENTION TRAINING AND EDUCATION

There was no documentation of DHCP receiving job or task-specific training on infection control policies and upon hire, annually, or when new tasks or procedures affect the employees' occupational exposure or according to state or federal requirements.

I.3 DENTAL HEALTHCARE PERSONNEL SAFETY

There was no exposure control plan tailored to the Office. There was no documentation that DHCP are trained on the OSHA Bloodborne pathogens standard. There were no employee health files. There was no documentation of immunizations, no recommendations to the employees regarding a list of recommended or required immunizations (e.g. hepatitis B, MMR, varicella, tetanus, diphtheria or pertussis.) There was no evidence that employees were aware of availability of vaccination for Hepatitis B at no cost to them if they are at risk of occupational exposure to blood or other potentially infectious material. There was no evidence of post vaccination screening for Hepatitis B, documentation that DHCP are offered annual influenza vaccination. There was no baseline TB screening, no log of needlesticks or employee exposure events. There was no documentation of any referral arrangement in place to qualified health care professionals to ensure prompt and appropriate post-exposure management and follow-up at no cost to the employee. There was no well-defined policy concerning contact of personnel with patients who have potentially transmissible conditions.

I.4 PROGRAM EVALUATION

There were no written policies for monitoring any office infection control program. There is no adherence to practices that would provide DHCP with monitoring or feedback on

infection control protocols such as hand hygiene, proper use of PPE, sterilization monitoring, or immunizations.

I.5 HAND HYGIENE

There was no documentation regarding appropriate training for hand hygiene.

I.6 PERSONAL PROTECTIVE EQUIPMENT (PPE)

There was a limited supply of face shields, gowns, and KN95 respirators. There were no utility gloves on premises, no bonnets, but an adequate amount of gloves (non-sterile gloves). There were no glasses with side shields or N95 respirators on premises for use by DHCP. There was no documentation that DHCP receive training on the proper selection and use of PPE.

I.7 RESPIRATORY HYGIENE/COUGH ETIQUETTE

There was no documentation of policies or procedures to contain respiratory secretions in people exhibiting signs and symptoms of a respiratory infection beginning at the point of entry to the dental practice. There was no documentation of posted signs at entrances to instruct patients in proper respiratory hygiene, no provision of tissues or no-touch receptacles for discarding tissues, no provision of tissues in bathroom for patients, no provision of face masks to symptomatic patients upon entrance to the practice. The practice does provide patients with resources for patients to perform hand hygiene near the reception area. There was no documentation that DHCP receive training regarding the importance of containing respiratory secretions in people exhibiting signs and symptoms of a respiratory disease.

I.8 SHARPS SAFETY

There were no written policies, procedures, or guidelines regarding exposure prevention and post-exposure management. There was no documentation of DHCP training in devices with engineered safety features.

I.9 SAFE INJECTION PRACTICES

There were no written policies, procedures or guidelines for safe injection practices.

I.10 STERILIZATION AND DISINFECTION OF PATIENT CARE ITEMS AND DEVICES

There were no written policies or procedures available to ensure reusable patient care instruments and devices are cleaned and reprocessed appropriately before use on another

patient. There was no evidence of any training of DHCP that are responsible for reprocessing reusable dental instruments and devices. There was no documented training to prevent DHCP from exposure to infectious agents. It does appear that routine maintenance is being performed on sterilization equipment according to manufacturer's instructions and is documented by maintenance records.

I.11 ENVIRONMENTAL INFECTION PREVENTION AND CONTROL

There were no written policies or procedures available for routine cleaning and disinfection of environmental surfaces. There was no documentation of any training for DHCP regarding management of clinical contact and housekeeping surfaces. There was no documented training to ensure DHCP wear appropriate PPE to prevent exposure to infectious agents or chemicals. There was no documentation of written policies or procedures regarding cleaning, disinfection, use of surface barriers. There was no documentation in place for procedures related to decontamination of spills of blood or other potentially infectious material.

I.12 DENTAL UNIT WATER QUALITY

There was no documentation of policies or procedures for maintaining dental unit water quality.

Section II: Direct Observation of Personnel and Patient Care Practices

II.1 HAND HYGIENE IS PERFORMED CORRECTLY

Hand hygiene was observed being done correctly when hands are visibly soiled, when barehanded touching of instruments, equipment, materials and other objects likely to be contaminated by potentially infectious material, before and after treating each patient and before putting on gloves. However, the Respondent was observed not washing his hands immediately after removing gloves.

II.2 PERSONAL PROTECTIVE EQUIPMENT (PPE) IS USED CORRECTLY

PPE was not removed prior to leaving the operatory. After completion of an aerosol generating procedure, the Respondent accompanied a patient to the front desk area in his PPE. DHCP walked to the processing area with the same PPE as used on the patient. Dr. The Respondent and DHCP did not wear an N95 or KN95 respirator, did not double mask with a surgical mask during aerosol generating procedures. Neither the Respondent nor DHCP changed their masks in between patients. The Respondent and DHCP did not wear eye protection with solid side shields or a face shield during procedures.

There were no puncture- or chemical-resistant utility gloves to be used when cleaning instruments or performing housekeeping tasks that could involve contact with blood or other potentially infectious material.

DHCP wear protective clothing that covers personal clothing and skin that could be exposed to blood or other potentially infectious material. The Respondent and DHCP did not change their protective clothing even after performing aerosol generating procedures.

II.3 RESPIRATORY HYGIENE/COUGH ETIQUETTE

There were no signs posted at entrances advising patients to cover their mouth and nose when coughing or sneezing. There were no tissues provided, no no-touch receptacles for tissue disposal, and no face masks available or offered to patients who have respiratory symptoms. Patients who have respiratory symptoms are not being advised to distance themselves from others in the reception area.

II.4 SHARPS SAFETY

The puncture resistant containers are in a utility room. The containers are not spill resistant. Container openings are so large as to allow for someone to stick their hand into the container. It appears that biohazardous waste is disposed of in accordance with Federal, State and local medical waste rules and regulations.

II.5 SAFE INJECTION PRACTICES

(The Inspector was not able to observe the Respondent's injection practices because the Respondent did not perform any injections on the day of the inspection.)

II.6 STERILIZATION AND DISINFECTION OF PATIENT CARE ITEMS AND DEVICES

Items are thoroughly cleaned according to manufacturer's instructions and visually inspected for residual contamination before sterilization. There was no long-handled brush or puncture- and chemical-resistant gloves available for staff to process instruments. After cleaning and drying, instruments were appropriately wrapped, a chemical indicator IS used inside each package, but there was no labelling of any kind on the instrument packages (no date, no indication of sterilizer used, no load number).

It appears that spore testing is done at least weekly, but separate identifiable testing logs for each sterilizer cycle did not exist. After sterilization, dental devices and instruments are stored properly so sterility is not compromised. It appears that the practice will not use those packages if chemical or mechanical indicators indicate inadequate processing of instruments. The instrument processing area does have a workflow pattern that clearly

separates clean from contaminated workspaces and flows from contaminated to clean areas. Reusable, heat-sensitive semi-critical items that cannot be replaced by a heat-stable or disposable alternative are high-level disinfected according to manufacturer's instructions. High level disinfection products are used and maintained according to manufacturer's instructions.

Dental handpieces (including the low-speed motor) and other devices not permanently attached to air and waterlines are cleaned and heat-sterilized according to manufacturer's instructions.

Digital radiography is utilized in the practice, barriers cover the sensors, and are changed in between patients. After removal of barrier the sensor is cleaned according to manufacturer's instructions.

II.7 ENVIRONMENTAL INFECTION PREVENTION AND CONTROL

Clinical contact surfaces are either barrier-protected or cleaned and disinfected appropriately after each patient. However, barriers were not used on the computer keyboards, the chair light, the bracket table, or the radiograph head. DHCP engaged in environmental cleaning wear are not wearing appropriate PPE to prevent exposure to infectious agents or chemicals.

II.8 DENTAL UNIT WATER QUALITY

There is no documentation that dental unit waterlines have ever been tested or treated to ensure water meets EPA regulatory standards for drinking water for routine dental treatment output water (no surgical procedures are performed in this practice so the use of sterile saline or water is not applicable to this practice).

CDC Guidelines Addendum Re: COVID-19

Governors certificate on file: No.

Patient Prescreening for temperature and symptom check is performed: Yes.

Staff Prescreening for temperature check and symptom check is performed: No documentation.

One week of PPE available for elective procedures: No bonnets, No N95, No Glasses with side shields, LIMITED KN95, gowns, face shields.

Use of N95 or equivalent during aerosol generating procedures: No.

Wearing eye protection in addition to facemask/respirator: no side shields available.

Appropriate PPE used, donned, doffed, changed in between patients and disposed of properly: No. Neither the Respondent nor DHCP changed PPE between patients except gloves.

Telephone screening and triage of patients prior to appointing: No.

Facemasks covering mouth and nose by clinicians, staff, patients except when staff eating a meal: Yes. However, DHCP at front desk was observed several times wearing a mask that was not covering her nose.

Social distancing implemented in all areas of practice: No.

Surface disinfection and barriers used and changed in between patients with adequate time for disinfection of treatment rooms between patients: Yes.

Barriers used at front desk as well as in between treatment rooms: There was a barrier in between the front desk and reception area.

Respiratory precaution signs prominent and respiratory hygiene/cough etiquette practiced: No.

Observed presence of supplies and performance of hand hygiene: Yes.

If aerosol generating procedures performed, use of four-handed dentistry, high evacuation suction, and dental dam use to minimize droplet spatter and aerosols: (No opportunity to view rubber dam use.) High volume suction was performed as well as four-handed dentistry.

All operatories set up efficiently, supplies and patient treatment items not exposed to aerosols and as few individuals in treatment room as possible: Yes.

Post-op instructions to patients including follow-up if patient tests positive for Covid-19 following dental visit: No.

7. Based on the observations made by the Board Inspector, and the conclusions of the Board Expert, the Respondent as the owner of the Office failed to ensure compliance with CDC Guidelines at the Office.

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 Act as cited above, specifically: the Respondent's conduct as described above, including but not limited to failing to ensure compliance with the CDC Guidelines at the Office as described above, 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 failing to comply with Centers for Disease Control's guidelines on universal precautions in violation of Health Occ. § 4-315(a)(28).

ORDER

It is, on the affirmative vote of a majority of the Board, hereby:

ORDERED that the Respondent shall ensure that the Office immediately ceases all dental treatment until the Board issues a separate Order terminating this provision (the "**Order Lifting Voluntary Cessation**"); and it is further

ORDERED that upon the Board's receipt of verified documentation that the Respondent has formally retained the services of a qualified Board-approved infection control consultant and that the consultant has issued a favorable report substantiating that the Respondent and her office staff are in substantial compliance with CDC Infection Control Guidelines, the Board shall issue an **Order Lifting Voluntary Cessation**, which shall allow the practice cited above to resume dental treatment; and it is further

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

ORDERED that from the date of the Board's the **Order Lifting Voluntary Cessation**, the Respondent shall be placed on **PROBATION** for a period of **TWO (2) YEARS** under the following terms and conditions:

1. A Board-assigned inspector shall conduct an unannounced inspection within ten (10) business days (or as soon as practicable) in order to evaluate the Respondent and staff regarding compliance with the Act and infection control guidelines. The Board-assigned inspector shall be provided with copies of the Board file, the Consent Order, and any other documentation deemed relevant by the Board;
2. On a continuing basis, the Respondent shall provide to the Board-assigned inspector a schedule of the Office's regular weekly hours of practice and promptly apprise the consultant 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 with 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, including enhanced COVID-19 related precautions; and
6. At any time during the period of probation, if the Board makes a finding that the Respondent is not in compliance with CDC and/or OSHA guidelines, the Respondent shall have the opportunity to correct the infractions within seven (7) days and shall be subject to a repeat inspection within seven (7) days to confirm that the violation has been remedied.
7. The Respondent is fined in the amount of **TWO THOUSAND FIVE HUNDRED DOLLARS (\$2500)**, due within two years of the

date of the reinstatement of the Respondent's license, to the board;

8. Within three (3) months of the date of the reinstatement of the Respondent's license, the Respondent shall successfully complete a Board-approved in-person (or, if in-person courses are not available due to the current State of Emergency, then by video-conference) four (4) credit hour course(s) in infection control protocols, presented by a board-approved instructor, which may not be applied toward his license renewal.
9. Within three (3) months of the date of the reinstatement of the Respondent's license, the Respondent shall successfully complete a Board-approved in-person (or, if in-person courses are not available due to the current State of Emergency, then by video-conference) two (2) credit hour course(s) in ethics, presented by a board-approved instructor, which may not be applied toward his license renewal.
10. If the above-mentioned courses are not completed within three (3) months of the date of the Consent Order, the Board may allow an extension of three (3) additional months if the Respondent demonstrates to the Board's satisfaction that he was unable to complete the courses despite a good-faith effort.
11. The Respondent may file a petition for early termination of his 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, shall grant the petition if the Respondent has satisfactorily complied with the terms and conditions of this Consent Order.

AND IT IS FURTHER ORDERED that no part of the training or education that the Respondent receives in order to comply with this Consent Order may be applied to his required continuing education credits, 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 under this Consent Order; and it is further

ORDERED that after a minimum of two (2) years from the effective date of the Order for Reinstatement, 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. 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 or outstanding complaints related to the findings of fact in this Consent Order; and it is further

ORDERED that if the Respondent allegedly fails 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 this Consent Order is a public document pursuant to Md. Code Ann., Md. Code Ann., Gen. Prov. §§ 4-101 et seq. (2014).

August 27, 2021
Date

Francis X. McLaughlin, Jr.
Francis X. McLaughlin, Jr., Executive Director
Maryland State Board of Dental Examiners


CONSENT

By this Consent, I, Cletus Fonmedig, D.D.S., agree and accept to be bound by this Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact and Conclusions of Law.

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 as provided by law. I acknowledge the legal authority and the jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I also affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing.

I sign this Consent Order after having had the opportunity to consult with counsel, and I fully understand and comprehend the language, meaning and terms of this Consent Order. I voluntarily sign this Order, and understand its effect.

07/23/2021
Date

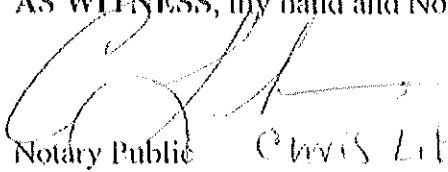

Cletus Fommedig, D.D.S.
Respondent

NOTARY

STATE OF Maryland
CITY/COUNTY OF: Baltimore

I HEREBY CERTIFY that on this 23 day of July 2021, before me, a Notary Public of the State and County aforesaid, personally appeared Cletus Fommedig, D.D.S., and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.


Notary Public Christopher Liberto

My commission expires: 9/21/2025

CHRISTOPHER MICHAEL LIBERTO
Notary Public
Baltimore County
Maryland
My Commission Expires Apr 21 2025