IN THE MATTER OF	*	**BEFORE THE MARYLAND**
JAY HUSTEAD, D.M.D.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 9624	*	**Case Number: 2020-079**

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE DENTISTRY

The Maryland State Board of Dental Examiners (the "Board") hereby **SUMMARILY SUSPENDS** the license of **JAY HUSTEAD, D.M.D.** (the "Respondent"), License Number 9624, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under Md. Code Ann., State Gov't ("State Gov't") § 10-226(c) (2014 Repl. Vol.), finding that the public health, safety, or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

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

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 February 18, 1988, under License Number 9624. The Respondent's license is current through June 30, 2020.

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

2. At all times relevant, the Respondent practiced dentistry at a dental practice in Waldorf, Maryland (the "Office") owned by another dentist ("Dentist A").

II. COMPLAINT

3. On or about January 22, 2020, the Board received a complaint from a former temporary employee (the "Complainant") at the Office 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. [2]

III. INFECTION CONTROL INSPECTION

5. Due to allegations of potential infection control issues at the Office, on or about February 24, 2020, 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. Dentist A was not present. Also present were at least the following individuals: an office manager/receptionist, a financial coordinator, an office staff member, and four clinical staff members.

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[2] The Centers for Disease Control and Prevention ("CDC") is a federal agency dedicated to designing protocols to prevent the spread of disease. The CDC has issued guidelines (the "CDC Guidelines") for dental offices which detail the procedures deemed necessary to minimize the chance of transmitting infection both from one patient to another and from the dentist, dental hygienist and dental staff to and from the patients. These guidelines include some very basic precautions, such as washing one's hands prior to and after treating a patient, and also sets forth more involved standards for infection control. Under the Act, all dentists are required to comply with the CDC guidelines, which incorporate by reference Occupational Safety and Health Administration's ("OSHA") final rule on Occupational Exposure to Bloodborne Pathogens (29 CFR 1910.1030). The only exception to this rule arises in an emergency which is life-threatening *and* where it is not feasible or practicable to comply with the guidelines.

7. 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.

8. During the inspection, the Board Inspector was able to directly observe patient treatment by dental practitioners employed at the Office, including the Respondent.

9. Based on the inspection, the Board Inspector made the following findings:

Section I: Policies and Practices

1.1 ADMINISTRATIVE MEASURES

A. There were no employee (records/assessments) folders of any kind. There was no office manual of any kind and no records whatsoever of training on infection prevention policies and procedures upon hire, reassessed at least annually, or according to state and federal requirements. There was no record of Infection Prevention/OSHA Bloodborne Pathogens Training according to federal and state requirements or based on evidenced based guidelines. There was no annual training, on-boarding, or updates of any kind that could be provided at this site visit.

B. There are no infection prevention policies and procedures that are reassessed at least annually or according to state or federal requirements and updated if appropriate. One employee said she took a one-hour online course on Bloodborne Pathogens Training. This was the extent of any training anyone in the entire practice has ever taken to the best of their recollection.

C. There was no individual officially responsible for coordinating the infection control program according to anyone present, even according to the Respondent. The Respondent could not provide any data or documentation that supports that he has ever had training in infection prevention.

D. There was a great lack in the necessary supplies for adherence to Standard Precautions. There were no utility gloves available in the sterilization area.

E. The facility has no system in place for early detection and management of potentially infectious persons at initial points of encounter. There was no precautions poster posted for patients. The policies and procedures to contain respiratory secretions in people who have signs and symptoms of respiratory infection, beginning at the entry to the dental setting could not be provided. There are no signs at entrances to instruct patients on procedures necessary to prevent the spread of their respiratory issues. There are no signs offering face masks to coughing patients and other symptomatic persons when they are entering the setting. There is no documentation that Dental Health Care Practitioners ("DHCP") receive training on protocols for containing respiratory infections.

1.2 INFECTION PREVENTION EDUCATION AND TRAINING

A. There was no documentation that DHCP received any job or task specific training on infection prevention policies and procedures and the OSHA Bloodborne Pathogens Standard at all, whether upon hire, annually, or when new tasks or procedures affect the employee's occupational exposure.

B. Training records are not maintained in accordance with state and federal requirements.

1.3 DENTAL HEALTH CARE PERSONNEL SAFETY

A. The Office has no exposure control plan that is tailored to the specific requirements of the facility.

B. There is no documentation stating that the DHCP for whom contact with blood or other potentially infectious material ("OPIM") is anticipated are trained on the OSHA Bloodborne Pathogens Standard at all, whether upon hire or at least annually.

C. There was no documentation of current CDC recommendations for immunizations, evaluation, and follow-up available. There is no written policy regarding immunizing DHCP, including a list of all required and recommended immunizations for DHCP.

D. There was no documentation at the Office that Hepatitis B vaccination is available to all employees who are at risk of occupational exposure to blood or OPIM.

E. There is no documentation that post-vaccination screening for protective levels of Hepatitis B surface antibody is conducted.

F. There was no documentation that all DHCP are offered annual influenza vaccination.

G. There was no documentation that all DHCP receive baseline TB screening upon hire regardless of the risk classification of the setting at the time of inspection.

H. There was no log of needle-sticks, sharps injuries, and other employee exposure events that is maintained according to state and federal requirements at the time of the inspection.

I. There was no documentation that referral arrangements are in place to qualified healthcare professionals to ensure prompt and appropriate provision of preventative services, occupationally-related medical services, and post-exposure management with medical follow-up.

J. There was no documentation that following an occupational exposure event, that there is a post-exposure evaluation and follow-up, including prophylaxis as appropriate, are available at no cost to the employee, and are supervised by a qualified healthcare professional.

K. There is no documentation that the facility has well-defined policies concerning contact of personnel with patients when personnel have potentially transmissible conditions, including: work-exclusion policies that encourage reporting of illnesses and do not penalize staff with loss of wages, benefits, or job status; and education of personnel on the importance of prompt reporting of illnesses to supervisors.

1.4 PROGRAM EVALUATION

A. There was no documentation that written policies and procedures for routine monitoring and evaluation of the infection prevention and control program are available.

B. There was no documentation of adherence with practices such as: immunizations, hand hygiene, sterilization monitoring, and proper use of Personal Protective Equipment ("PPE") with feedback provided to DHCP.

1.5 HAND HYGIENE

A. There are inconsistent supplies necessary for adherence to hand hygiene for routine dental procedures.

B. There is no documentation that DHCP are trained regarding appropriate indications for hand hygiene including: handwashing, hand-antisepsis, and surgical antisepsis.

1.6 PERSONAL PROTECTIVE EQUIPMENT

A. There is insufficient and inappropriate PPE available.

B. There is no documentation that DHCP receive training on proper selection and use of PPE.

1.7 RESPIRATORY HYGIENE/COUGH ETIQUETTE

A. There was no documentation of policies and procedures to contain respiratory secretions in people who have signs and symptoms of a respiratory infection, beginning at the point of entry to the dental setting. There were no signs posted at the entrances stating the protocol to cover their

mouth and nose when coughing or sneezing, use and disposal of used tissues, and hand hygiene after respiratory secretion contact. There were tissues provided and there was a trash can in the waiting room but it had no lid. There was no hand sanitizer in the waiting room. Face masks are not offered to coughing/symptomatic patients.

B. There is no documentation that DHCP receive training on the importance of containing respiratory secretions in people who have signs and symptoms of respiratory infection.

1.8 SHARPS SAFETY

A. There was no documentation of written policies, procedure, and guidelines for exposure prevention and post-exposure management that are available.

B. There was no evidence of policy that DHCP identify, evaluate, and select devices with engineered safety features, either annually or as they become available in the market.

1.9 SAFE INJECTION PRACTICES

A. There was no documentation of written policies, procedures, and guidelines for safe-injection practices that are available.

B. There was no documentation or policy that clearly states that injections are required to be prepared using aseptic technique in a clean area free from contamination or contact with blood, body fluids, or contaminated equipment.

1.10 STERILIZATION AND DISINFECTION OF PATIENT-CARE ITEMS AND DEVICES

A. There was no documentation of written policies and procedures that are available to ensure reusable patient care instruments and devices are cleaned and reprocessed appropriately before use on another patient.

B. There was no documentation of policies, procedures, and manufacturer reprocessing instructions for reusable instruments and dental devices that are available.

C. There was no documentation that DHCP responsible for reprocessing reusable dental instruments and devices are appropriately trained upon hire, at least annually, or whenever new equipment or processes are introduced.

D. There was no documentation that there is the training and all essential equipment available to ensure that DHCP wear appropriate PPE.

E. There was no proper documentation that routine maintenance for sterilization equipment is performed to manufacturer instructions and documented by written and complete maintenance logs.

F. There was no documentation of policies and procedures that were in place outlining the dental setting response in the event of a reprocessing error/failure. There was no information on site about spore tests.

1.11 ENVIRONMENTAL INFECTION PREVENTION and CONTROL

A. There was no documentation of written policies and procedures that are available for routine cleaning and disinfection of environmental surfaces.

B. There was no documentation that DHCP performing environmental prevention procedures receive job-specific training about infection prevention and control management of clinical contact and housekeeping surfaces upon hire, at least annually, or when procedures/policies change.

C. There was no documentation to confirm that cleaning, disinfection, and use of surface barriers are periodically monitored and evaluated to ensure that they are consistently and correctly performed.

D. There was no documentation that cleaning, disinfection, and use of surface barriers are periodically monitored and evaluated to ensure that they are consistently and correctly performed.

E. There was no documentation that procedures are in place for decontamination of spills of blood or other body fluids.

1.12 DENTAL UNITY WATER QUALITY

A. There is no documentation that policies and procedures are in place for maintaining dental unit water quality that meets EPA regulatory standards for drinking water.

B. There was no documentation that policies and procedures are in place for using sterile water as a coolant/irrigant when performing surgical procedures.

C. There is no documentation that written policies and procedures are available outlining the response to a community boil-water advisory.

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

II.1 HAND HYGIENE IS PERFORMED CORRECTLY

A. Hands were washed when visibly soiled.

B. Barehanded touching of instruments was not observed.

C. There was inconsistency of washing hands between patients. The gloves would be removed and fresh ones put on for a new patient, but compliance of the hand-washing for every patient was inconsistent.

D. There was an inconsistency with hand-washing before putting on gloves.

E. There was inconsistency with hand-washing immediately after removing gloves.

F. There were no surgical procedures being performed, so surgical hand scrubbing couldn't be observed.

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

A. PPE was not removed before leaving the work area. All assistants, hygienists, and the Respondent never changed their PPE jacket while going from patient to the sterilization area, to the front desk, and back. Only the Respondent took off his PPE jacket (cloth) during lunch.

B. There was inconsistent observation of hand hygiene being performed immediately after removal of PPE.

C. Masks were worn for every patient encounter but in some cases, not properly. The Respondent never had the mask cover his nose. Not a single employee used eye protection with solid side shields. One employee did not wear eye protection at all.

D. The providers consistently wear gloves when there is potential contact with blood, bodily fluids, mucous membranes, non-intact skin, or contaminated equipment. Gloves were never reused. There were no puncture- and chemical-resistant utility gloves at the Office for use when cleaning instruments in the sterilization area or when housekeeping tasks involving contact with blood or OPIM occurred.

E. DHCP do not wear PPE/protective clothing properly. There are no disposable gowns at all. Quite often the staff did not remove their PPE/protective clothing when leaving the sterilization/instrument processing area, or going to lunch, or even when they go home. They are expected to clean their own PPE at home. The gloves very rarely covered the wrists of the DHCP. Even when the PPE (jackets) was visibly dirty, the DHCP never changed it.

II.3 RESPIRATORY HYGIENE/COUGH ETIQUETTE

A. Signs (Cover Your Cough) were not posted at entrances with instructions to patients with symptoms of respiratory infection and all other associated notifications.

B. There were tissues in the reception area, but there was only a trash can without a lid for dirty tissues.

C. There was a bathroom for patients to perform hand hygiene near the reception area.

D. There are no face masks in the waiting area and there is no documentation that they would be offered to any patient with a respiratory condition.

E. There is no documentation demonstrating a policy or any training to ask patients with respiratory symptoms being encouraged to move away from other patients in the reception area. However, no one with visible respiratory symptoms appeared during the inspection so this practice could not be directly observed during the inspection.

II.4 SHARPS SAFETY

A. Engineering controls are not used to prevent injuries.

B. Work practice controls are not used to prevent injuries.

C. DHCP recap used needles by using both hands or other inappropriate ways.

D. DHCP occasionally used a one-handed scoop technique, but never a safe mechanical device to recap needles.

E. All sharps are disposed of in a puncture resistant container. They were located in the operatories but in extremely poor locations. A puncture resistant container was in the sterilization area, but also in a poor location. Staff stated that the containers, when full, are eventually disposed of with the rest of the biohazard waste. There was a biohazard box, but there was nothing

in there. The biohazard box in the lab was in such a difficult place to access that it would take several minutes to remove what was interfering with its access. There was no documentation that the biohazard box was picked up in at least two months. There were no biohazard containers in the operatories -- only regular trashcans were in the operatories.

F. The inspector was informed that sharps containers are disposed of in accordance with federal, state, and local regulated medical waste rules and regulations, but it couldn't be verified in any fashion.

II.5 SAFE INJECTION PRACTICES

A. Injections are not prepared using an aseptic technique in a clean area. Many syringes were set up before the patient was seated. Additionally, those prepared syringes were left directly on a dirty countertop.

B. Needles and syringes are used for only one patient.

[C. D. E. F. G. H. I. - There were no surgical procedures performed during our inspection, so these sections could not be evaluated.]

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

A. Single use devices are discarded after one use.

B. Reusable critical dental items are ostensibly cleaned and heat sterilized according to the manufacturer instructions between use. However, spore test logs did not exist. Autoclave logs were non-existent. Therefore, it is impossible to verify sterilization.

C. Items are thoroughly cleaned and visually inspected before sterilization.

D. FDA cleared ultrasonic cleaners are properly used.

E. There were no long-handled brushes available and no puncture resistant gloves being used.

F. After cleaning and drying, the instruments were packed appropriately.

G. Chemical indicators are not used inside sterile packages. Sterile packs had external chemical indicators only.

H. All sterile packs were not labeled with the sterilizer used, the cycle or load number, or the date of sterilization.

I. FDA-cleared medical devices for sterilization are used according to manufacturer instructions.

J. Because there were no logs for the sterilizers, it is impossible to tell if the spore test is used at least weekly and with every load containing implantable items.

K. Logs for each sterilizer cycle are non-existent.

L. It appears that after sterilization the packets are stored so sterility is not compromised. However, since the packets are not labeled at all with the required information, there is no way to determine their integrity or when they are out of date.

M. It did not appear that any compromised packages had been used.

N. It did not appear that any defectively autoclaved packages were utilized.

O. The instrument processing area has less than an ideal workflow, and there is completely inadequate space to do a proper job. Because all the working areas are so close together, there is a chance that the dirty to clean procedure flow can easily be broken. The initial trays with dirty instruments should be to the right of the sink. Now dirty instruments are sitting next to the autoclave, which should be a cleaner area. The counter surface material is breaking down, impossible to clean, and just plain filthy. In this area, biohazardous waste appears to be put in regular waste cans. The biohazard box was inaccessible. A model trimmer was sitting in such close proximity to this area, that it is almost certainly covered with OPIM.

P. & Q. High level disinfection products are used and contained according to manufacture instructions.

R. Dental high-speed handpieces are cleaned and heat-sterilized according to manufacturer instructions. The low-speed handpieces remain attached even though they are not permanently attached to the air and water lines, and are only wiped down.

S. FDA cleared barriers are used on the digital radiology sensors and are changed between uses. After the barrier is used the sensor was cleaned and sterilized.

II.7 ENVIRONMENTAL INFECTION PREVENTION AND CONTROL

A. Clinical contact surfaces are inconsistently barrier-protected. Radiologic exposure control buttons were not barrier-protected. Other surfaces are cleaned with appropriate disinfectants. Barriers were not used on A/W syringes, HVE, and SVE.

B. Surface barriers are inconsistently used on equipment, but those that were used were changed between patients. The computer keyboard and mouse were never protected.

C. Cleaners and disinfectants appeared to be used in accordance with manufacturer instructions.

D. There is no record of regulated medical waste being disposed of according to local, state, and federal regulations. If it occurs, there were no records/manifests of the dates of the pick-ups. The main medical waste box was poorly placed in a very difficult-to-access area in the sterilization area. This could potentially cause accidental contact with OPIM. In each operatory there were only puncture resistant sharps containers and a regular trash can. In the regular trash can quite often OPIM was found.

E. DHCP engaged in environmental cleaning failed to wear appropriate PPE to prevent exposure to infectious agents and chemicals.

In addition, the Board Inspector made the following additional observations regarding environmental infection prevention and control:

1. The portable oxygen/nitrous oxide cart was dirty and was located in a filthy area next to an open furnace.
2. Unopened sterile packets were placed on a tray occasionally where the instruments were eventually dropped onto when the packets were opened. The outside of the packets was not sterile and should not touch an area where working instruments are placed.
3. The parts that held the saliva ejectors, HVE tips, and A & W syringes never had protective barriers.
4. The eye-wash station in the office was positioned in a manner where the user would have to put his head under a cabinet to utilize it, which would make proper usage very difficult. Additionally, it was attached to the faucet of the sink where the dirty instruments are initially placed. That means the eye-wash device could get contaminated with OPIM.
5. There was no emergency medical kit available.
6. Radiograph rings and sensors were placed on (potentially infectious) trays where the outside of unopened sterile packets was lying. This made the rings potentially unsterile because the outside of the packets could have been compromised.
7. Not a single provider wore a radiation badge during the inspection.

II.8 DENTAL UNIT WATER QUALITY

A. There was no evidence that waterline testing was ever performed. No employee was aware of any maintenance logs or waterline treatment products.

B. No one could verify that daily or weekly flushing of the dental unit water lines was being performed.

C. No surgical procedures were performed during the inspection. Therefore, the Inspector could not verify that sterile saline or sterile water is used when performing surgical procedures.

10. Based on his direct observations during the inspection, the Board Inspector determined that the Respondent, as a practicing dentist at the Office, failed to comply with CDC Guidelines as set forth above, which posed a direct risk to patient safety.

CONCLUSIONS OF LAW

Based on the foregoing investigative findings, the Board concludes as a matter of law that there is a substantial likelihood that the Respondent's failure to comply with CDC Guidelines poses a risk of harm to the public health, safety and welfare, which imperatively requires the immediate suspension of her license, pursuant to State Gov't § 10-226(c)(2) (2014 Repl. Vol. and 2019 Supp.).

ORDER

Based on the foregoing investigative findings, it is, by a majority of the Board considering this case, pursuant to authority granted to the Board by State Gov't § 10-226(c)(2) (2014 Repl. Vol. and 2019 Supp.):

ORDERED that the Respondent's license to practice dentistry in the State of Maryland, License Number 9624, is hereby **SUMMARILY SUSPENDED**; and it is further

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

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

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

ORDERED that this document constitutes an order of the Board and is therefore a public document for purposes of public disclosure, as required by Md. Code Ann., Gen. Provisions §§ 4-101 *et seq.* (2014).

May 21, 2020
Date

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

NOTICE OF HEARING[3]

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

At the conclusion of the Show Cause Hearing held before the Board, the Respondent, if dissatisfied with the result of the hearing, may, within ten (10) days, file a written request for an evidentiary hearing. Unless otherwise agreed to by the parties, the Board shall provide a hearing within forty-five (45) days of the Respondent's written request. The Board shall conduct an evidentiary hearing under the contested case provisions of State Gov't §§ 10-201 *et seq.* (2014 Repl. Vol. and 2019 Supp.).

[3] Due to the current pandemic, Board hearings may be held remotely by teleconference.