IN THE MATTER OF	*	**BEFORE THE MARYLAND**
JOHN V. LOUIS, D.M.D.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 11448	*	**Case Number: 2020-110**

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CONSENT ORDER

On May 21, 2020, the Maryland State Board of Dental Examiners (the "Board") summarily suspended the license of **JOHN V. LOUIS, D.M.D.**, (the "Respondent"), License Number 11448, and charged him with violating the Maryland Dentistry Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 4-101 *et seq.* (2014 Repl. Vol. and 2019 Supp.).

Specifically, the Board charged the Respondent with violating the following provisions of the Act under Health Occ. I § 4-315:

> (a) *License to practice dentistry* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may... reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if... the licensee:
>
> (16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession; [and]
>
> (30) Except in an emergency life-threatening situation where it is not feasible or practicable, fails to comply with the Centers for Disease Control's guidelines on universal precautions[.]

On June 3, 2020, a Case Resolution Conference was held before a committee of the Board. As a resolution of this matter, the Respondent agreed to enter this public Consent Order consisting of Findings of Fact, Conclusions of Law, Order and Consent.

FINDINGS OF FACT

The Board makes the following Findings of Fact:

I. LICENSING BACKGROUND

1. At all times relevant, the Respondent was and is licensed to practice dentistry in the State of Maryland. The Respondent was originally licensed to practice dentistry in Maryland on July 20, 1994, under License Number 11448. The Respondent's license is current through June 30, 2020.

2. At all times relevant, the Respondent owned a dental practice with locations in Easton (the "Easton Office") and Salisbury (the "Salisbury Office"), Maryland. The Respondent practiced dentistry at both locations, but at the Salisbury Office he practiced dentistry with at least one other staff dentist ("Dentist A").

II. COMPLAINT

3. On or about February 13, 2020, the Board received a complaint from a former employee (the "Complainant") at the Salisbury Office alleging, among other complaints, that the Respondent performed grafting procedures on multiple patients at different times using the same sterile bone and membrane grafting packet that was meant to be discarded after one-time use. The Complainant further alleged that the Respondent at times reused contaminated gloves during patient treatment.

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

III. INFECTION CONTROL INSPECTION

5. Due to allegations of potential infection control issues at the Salisbury Office, on or about March 2, 2020, a Board-contracted infection control inspector (the "Board Inspector"), along with a Board investigator, visited the Salisbury Office and conducted an infection control inspection.

6. Present during the inspection were the following individuals: Dentist A, the office director (the "Office Director"), two dental hygienists, a dental radiation technologist/dental assistant, a dental assistant and a patient care coordinator. The Respondent was not present during the inspection.

7. As part of the inspection, the Board Inspector utilized the Centers for Disease Control and Prevention ("CDC")[1] Infection Prevention Checklist for Dental Settings.

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

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

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

Section I: Policies and Practices

a. **Administrative Measures** – As the practice owner, the Respondent failed to maintain on site any documented: written infection control policies and procedures specific to the Salisbury Office; annual reassessments of those policies and procedures; training on Infection Prevention/OSHA Bloodborne Pathogen; or utility gloves in the sterilization area. The Respondent maintained a partial system for early detection and management of potentially infectious persons at initial points of patient encounter. The Respondent posted precautions poster for patients and offered face masks for patients but failed to designate a separate area for patients with respiratory symptoms and train staff on the importance of containing respiratory infection.

b. **Infection Prevention Education and Training** – As the practice owner, the Respondent failed to maintain a log of personnel training (upon hire, annually and new tasks or procedure) on infection prevention and bloodborne pathogens standards. Subsequent to the inspection, the Respondent provided the Board a sign-in sheet for a bloodborne pathogens training that occurred on December 16, 2019, four months after the Respondent acquired the Salisbury Office. At least three employees presently working at the Salisbury Office failed to attend this training.

c. **Dental Health Care Personnel Safety** – As the owner of the practice, the Respondent failed to maintain on site any documented: exposure control plan specific to the Salisbury Office; employee training on OSHA Bloodborne Pathogens Standard (upon hire and at least annually); current CDC recommendations and office-specific policies on immunization, evaluation and follow-up; availability of Hepatitis B vaccination; post-vaccination screening of Hepatitis B surface antibody; availability of annual influenza vaccination; baseline tuberculosis screening for all dental health care personnel; a log of needlesticks, sharps injuries and other exposure events; referral arrangements to qualified health care professionals; post-exposure evaluation and follow-up; or well-defined policies concerning contact of personnel with potentially transmittable conditions with patients.

d. **Program Evaluation** – As the owner of the practice, the Respondent failed to maintain on site any documented policies and procedures on routine monitoring and evaluation of infection prevention and control program, and adherence to certain practices such as immunization, hand hygiene, sterilization monitoring and proper use of Personal Protective Equipment.

e. **Hand Hygiene** – As the owner of the practice, the Respondent failed to maintain on site any documented dental personnel training

regarding appropriate indications for hand hygiene including handwashing, hand antisepsis and surgical hand antisepsis.

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

g. **Respiratory Hygiene/Cough Etiquette** – As the owner of the practice, the Respondent failed to maintain on site any documented policies/procedures and personnel training logs on containing respiratory secretion in people with signs and symptoms of respiratory infection. The Respondent also failed make available hand sanitizer in the waiting area or provide separate space for persons with respiratory symptoms.

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

i. **Safe Injection Practices** – As the owner of the practice, the Respondent failed to maintain on site any documented policies, procedures and guidelines for safe-injection preparation and practices.

j. **Sterilization and Disinfection of Patient-Care Items and Devices** – As the owner of the practice, the Respondent failed to maintain on site documentation, policies or procedures regarding: appropriate cleaning and processing of reusable instruments and devices; manufacturer's reprocessing instructions; upon hire and annual personnel training log on reprocessing of reusable instruments and devices; personnel training logs on appropriate use of PPE; maintenance logs on sterilization equipment; and responses in the event of a reprocessing error/failure. The Respondent had inconsistent information on spore testing and failed to designate a staff in charge of sterilization and disinfection.

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

l. **Dental Unit Water Quality** – As the owner of the practice, the Respondent failed to maintain on site any policies and procedures for:

maintaining dental unit water quality; using sterile water as a coolant/irrigant when performing surgical procedures; and responding to a community boil-water advisory.

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

m. **Performance of Hand Hygiene** – As the owner of the practice, the Respondent failed to ensure that dental health care personnel ("DHCP") at the Salisbury Office consistently perform handwashing before putting on gloves and after removing gloves between treating patients.

n. **Use of Personal Protective Equipment (PPE)** – As the owner of the practice, the Respondent failed to ensure that DHCP at the Salisbury Office consistently perform handwashing before removing PPE. DHCP also failed to remove PPE before leaving the sterilization/instrument processing area. The Respondent failed to have available utility gloves in the sterilization area.

o. **Respiratory Hygiene/Cough Etiquette** – As the owner of the practice, the Respondent failed to make available face masks and separate waiting area for patients who may have respiratory symptoms.

p. **Sharps Safety** – As the owner of the practice, the Respondent failed to place sharps containers in readily accessible areas of the operatories.

q. **Sterilization and Disinfection of Patient-Care Items and Devices** – As the owner of the practice, the Respondent failed to: have available puncture and chemical resistant utility gloves for manual cleaning; use a chemical indicator inside each sterilization package; label sterilization packages with sterilizer used, the cycle or load number, and the date of sterilization; and maintain logs for each sterilization cycle. The Respondent also failed to maintain consistent documentation on spore testing on site.

r. **Environmental Infection Prevention and Control** – As the owner of the practice, the Respondent failed to consistently barrier-protect clinical contact surfaces such as radiologic exposure button, A/W syringes, HVE and SVE. Unopened sterile packs were placed on the same tray as used instruments. The Board Inspector also did not see an emergency medical kit, and the eye-wash station was not working properly. The medical waste box was placed at a poorly accessible area, and waste disposal manifest was poorly documented.

s. **Dental Unit Water Quality** – As the owner of the practice, the Respondent failed to perform waterline testing and treatment to monitor dental water unit quality.

12. During the inspection, several staff members reported to the Board's investigator of having observed the Respondent transporting previously opened packages of membrane and grafting materials from his Easton Office to the Salisbury Office. They

reported observing the Respondent using the membrane and grafting materials from the already opened packages on multiple patients at the Salisbury Office. Packages of membrane and grafting materials were meant for one-time use once the package is opened with the unused material discarded.

13. Based on the results of the inspection, the Board Inspector determined that the Respondent, as the owner of and a practicing dentist at the Salisbury Office, failed to comply with CDC Guidelines as set forth above, which posed a direct risk to patient safety.

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

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's failure to comply with CDC Guidelines in his practice of dentistry at the Dental Office constitutes: behaving dishonorably or unprofessionally, or violating a professional code of ethics pertaining to the dentistry profession, in violation of Health Occ. § 4-315(a)(16); and except in an emergency life-threatening situation where it is not feasible or practicable, failing to comply with the Centers for Disease Control's guidelines on universal precautions, in violation of § 4-315(a)(30).

ORDER

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

ORDERED that the Board's *Order for Summary Suspension* of the Respondent's license to practice dentistry in the State of Maryland, issued on May 21, 2020, is hereby **TERMINATED**; and it is further

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

ORDERED that the Respondent is placed on **PROBATION** for a period of **THREE (3) YEARS**, subject to the following terms and conditions:

1. A Board-assigned inspector shall conduct an unannounced inspection of the Salisbury Office as soon as practicable following the date of this Consent Order in order to evaluate the Respondent and his staff regarding compliance with the Act and infection control guidelines. The Board-assigned inspector shall be provided with copies of the Board's file, the Consent Order, and any other documentation deemed relevant by the Board.

2. The Respondent shall provide to the Board-assigned inspector a schedule of the Salisbury Office's regular weekly hours of practice and promptly apprise the inspector of any changes.

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

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

5. If the Board-assigned inspector finds any non-compliance with CDC Guidelines in the Salisbury Office, the Respondent consents and the Board reserves the right to conduct unannounced inspection of the Respondent's Easton Office.

6. The Respondent shall provide a listing to the Board on a monthly basis of all bone grafting or membrane materials used on patients, including the type of material used, the lot number, the package reference number, the patient involved, the type of procedure performed and the date of the procedure. The Respondent shall also verify that all bone grafting and membrane materials used were properly registered.

7. 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.

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

9. On or before the fifth day of each month, the Respondent shall provide to the Board a copy of his current patient appointment book at the Salisbury Office for that month.

10. Within ninety (90) days, the Respondent shall pay a fine in the amount of **FIVE THOUSAND DOLLARS** ($5,000) by bank certified check or money order made payable to the Maryland Board of Dental Examiners.

11. Within six (6) months of the date of this Consent Order, the Respondent shall successfully complete a Board-approved six (6) credit hour course(s) in infection control protocols and six (6) credit hour course(s) in ethics, which may not be applied toward his license renewal.

12. The Respondent may be eligible to file a petition for early termination of his probation after two (2) years from the date of this Consent Order. After consideration of the petition, the Board, or a designated committee of the Board, may grant or deny such petition at its sole discretion. Condition six (6) of probation involving monthly submission to the Board of a listing of bone grafting or membrane materials used on patients may not be terminated for a period of three (3) years from the date of the Consent Order.

AND IT IS FURTHER ORDERED that, unless otherwise ordered by the Board, after the conclusion of the **THREE (3) YEAR** probationary period, the Respondent may

submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated, through an order of the Board, or a designated Board committee. The Board, or designated Board committee, may grant the termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints of similar nature; and it is further

ORDERED that if the Board has reason to believe that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be an evidentiary hearing before the Board. If there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before the Board; and it is further

ORDERED that after the appropriate hearing, if the Board determines that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice dentistry in Maryland. The Board may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent; and it is further

ORDERED that the Respondent shall at all times cooperate with the Board, any of its agents or employees, and with the Board-assigned inspector, in the monitoring, supervision and investigation of the Respondent's compliance with the terms and conditions of this Consent Order; and it is further

ORDERED that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Provisions §§ 4-101 *et seq.* (2014).

June 4, 2020
Date

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

CONSENT

I, John V. Louis, D.M.D., acknowledge that I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed after any such hearing.

I sign this Consent Order voluntarily and without reservation, after having an opportunity to consult with counsel, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

June 4th, 2020
Date

John V. Louis, D.M.D.
The Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Talbot

I HEREBY CERTIFY that on this 4th day of June _____, 2020, before me, a Notary Public of the foregoing State and City/County personally appear John V. Louis, D.M.D., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notary seal.

Notary Public

My commission expires: 3/16/2022