IN THE MATTER OF	*	**BEFORE THE MARYLAND**
THOMAS STACK, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 14396	*	**Case Number: 2019-127**

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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 **THOMAS STACK, D.D.S.** (the "Respondent"), License Number 14396, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under: Md. Code Regs. ("COMAR") 10.44.07.22, determining that there is a substantial likelihood that the Respondent poses a risk of harm to the public health, safety, or welfare; and Md. Code Ann., State Gov't § 10-226(c)(2) (2014 Repl. Vol. & 2018 Supp.), concluding that the public health, safety and welfare imperatively require emergency action.

INVESTIGATIVE FINDINGS

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

1. At all times relevant hereto, the Respondent was licensed to practice dentistry in the State of Maryland. The Respondent was initially licensed on March 16, 2010. His license is current through June 30, 2020.

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[1] The statements regarding the Respondent's conduct identified herein are intended to provide the Respondent with reasonable notice of the asserted facts. 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.

2. At all times relevant hereto, the Respondent has practiced dentistry at a private practice located at 20 East Timonium Road, Suite 300, Timonium, Maryland 21093 (the "Office").

3. The Respondent stated to a Board investigator that on or about March 29, 2019, he bought and became the sole owner of the Office.

Complaint

4. On or about March 25, 2019, the Board received a complaint (the "Complaint") from an individual (the "Complainant") who identified herself as a former patient of the Office and complained in part about the dental care she received from four (4) dentists at the Office in early 2017. The Complaint did not name the Respondent.

5. The investigation indicated the following regarding the four dentists ("Dentists A, B, C, & D") named in the Complaint:

- Dentist A was not regularly associated with the Office, but treated the Complainant at the Office in early 2017 on an *ad hoc* basis.
- Dentist B treated the Respondent in early 2017, and was the owner of the Office at the time of the treatment.[2]
- Dentists C & D were employed as dentists at the Office and treated the Respondent in early 2017; they currently treat patients at and are employees of the Office.

6. In the Complaint, the Complainant indicated that following treatment at the Office, she developed a serious infection that the named dentists failed to promptly diagnose,

[2] According to the Respondent, on March 29, 2019, four days after the Complaint was submitted to the Board, ownership of the Office transferred from Dentist B to the Respondent.

and that caused her severe pain, weakness, and other debilitating symptoms for several months afterward.

7. Additionally, the Complaint alleged that during her treatment, which took place after business hours, a team of cleaners "were down the hall vacuuming, wiping counters, moving equipment. In hindsight, it didn't appear to be an aseptic area."

8. Based on the Complaint, the Board initiated an investigation regarding the Office's compliance with CDC guidelines. [3]

9. In furtherance of the investigation, the Board assigned an expert in infection control protocols (the "CDC Expert") to conduct an inspection of the Office.

Office Inspection

10. On or about April 11, 2019, the CDC Expert, accompanied by a Board investigator, conducted an inspection to determine whether the Office was complying with the CDC guidelines. The Respondent and Dentist D were present and treating patients at the Office during the inspection.

Expert Report

11. Following the inspection, the CDC Expert completed a report (the "Expert Report") regarding compliance with CDC Guidelines at the Office.

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[3] 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.

12. In the Expert Report, the CDC Expert noted violations of the CDC Guidelines in a range of areas, specifically as outlined below.[4]

Section I: Policies and Practices

- **I.1 Administrative Measures**
  - The Office had a CDC Manual, but it dated from 1992 and contained no updates
- **I.2 Infection Prevention Education and Training**
  - No Documentation of "Time of Hire" training
  - Last "annual" training documented as April 2017
- **I.3 Dental Health Care Personnel Safety**
  - No Documentation of training
  - No documentation of training regarding post-exposure protocol
  - No documentation of compliance with hepatitis B vaccination requirements for dental healthcare personnel (DHCP)
  - No documentation of tuberculosis screening of DHCP upon hire
- **I.4 Program Evaluation**
  - No documentation of program evaluation
- **I.5 Hand Hygiene**
  - No Documentation of training
  - No posting of "Hand Hygiene Protocol" in any of the treatment operatories, instrument processing area, or the staff rest room
- **I.6 Personal Protective Equipment (PPE)**
  - No documentation of training regarding PPE
  - Staff stated that they were following a policy implemented by the previous owner of the Office, Dentist B, to take their cloth labcoats home and

[4] The headings and numbering system used to outline the CDC-related issues herein are derived from the CDC's published "Infection Prevention Checklist," which the CDC Expert employed as a tool in completing her inspection.

personally launder them. This policy was reportedly implemented in order to save costs compared to the previous policy of laundering PPE on site. The policy was reportedly "under review" but still in place at the time of the Board's inspection.

- **I.7 Respiratory Hygiene/Cough Etiquette**
  - No documentation of policy in practice
  - No "Cover Your Cough" poster present in the reception area
  - No tissues, face masks, hand sanitizer, or trash receptacle available in the reception area
- **I.8 Sharps Safety**
  - No documentation of training, update or evaluation of policy
  - The last documented pickup date for "sharps" waste was April 2017
- **I.9 Safe Injection Practices**
  - No documentation of training, update or evaluation of policy
- **I.10 Sterilization and Disinfection of Patient Care Items and Devices**
  - No documentation of training, update or evaluation of policy
  - Instrument processing location and layout of equipment and materials indicates the Office is not following a "Single Loop" sequence of sterilization
  - Sealed sterilization pouches containing instruments are not labeled with the date and which processor was used for sterilization
- **I.11 Environmental Infection Prevention and Control**
  - No documentation of update or evaluation of policy
  - Last "annual" training documented as April 2017
  - Utility gloves were not available for use in the instrument processing area
  - Disinfectant container was not labeled with an activation date
- **I.12 Dental Unity Water Quality**

- No documentation of update or evaluation of policy
- Last "annual" training documented as May 2017

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

- **II.1 Hand Hygiene is Performed Correctly**
  - Hand hygiene practices by DHCP was inconsistent
  - Protocol was not posted in any of the operatories or the instrument processing area
- **II.2 Personal Protective Equipment (PPE) is Used Correctly**
  - Utility gloves not used while processing instruments
  - DHCP reportedly launder their cloth labcoats at home in the evenings after wearing them throughout the day at the Office
- **II.3 Respiratory Hygiene/Cough Etiquette**
  - No "Cover Your Cough" poster present in the reception area
  - No tissues, face masks, hand sanitizer, or trash receptacle available in the reception area
- **II.4 Sharps Safety**
  - Sharps containers available in operatories, but the last documented pickup date for "sharps" waste was April 2017
- **II.6 Sterilization and Disinfection of Patient Care Items and Devices**
  - Dental rotary burs, rubber dam clamps, rim lock trays and Palodent matrix showing indications of having been used (dental materials present) were placed in containers for possible reuse in dental operatory
  - Sealed sterilization pouches containing instruments are not labeled with the date and which processor was used for sterilization
  - Instrument processing location and layout of equipment and materials indicates the Office is not following a "Single Loop" sequence of sterilization

- **II.7 Environmental Infection Prevention and Control**
    - Barriers were not placed on the HVE, SVE or A/W Syringe
    - Disinfectant container was not labeled with an activation date
- **II.8 Dental Unit Water Quality**
    - Dental unit log for self-contained water bottles was inconsistent regarding dates of change and maintenance

13. The Expert concluded that based on the violations of the CDC Guidelines found during the CDC Inspection, in particular those listed above, there exists a potential risk to patient and staff safety at the Office.

14. As a licensed dentist who practices at and owns the Office, the Respondent failed to ensure compliance with the CDC Guidelines at all times.

CONCLUSIONS OF LAW

Based on the foregoing Investigative Findings, and pursuant to its authority under Md. Code Ann., State Gov't § 10-226(c)(2) (2014 Repl. Vol. & 2018 Supp.), the Board concludes that the public health, safety, and welfare imperatively require this emergency action of summary suspension. In addition, pursuant to COMAR 10.44.07.22, the Board concludes that there is a substantial likelihood that the Respondent poses a risk of harm to the public health, safety, or welfare.

ORDER

Based on the foregoing, it is by the Board hereby:

ORDERED that the Respondent's license to practice dentistry in the State of Maryland, under License Number 14396, 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, not to exceed thirty (30) days from the Board's receipt, 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 files a written request for a Show Cause Hearing and fails to appear, the Board shall uphold and continue the Summary Suspension; 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., General Provisions §§ 4-101 through 4-601 (2014 Repl. Vol. & 2018 Supp.).

NOTICE OF HEARING

Following the Board's receipt of a written request for hearing filed by the Respondent, a Show Cause Hearing will be held at the offices of the Maryland 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, not to exceed thirty (30) days.

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 Md. Code Ann., State Gov't §§ 10-210 *et seq*. (2014 Repl. Vol. & 2018 Supp.).

May 30, 2019
Date

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