IN THE MATTER OF	*	BEFORE THE
ARDEN BRONSTEIN, D.D.S.	*	STATE BOARD OF
RESPONDENT	*	DENTAL EXAMINERS
License Number: 10602	*	Case Number: 2013-228

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE DENTISTRY

The State Board of Dental Examiners (the "Board") hereby **SUMMARILY SUSPENDS** the license of **ARDEN BRONSTEIN D.D.S.** (the "Respondent"), License Number **10602**, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under Md. St. Gov't Code Ann. § 10-226(c)(2009 Repl. Vol.), concluding that the public health, safety and welfare imperatively require emergency action.

INVESTIGATIVE FINDINGS

Based on information received by, and made known to the Board, and the investigatory information obtained by, received by and made known to and available to the Board, including the instances described below, the Board has reason to believe that the following facts are true:[1]

A. Background

1. At all times relevant to this Order for Summary Suspension (the "Order"), the Respondent was licensed to practice dentistry in the State of Maryland. The Respondent was initially licensed to practice dentistry in Maryland on or about September 20, 1990, under License Number 10602. The Respondent was previously licensed to practice

[1] The statements respecting 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.

dentistry in the District of Columbia but allowed that license to expire on or about December 31, 1995.

2. At all times relevant to this Order, the Respondent operated a general dental practice in Hyattsville, Maryland. The Respondent is a solo practitioner who practices general dentistry and employs one or more dental assistants.

3. On or about May 21, 2013, the Board received a complaint from a former patient (the "Patient") alleging infection control violations, unprofessional conduct, harassment, intimidation, and deceptive billing practices.

4. In his complaint, the Patient expressed concerns about the Respondent's professional competence, demeanor and "unhygienic approach" to dentistry. Specifically, the Patient alleged that during his initial visit on December 21, 2012, the Respondent approached "[his] mouth with the same dirty gloves he used on another patient." When requested to remove his contaminated gloves, the Patient reported that the Respondent discarded his gloves and applied a small amount of hand sanitizer instead of washing his hands.

5. Following its review of the complaint, the Board initiated an investigation. On or about June 27, 2013, the Board retained an independent infection control expert ("the Board Expert") to conduct an inspection of the Respondent's dental office.

6. On August 1, 2013, the Board Expert conducted an unannounced inspection of the Respondent's office to determine whether the Respondent was in compliance with the Maryland Dentistry Act (the "Act") and the Centers for Disease Control ("CDC")[2]

[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 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 Blood borne Pathogens (29 CFR 1910.1030). The only exception to this rule arises in an emergency which is: 1) life-threatening; and (2) where it is not feasible or practicable to comply with the guidelines.

guidelines on universal precautions. The Board expert found systemic and widespread CDC violations throughout the inspection. The Board Expert concluded that the "cleaning, disinfection, sterilization and infection control practices of [the Respondent's] office are unacceptable".

7. A report of the Board Expert's findings was issued on August 2, 2013. A summary of those findings is set forth *infra*.

B. Board Expert's findings

8. At approximately 12:30 p.m. on August 1, 2013, the Board Expert and the Board's investigator arrived at the Respondent's office for an unannounced, onsite inspection. At that time, the Respondent indicated that he had lunch plans but would return in one (1) hour to treat his afternoon patients. He granted the Board Expert and Board investigator full access to his office in order to begin the inspection process.

9. The Board Expert noted that the Respondent's waiting room and reception area were tidy and reasonably well maintained and that his business office was well staffed and reasonably uncluttered.

10. The Respondent's office housed five (5) dental operatories, of which three (3) were used to treat patients. There was also a sterilization room, lunch room and a lavatory.

11. The Board expert found:

> [t]he equipment, while serviceable, appeared dirty and not well maintained. Upon inspecting the dental operatories and all clinical/sterilization areas as well as directly observing treatment being performed, I found that the complaints of . . . [the Patient] . . . were well founded. There were multiple and significant breaches in infection control identified in this inspection and patients treated in his office have been put at risk for transmission for infectious disease(s).

* * *

Based on the inspection of August 1, 2013 it is my opinion that it is unsafe for patients to undergo dental treatment in the office of Arden Bronstein D.D.S.

12. Among other things, the Board Expert concluded:

(a) The Respondent's office's Exposure Control Plan was incomplete and outdated, with the last documented update in 2003. The office manual that details proper infection prevention procedures was missing; nonetheless, the Respondent maintained continuing education certificates[3] verifying that he was fully aware and had been repeatedly instructed on the principles of infection control requirements;

(b) Drawers and cabinets housing instruments, containers used to store expendables, and x-ray heads and bodies, all contained accumulated dust, dirt and debris, which evidenced a prolonged and "serious breach in infection control" and "significant risk of cross contamination";

(c) "[F]ilthy" Burs were stored in "dirty blocks" with visible fingerprints evidencing contaminated gloves/hands. "This is a clear indication [of] a lack of cleaning and sterilization" that poses a "significant risk of cross contamination" and "[r]euse of these burs is a threat to patient health and safety";

(d) The design of the sterilization area was substandard, leading to serious deficiencies in cleaning and sterilization. Dirty and clean instruments were in close proximity to one another. The ultrasonic cleaning device was available but instead of using it, the Respondent and his staff were observed hand washing contaminated instruments. "The assistant took the instruments into the sterilization area and scrubbed them by hand", left the instruments in the sink while she disposed of the expendables, disinfected the tray for future use, while using the same pair of gloves worn during the previous patient's treatment;

(e) Many instruments were housed in torn or open bags, some containing debris. None were labeled or dated. There was evidence that food was being consumed in the sterilization area;

(f) Each operatory contained unlabeled and uncapped syringes. This created an unacceptable risk of injury, cross contamination and inadvertent administration of unnecessary and improper medication. Upon direct observation of the Respondent's administration of a mandibular block in preparation for an extraction, the Respondent was

[3] The Respondent provided documentation that he had successfully completed several infection control courses given by the Board Expert.

observed re-capping a needle by hand, and repeatedly cross contaminating the patient's mouth and the hand control to the Respondent's dental chair. At no time during this observation did the Respondent or his staff ever change their gloves;

(g) Multiple working surfaces were dirty and littered with particles, dust, debris and unidentifiable spots that may have been blood or other splatter from previous patients. There was no visible evidence of surface disinfection in patient treatment areas. Although there was a small spray bottle of a surface disinfectant in the sterilization area, it was evident from the accumulation of debris and stains that no effective surface disinfection had been performed "for a considerable period of time";

(h) There was no treatment of the dental unit waterlines thereby exposing every patient to potential biofilm contamination. There was a self-contained water delivery system but the Respondent elected to dismantle it for reasons unknown;

(i) High, low and ultrasonic handpieces were affixed in each operatory with barriers attached, but the "barriers were more for show than function as they appeared well used and obviously not changed between patients". There were no replacement handpieces or covers on any of the dials or surfaces of the ultrasonic units. Ultrasonic tips were covered with sterilization bags, many of which were open, rendering the tips non-sterile;

(j) As the inspection proceeded, it became more and more apparent that the Respondent's office "fundamentally lacked standard operating procedures related to asepsis, infection control, and sterilization", and that the Respondent did "little or nothing to prevent cross-contamination.

C. <u>Respondent's response to complaint</u>

13. On or about August 5, 2013, Board staff formally requested that the Respondent provide a response to the Patient's complaint.

14. The Respondent provided a written response, dated August 19, 2013. With respect to the infection control aspect of the Patient's complaint, the Respondent acknowledged that the Patient requested that he change his gloves prior to treatment. The Respondent claimed that he had already washed his hands and had changed his gloves in a different operatory prior to entering the Patient's treatment room. When requested to

change his gloves, he used hand sanitizer "because the last time I had used soap and I wanted to change the method of hand cleaning". When instructed by Patient A that "[the Respondent] should know better", he did not argue or explain because he allegedly felt that a response at that time would further antagonize Patient A.

15. The Board's investigation revealed a pervasive and dangerous pattern of infection control violations which included the use of contaminated gloves. Based on the direct observations of the Board Expert, the Respondent's claim that he had previously changed his gloves and washed his hands prior to entering the Patient's treatment room, is suspect.

D. Summary of Violations

16. Based on the above investigative allegations, the Board has a basis to charge the Respondent with committing prohibited acts as set forth in the Act under H.O. § 4-315. Specifically, the Board finds that the Respondent violated one or more of the following subsections of H.O. § 4-315(a):

> (6) Practices dentistry in a professionally incompetent manner or in a grossly incompetent manner;
>
> (16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession; [and]
>
> (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 guidelines on universal precautions[.]

17. Based on the above investigative allegations and the opinions of the Board Expert, the Board concludes that the Respondent represents an imminent threat to the public, which imperatively requires the suspension of his license.

CONCLUSIONS OF LAW

Based on the foregoing investigative facts, the Board concludes that the Respondent constitutes a danger to the public and that the public health, safety or welfare imperatively require emergency action in this case, pursuant to Md. State Gov't Code Ann. § 10-226(c)(2)(2009 Repl. Vol.).

ORDER

Based on the foregoing findings, it is this 20th day of September 2013, by a majority vote of a quorum of the State Board of Dental Examiners, by authority granted to the Board by Md. St. Govt. Code Ann. § 10-226(c)(2) (2009 Repl. Vol.), it is hereby:

ORDERED that the Respondent's license to practice dentistry in the State of Maryland, under License Number 10602, 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 the 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; and it is further

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

ORDERED that this document constitutes a Final Order of the Board and is therefore a public document for purposes of public disclosure, as required by Md. State Govt. Code Ann. § 10-617(h) (2009 Repl. Vol.).

Ngoc Quang Chu, D.D.S., President
Maryland State Board of Dental Examiners

NOTICE OF HEARING

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, following the Board's receipt of a written request for 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 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. State Gov't Code Ann. §§ 10-210 *et seq.*