IN THE MATTER OF	*	BEFORE THE
RUBEENA HOSAIN, D.D.S.	*	STATE BOARD OF
RESPONDENT	*	DENTAL EXAMINERS
License Number: 13117	*	Case Number: 2014-231

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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 **RUBEENA HOSAIN, D.D.S.** (the "Respondent"), License Number 13117, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under Md. Code Ann., State Gov't § 10-226(c) (2009 Repl. Vol. & 2013 Supp.), concluding that the public health, safety and welfare imperatively require emergency action.

INVESTIGATIVE FINDINGS[1]

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. 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 December 7, 2001, under License Number 13117.

[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.

2. At all times relevant to this Order, the Respondent operated a general dental practice at two sites: the office at issue is located in Towson, Maryland ("Towson office"). The Respondent's second office is located in Pikesville, Maryland. The Respondent is a solo practitioner.

3. The Board initiated an investigation of the Respondent after reviewing a complaint from one of her patients ("Patient A") who was seen in the Towson office location.[2] Patient A alleged in large part, unsanitary conditions of the Respondent's Towson office.

4. As part of its investigation, the Board ordered a Centers for Disease Control and Prevention ("CDC")[3] inspection of the Respondent's Towson office by an independent infection control consultant ("Board expert").

5. The Board's regulations pursuant to Md. Code Regs. 9.12.31 require compliance with the Occupational Exposure to Bloodborne Pathogens Standard ("BPS"); and pursuant to Md. Code Regs. 10.52.11, CDC Guidelines for Infection Control in Dental Health Care Settings ("ICDHC") referenced in the Universal Infection Control Precautions Standard.

6. On June 24, 2014, the Board expert conducted an unannounced inspection of the Respondent's Towson office to determine whether the Respondent

[2] In order to maintain confidentiality, patient names will not be used in this document, but will be provided to the Respondent on request.

[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 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: 1) life-threatening; and (2) where it is not feasible or practicable to comply with the guidelines.

was in compliance with the Maryland Dentistry Act (the "Act") and the CDC guidelines on universal precautions. The Board expert found numerous CDC violations she defined as "multiple safety issues" during the inspection, and opined as to the Respondent's Towson office, "The facility is not a safe and healthy place in which to receive dental care." The Board expert's findings are set forth in pertinent part below.

7. On or about July 7, 2014, the Respondent submitted to the Board expert supplemental documentation, photographs of corrections she had made and a note of explanation. Notwithstanding the additional documentation and photographs, the Board expert opined that the Respondent's implementation of safety protocols was inconsistent and reaffirmed the Respondent's office was not a "safe and healthy place to receive dental care."

JUNE 24, 2014 OFFICE INSPECTION

8. The Board expert conducted a three hour inspection of the Towson office, during which time patients were present and being treated by the Respondent.

9. The Board expert based her analysis of the Respondent's compliance with infection control on direct observation of patient treatment using personal protective equipment, preparation of patient care items, protection/disinfection of environmental surfaces, and sterilization of reusable instruments at the Towson office, as well as discussions with the Respondent.

10. The Respondent has one employee at the Towson office; however, on the date of the inspection, he (the employee) was not present. The employee does not engage in patient care; he is responsible for working at the front desk, preparing instruments for sterilization and performing general office cleaning.

11. The Respondent's Towson office consists of a reception area with an adjacent business office, two active treatment rooms, an instrument preparatory alcove and a sterilization area. Two operatories have been converted into a staff lounge and private office, respectively, and are not used for treatment purposes. Lastly, a storage closet is in the clinic area, and additionally, there is a second private office and a bathroom.

12. The Board expert issued a June 27, 2014 report summarizing her findings during the inspection:

A. STANDARD PRECAUTIONS AND PERSONAL PROTECTIVE EQUIPMENT

a. The overall presentation of the treatment and instrument preparation rooms was of "clutter and disorganization";
b. Cabinets and countertops had visible stains and soiled areas;
c. The floors were carpeted with worn and soiled areas;
d. Various LEGO[4] structures in varying degrees of completion were displayed throughout the office and those in the treatment rooms were dusty;
e. The Respondent was unable to provide recordkeeping to the Board expert for a Health and Safety Program (including an Exposure Control Plan), employee Hepatitis B vaccination records, clinic maintenance, or any documents relating to infection control compliance;
f. The Respondent failed to post the required "We Take Precautions for You" poster[5] or the Board Radiation Machine facility registration;
g. The Respondent failed to post and was unable to produce a current dental license;[6]
h. There was no alcohol hand sanitizer present;
i. The Respondent failed to wash her hands with soap and water during the Board expert's three hour visit;[7]
j. The Respondent wore used treatment gloves while walking around the office during the inspection;

[4] A brand name for a popular line of construction toys.
[5] Md. Code Regs. 10.52.11.04A(2) requires that the notice be posted at the entrance to the health care facility.
[6] Md. Code Ann., Health Occ. § 4-313(b).
[7] BPS requires handwashing before and after glove use.

k. The Respondent required "prompts" from the Board expert to wear utility gloves during instrument preparation, and the gloves were worn and damaged;

l. During the three hour visit, the Respondent failed to change her used mask until prompted by the Board expert;

m. Spare laboratory coats hanging in the office appeared to have been worn, and not subsequently cleaned. The Respondent was unable to provide information regarding a laundry service used by the Towson office; and

n. The Respondent, who wore prescription eyewear, failed to have side shields on her glasses during patient treatment. The Respondent was able to verbally provide to the Board expert the protocol for rinsing the eyes after exposure, but was unable to produce the written protocol.

B. STERILIZATION PROTOCOL[8]

a. The Respondent failed to establish a protocol to remove dental handpieces from the dental unit after each patient and verifiably sterilize them;

b. The Respondent failed to verifiably sterilize the reusable instruments and burs[9] in the general treatment area;

c. The Respondent failed to establish an event-related protocol for the use of bagged instruments;

d. The Respondent has been reusing sterilization bags, rendering the process monitors ineffective;

e. The Respondent did not have any new unused sterilization bags in the office during the inspection; and

f. Although there was a note on the autoclave reflecting that a spore test was scheduled to be run on the following Monday, the Respondent was unable to produce records for weekly spore testing to evaluate the effectiveness of the heat source.[10]

C. TREATMENT ROOM DISINFECTION AND CROSS CONTAMINATION PREVENTION

a. Re-usable instruments that the Respondent stored in drawers and cabinets were not consistently sealed in intact sterilization bags with activated process monitors;

b. A stockpile of disposable mouth mirrors were located in treatment room cabinets. Many of the mouth mirrors appeared to have been used;

[8] Md. Code Regs. 10.52.11.03(c) and 10.52.11.04(1)(c) require care with regard to disinfection and sterilization of reusable devices used in patient care procedures.

[9] Type of cutter used in a handpiece for cutting hard tissue such as tooth or bone.

[10] The standard requires weekly records for a minimum of three years.

c. Although the Respondent had a protocol in place for barrier protection and surface decontamination, and barriers were removed after each patient, prompts from the Board expert were necessary for this to occur; and

d. The Respondent uses a countertop in the operatory to document in patient charts potentiating cross contamination.

D. SHARPS MANAGEMENT AND REGULATED/BIOHARZADOUS WASTE DISPOSAL

a. A small red medical waste bag was overfilled in a cabinet under the autoclave;[11]

b. The single sharps container was overfilled; and

c. The Respondent was unable to produce the required recordkeeping for infectious/medical waste.

E. DENTAL UNIT WATERLINE POLICY

a. The Respondent failed to establish a Dental Unit Waterline Policy as required by CDC guidelines for ICDHS.

F. RADIATION SAFETY

a. The Radiation Machine Facility Registration was not available in the Towson office;

b. The Respondent was unable to adequately produce dosimetry tests;[12]

c. The Respondent was unable to produce calibration or inspection certificates for the Towson office; and

d. The Respondent was unable to produce a written protocol for disposal of lead foils and processing chemicals.

G. FIRST AID, EMERGENCY PROCEDURES AND EXPIRATION DATES

a. There was no emergency evacuation plan available for the Towson office;

b. There was no written policy for Managing Occupational Exposure to BPS; and

c. There was no Cardiopulmonary Resuscitation ("CPR") mask available in the Towson office.

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[11] The standard is that all disposable items saturated with blood or saliva, and/or caked with dried blood/saliva should be disposed of in a regulated biohazardous waste container. Additionally, the CDC/ICDHS (Infection Control in Dental Health-Care Settings) states: "Dental health care facilities should dispose of medical waste regularly to avoid accumulation." The small red medical waste bag did not meet the standard to contain medical waste. Md. Code Regs. 10.52.11.03C(2) requires proper disposal of needles and other sharps devices.

[12] The standard requires six months or six consecutive quarters of dosimetry tests.

JULY 3, 2014 ADDENDUM TO THE BOARD EXPERT REPORT

13. Subsequent to the June 24, 2014 inspection, the Respondent provided the following documents to the Board expert:

a. A copy of the Respondent's current dental license;
b. Evidence of continuing education in infection control including one credit for 2012 and 13 credits for 2005-2008;
c. May 2012 through April 2013 and May 1, 2013 through June 17, 2014 documentation of sterilization monitoring (spore testing);
d. April 2, 2009 and November 8, 2012 documentation of biological waste disposal;
e. Documentation of radiation detection service from September 27, 2012 through April 18, 2013; and
f. June 30, 2014 declination of Hepatitis B vaccination by employee.

14. The Respondent also submitted photographs reflecting the following:

a. That she had subsequently posted in her Towson office the Board mandated "We Take Precautions for You" poster and the radiation machine facility registration;
b. That the Respondent placed new unused sterilization bags in the sterilization alcove;
c. Operatory countertops and cabinets appear to have been cleaned and drawers reorganized;
d. Re-usable instruments stored in the drawers appear to have been sealed in intact sterilization bags; and
e. Development of a new sharps container preparatory alcove. The area appears clean and organized.

15. After reviewing the additional documents and photographs submitted by the Respondent noted in ¶¶13 and 14, the Board expert filed an addendum to her initial report. The Board expert opined that with the additional submissions, the following "serious violations to the Occupational Exposure to [BPS]...and CDC Guidelines for [ICDHS] referenced in the Universal Infection Control Precautions Standard..." remained in the Towson office:

a. Lacked written records for annual safety evaluation;
b. No written Exposure Control Plan with safety protocols;
c. No employee training records for at least the prior three years;

d. No Hepatitis B vaccination records for the Respondent and any prior employees;
e. No written post-exposure protocol;
f. The Respondent wore used treatment gloves while walking around the office during the June 24, 2014 inspection;
g. The Respondent re-used sterilization bags as viewed during the June 24, 2014 inspection;
h. the Respondent did not promptly process instruments after use as viewed during the June 24, 2014 inspection;
i. The medical waste container was undersized, overfilled and located in the "clean" sterilization area inside a cabinet with poor access as viewed during the June 24, 2014 inspection;
j. The office lacked consistent, verifiable sterilization of all re-usable intra-oral instruments including high and low handpieces, ultrasonic scalers, burs and some hand instruments;
k. The disposable mouth mirrors appeared to have been re-used as viewed during the June 24, 2014 inspection;
l. Dental unit waterline maintenance policy is not established;
m. Lacked three years of continuous biohazardous waste manifests showing regular medical waste removal and/or safe processing;
n. The Respondent failed to dispose of sharps in a proper and timely manner as viewed during the June 24, 2014 inspection;
o. A CPR mask was not available; and
p. Multiple medical emergency supplies had expired.

16. Additionally, on inspection, calibration and inspection documentation for radiographic equipment was not available.

17. Based on the above investigative facts, the Board concludes that the Respondent constitutes an imminent threat to the public, which imperatively requires the suspension of her 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. Code Ann., State Gov't § 10-226(c)(2)(2009 Repl. Vol. & 2013 Supp.).

ORDER

Based on the foregoing findings, it is this 22nd day of July, 2014, by a majority vote of a quorum of the State Board of Dental Examiners, by authority granted to the Board by Md. Code Ann., State Govt. § 10-226(c)(2) (2009 Repl. Vol. & 2013 Supp.), it is hereby:

ORDERED that the Respondent's license to practice dentistry in the State of Maryland, under License Number 13117, 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 her 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. Code Ann., State Govt. § 10-617(h) (2009 Repl. Vol. & 2013 Supp.).

Maurice Miles DDS

Maurice S. Miles, 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 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.*