IN THE MATTER OF	*	**BEFORE THE MARYLAND**
JOSPEH LEE DYSON, JR., D.D.S.	*	**STATE BOARD OF DENTAL**
RESPONDENT	*	**EXAMINERS**
LICENSE NUMBER: 8597	*	**CASE NUMBER: 2011-137**

* *

ORDER FOR SUMMARY SUSPENSION

Pursuant to Md. State Govt. Code Ann. §10-226 (c) (2009 Repl. Vol.), the State Board of Dental Examiners (the "Board") hereby summarily suspends the license of Joseph Lee Dyson, Jr. D.D.S. (" the Respondent"), License Number: 8597, to practice dentistry under the Maryland Dentistry Act, Md. Health Occ. ("H.O.") Code Ann. §§ 4-101 *et seq.* (Repl. Vol. 2009). This Order is based on the following investigative findings, which the Board has reason to believe are true:[1]

INVESTIGATIVE FINDINGS

1. At all times relevant hereto, the Respondent was and is licensed to practice dentistry in the State of Maryland. The Respondent initially received his license to practice dentistry on or about September 22, 1983.

2. The Respondent's license to practice dentistry expires on June 30, 2015.

3. The Respondent owns and operates a dental practice located in Baltimore, Maryland.

[1] The statements regarding the Respondent's conduct are only intended to provide the Respondent with notice of the basis for the Board's action. 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 this matter.

4. On or around January 2011, the Board received a complaint alleging that the Respondent was not in compliance with CDC guidelines.[2] The complaint also alleged that the Respondent was inappropriately billing patients and insurance providers.

5. As a result of the complaint, the Board requested that Dr. A., a Board approve expert conduct an inspection of the Respondent's dental practice. [3]

6. On February 28, 2013, Dr. A conducted an inspection of the Respondent's dental practice.

7. During her inspection of the Respondent's dental practice, Dr. A found numerous CDC violations. In a subsequent report to the Board, Dr.AM indicated that some of the CDC violations that she found were significant.

8. The CDC violations found by Dr. A included: (1) failure to maintain slow speed hand pieces in verifiably sterilized, seal bags; (2) inadequate weekly spore testing; (3) inadequate medical waste disposal; (4) failure to maintain hepatitis B records prior to 2005; and (5) inadequate dental waterline protocol baseline.

9. On or about June 18, 2014, the Board agreed to issue the Respondent an Advisory Letter, instead of taking disciplinary action against his license. One of the conditions set forth in the Advisory Letter required that the

[2] The Center for Disease Control (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 and the dentist's staff to and from patient.

[3] To ensure confidentiality, names are not used in this document. The Respondent may obtained the names by contacting the Administrative Prosecutor.

Respondent come into compliance with CDC and OSHA guidelines within fifteen days.

10. The Advisory Letter dated June 18, 2014, also advised the Respondent that the Board would conduct a random and unannounced inspection of his dental office.

11. On or about July 2, 2014, the Respondent agreed to the conditions set forth in the Advisory Letter.

12. On August 22, 2014, an unannounced inspection of the Respondent's dental practice was conducted. The inspection was conducted by Dr. B., a Board approved expert.

13. During his inspection of the Respondent's dental office, Dr. B. found the following CDC violations:

A. The dental practice did not maintain an up to date exposure control plan for proper infection prevention;

B. There were no provisions made for the separation of clean and dirty instruments in order to prevent the risk of cross contamination;

C. The ultrasonic unit solution was dirty and had not been changed for some time. The ultrasonic unit was dirty and poorly maintain. Dental instruments were left in the ultrasonic unit overnight or longer;

D. The autoclave was poorly maintained and had not been cleaned or serviced for some time;

E. Heat tolerant instruments were found in cold sterilization solution. The container holding the cold sterilization solution was dirty and unlabeled.

There was no date on the cold sterilization container to document when the cold sterilization solution had been changed;

F. The cleaning of contaminated instruments was inadequate. Instruments that were wrapped and processed were not properly pre-cleaned. Debris was observed on instruments inside the sterilization pouches and within the processed sterilization pouch. Instruments were rusted and covered with stain, dirt, and/or debris. Considerable debris was found on one elevator an elevator that was removed from a pouch;

G. There were significant deficiencies in sterilization. Multiple instruments packs did not display the proper chemical indicator which would confirm that proper sterilization parameter had been met. Biological monitoring was not being performed on a weekly basis; and

H. There were no provisions in any operatory for the delivery of effluent water that meets CDC guidelines.

14. The conditions of the Respondent's dental practice, as set forth herein, warrants the suspension of the Respondent's license to practice dentistry.

CONCLUSIONS OF LAW

Based on the foregoing investigative findings, the Board concludes that the public health, safety, and welfare imperatively require emergency action in this case, pursuant to Md. State Gov't. Code Ann. § 10-226(c)(2).

ORDER

Based on the foregoing Investigative Findings and Conclusions of Law, it is this _14th__ day of _October__ 2014, by a majority of the quorum of the Board, hereby

ORDERED that the license issued to the Respondent to practice dentistry in the State of Maryland under license number: 8594 is hereby **SUMMARILY SUSPENDED**; and it is further

ORDERED that the Respondent is prohibited from practicing dentistry in the State of Maryland; and it is further

ORDERED that the Respondent shall immediately return his license to the Board; and it is further

ORDERED that this **ORDER FOR SUMMARY SUSPENSION** is a **PUBLIC DOCUMENT** as defined in Md. State Gov't Code Ann. §§ 10-611 *et seq.* (2009 Repl. Vol.)

10/14/2014
Date

Maurice Miles DDS
Maurice S. Miles, D.D.S., President
State Board of Dental Examiners