IN THE MATTER OF	*	BEFORE THE
NASSER MORADI, D.D.S.	*	STATE BOARD OF
RESPONDENT	*	DENTAL EXAMINERS
License Number: 4719	*	Case Number: 2013-101

* * * * * * * * * * * * *

ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE DENTISTRY

The State Board of Dental Examiners (the "Board") hereby **SUMMARILY SUSPENDS** the license of **NASSER MORADI, D.D.S.** (the "Respondent"), License Number 4719, 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]

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 August 11, 1969, under License Number 4719.

[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 in Elkton, Maryland (the "Elkton office"). The Respondent is a solo practitioner and does not employ any dental assistants.

3. The Board initiated an investigation of the Respondent after reviewing a complaint from one of his former patients (the "Patient"). On or about November 1, 2012, the Patient, then a man in his mid-fifties, sought dental treatment from the Respondent at his Elkton office. On this date, the Respondent extracted tooth number (#) 31.

4. In his complaint, the Patient expressed concerns about the condition of the Respondent's office and the treatment the Respondent provided to him. The Patient alleged that the Respondent's office was unsanitary and that the office dental equipment was not in working order. The Patient stated that during the extraction, the Respondent asked him to spit into a dirty trashcan instead of the cuspidor that was adjacent to the dental chair. The Patient reported that he went to his previous dentist two days later and was given antibiotics.

5. As part of its investigation, the Board ordered an inspection of the Respondent's Elkton office.

6. On March 21, 2013, an independent Board infection control consultant ("Board expert # 1") 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] guidelines on universal

[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.

precautions. Board expert # 1 found systemic and widespread CDC violations during the inspection.

7. The Board subsequently contacted the Respondent, who stated that he corrected the violations in question.

8. The Board then ordered a second inspection to determine the condition of the Respondent's office. On or about June 4, 2013, a second independent Board infection control consultant ("Board expert # 2") conducted a follow-up inspection of the Respondent's office and determined that many of the violations Board expert # 1 identified were still uncorrected. Board expert # 2 found several deficiencies in the condition of the Respondent's office.

9. A summary of these findings is set forth *infra.*

Office inspection, dated March 21, 2013

10. On March 21, 2013, Board expert # 1 conducted an infection control inspection of the Respondent's Elkton office. At the time of the inspection, the Respondent was in the office but did not have any patients scheduled for treatment. As a result, Expert # 1 did not observe the Respondent provide any dental treatment to any patients. The Respondent reportedly does not employ any dental hygienists, assistants or other personnel to assist him in his practice.

11. The Respondent's office consists of a waiting room, a business area, a lavatory, three dental operatories, of which two were used to treat patients (a third is used for radiographs alone), and a private office.

12. Board expert # 1 issued a report, dated March 21, 2013, in which he stated,

> [t]he equipment, while serviceable, appeared dirty and not well maintained. Upon inspecting these clinical areas, I found that the

complaints of . . . [the Patient] . . . were well founded. There were multiple and significant breaches in the standard of care for infection control identified in this inspection.

* * *

The cleaning, disinfection and sterilization practices of this office are below the standards of care. Based on the inspection of March 21, 2013, it is my opinion that it is unsafe for patients to undergo dental treatment in the office of Nasser Moradi, DDS.

13. Board expert # 1 made findings that included but were not limited to the following:

(a) The Respondent's office lacks an Exposure Control Plan or office manual that details the proper infection prevention procedures;

(b) Operatories lacked new barriers and items were cross-contaminated during procedures. Single use barriers were re-used. The few barriers on the light handles and headrest were soiled from multiple and repeated use;

(c) Instrument tray surfaces were unclean and contained dust, dirt and patient debris on almost every surface. The bracket tray surfaces were unclean and contained dust, dirt and patient debris on almost every surface. The tray covers were crumpled and dirty and indicated that they had not been changed in a considerable period of time. Used instruments were left opened on the trays;

(d) Almost every working surface was unclean and littered with particles, dust, debris and unidentifiable spots that may be blood or other splatter from previous patients. There was little evidence of surface disinfection. The one wipe-style container that was located in one of the working operatories contained wipes that were "bone dry," and it was "obvious that this has been the case for a considerable period of time";

(e) There was no treatment of the dental unit waterlines exposing patients to potential biofilm contamination;

(f) High, low and ultrasonic handpieces were left set up on bracket trays in each treatment room with barriers attached, but the barriers were "well used and obviously not changed between patients"; There was a bur housed in a handpiece that had debris in its flutes;

(g) There was no alcohol-based hand rub available and there were sinks in the treatment rooms to facilitate hand washing;

(h) Disposable facemasks were hanging in operatories and re-used;

(i) Clean laboratory coats were not available. The office had one laboratory coat, which was soiled and draped over a sofa in the dentist's office space;

(j) The surfaces of the dental laboratory had not been cleaned and contained debris and used film packets. There was no device or provision for cleaning contaminated instruments;

(k) The office did not have a tabletop ultrasonic cleaner, nor was there a place or device where instrument cleaning could be performed. The autoclave was small and stuffed in an operatory directly adjacent to patient care items facilitating the potential for significant cross contamination. "The dentist, when questioned, had no fundamental knowledge of the principles of cleaning and sterilization";

(l) The two operatories contained local anesthesia devices with syringes that were not wrapped or properly sterilized;

(m) The office contained a pack of burs that indicate that they were not sterilized. Other burs were in bur blocks that were dirty and were verifiably sterilized. The bur flutes were often contaminated with debris and tooth fragments. A floss container had evidence of blood/debris on it;

(n) The operatories contained three way syringes that had not been cleaned. The syringes had dirt and patient debris present on the tubing and bracket tray. The surface was scratched, making it difficult to clean and disinfect. The three way tips of both devices were dirty and had not been changed;

(o) Instrument packs were unsealed and/or were torn open, exposing the instruments within the packs to potential contamination;

(p) Instruments were found unwrapped in several drawers; and

(q) Processed and unprocessed instrument packs were mixed together.

Respondent's response to the Patient's Complaint and Report of Board expert # 1

14. Board representatives subsequently contacted the Respondent and requested that he provide a response to the Patient's complaint and Board expert # 1's inspection report.

15. The Respondent provided a written response, dated April 12, 2013. With respect to the Patient's complaint, the Respondent acknowledged that when the Patient requested to spit into the dental bowl, he directed him to spit into a trash can, claiming he did not want to contaminate the bowl further. The Respondent also stated that he could not retrieve the Patient's dental radiograph, speculating that he either gave it to the Patient or could not locate it.

16. With respect to Board expert # 1's report, the Respondent stated, "[m]y office was not as neat and clean right then. Some of the criticisms were correct and some were not."

Office inspection, dated June 4, 2013

17. On or about June 4, 2013, Board expert # 2 conducted a follow-up, unannounced inspection of the Respondent's Elkton office. No patients were present at the time of the inspection.

18. Board expert # 2 issued a report, dated June 10, 2013, in which she found that the Respondent failed to correct the overwhelming majority of the deficiencies Expert # 1 identified during his March 21, 2013, inspection.

19. Board expert # 2 identified the following uncorrected deficiencies:

(a) With respect to barriers and cross-contamination, there were no barriers on the headrests and when interviewed, the Respondent was not clear about his frequency of use of barriers;

(b) With respect to surface cleanliness and accessibility for cleaning, (i) available disinfecting wipes were dry and had an expiration date of 2010; and (ii) there remained excessive storage on countertops precluding access to clean and disinfect;

(c) With respect to handpiece sterilization, (i) all handpieces were not verifiably sterilized; (ii) multiple high speed handpieces were in single bags, with some of the bags open and with other bags that were without activated process monitors; and (iii) some slow speed handpieces were left on bracket trays;

(d) With respect to alcohol hand rub, no alcohol hand rub was available. The only sinks on the premises were in the bathroom and the alcove that was being prepared as a sterilization area, both of which were not conveniently available to any treatment rooms;

(e) With respect to the sterilization area, (i) the new sterilization area the Respondent was planning was not yet operational; (ii) a clean and dirty area was not established; (iii) the autoclave was on a counter in the main treatment room; (iv) an area to debride and package instruments was not available; and (v) instruments were not consistently bagged and verifiably sterilized;

(f) With respect to use of packaged instruments, (i) the Respondent noted that he was colorblind and could not clearly distinguish the activated process monitors; and (ii) some loose instruments and torn bags of instruments were stored in storage drawers;

(g) With respect to the presence of unbagged instruments, unbagged instruments were present in drawers and clinical areas;

(h) With respect to the presence of medical waste, (i) gloves and other intra-orally used items were found to be discarded in routine trashcans; and (ii) medical waste manifests were not available to indicate at least three years of appropriate disposal; and

(i) With respect to compliance with CDC guidelines, the Respondent had "significant lapses in compliance with CDCGICHCS" [Centers for Disease Control Guidelines for Infection Control in Dental Health-Care Settings].

20. Board expert # 2 identified the following CDCGICHCS violations in the Respondent's office:

(a) Dental handpieces were not consistently and verifiably sterilized;

(b) The Respondent is unable to consistently identify sterilized packaging;

(c) Due to poor access to hand washing facilities and/or hand sanitizers, hand washing cannot be conveniently performed before and after patient care;

(d) Personal protective equipment in the form of utility gloves is not available when preparing instruments for sterilization;

(e) Instruments are not properly processed after use;

(f) The Respondent's office lacked a well-organized sterilization area with distinct clean and dirty areas;

(g) The Respondent's office lacks consistent, verifiable sterilization of all re-usable intra-oral instruments, specifically slow speed handpieces, some high-speed handpieces, burs, and hand instruments;

(h) The Respondent's office contains expired products, such as surface disinfectants that expired in 2010;

(i) Expired anesthetic carpules and dental materials are in treatment areas;

(j) The Respondent did not establish a dental unit waterline maintenance policy;

(k) The Respondent's office lacks proper disposal of medical waste. At least three years of records should be available for waste manifests showing regular medical waste removal and/or safe processing;

(l) The Respondent's office does not have a CPR resuscitator mask available; and

(m) The Respondent's office does not have medical emergency supplies available.

21. Based on the above investigative facts, 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[.]

22. 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 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 18th 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 4719, 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, 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 makes a request for a Show Cause Hearing and fails to appear for it, the Board shall continue the Summary Suspension; and it is further

ORDERED that the Respondent shall immediately turn over to the Board all licenses to practice dentistry issued by the Board that are in his possession; 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 to determine why the Order for Summary Suspension should not continue will be held before the Board at Spring Grove Hospital Center, Benjamin Rush Building, 55 Wade Avenue, Baltimore, Maryland 21228, at the Board's next regularly scheduled meeting, following a written request 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, request an evidentiary hearing. Unless otherwise agreed by the parties, the Board shall provide a hearing within forty-five (45) days after the Respondent's request. The Board shall conduct an evidentiary hearing under the contested case provisions of Md. State Gov't Code Ann. §§ 10-210 *et seq.*