IN THE MATTER OF	*	**BEFORE THE MARYLAND**
MITCHELL E. WEINER, D.D.S.	*	**STATE BOARD OF**
RESPONDENT	*	**DENTAL EXAMINERS**
License Number: 9976	*	**Case Number: 2016-010**

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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 **MITCHELL E. WEINER, D.D.S.** (the "Respondent"), License Number 9976, 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)(2) (2014 Repl. Vol.), concluding that the public health, safety and welfare imperatively require emergency action.

The Board bases its action on the provisions of the Maryland Dentistry Act (the "Act"), codified at Md. Code Ann., Health Occ. ("H.O.") §§ 4-101 et seq. (2014 Repl. Vol). The pertinent provision of the Act, H.O. § 4-315(a), provides:

> (a) *License to practice dentistry.* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may deny a general license to practice dentistry...reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the ... licensee:
>
> (16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession;
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> . . .
>
> (30) Except in an emergency life-threatening situation where it is not feasible or practicable, fails to comply with the Centers for Disease Control and Prevention's guidelines on universal precautions.

The pertinent regulations under Code Regs. Md. ("COMAR") § 10.44.23.01 include:

A. A dentist...may not engage in unprofessional or dishonorable conduct.

B. The following shall constitute unprofessional or dishonorable conduct in the practice of dentistry...:

(8) Committing any other unprofessional or dishonorable act or omission in the practice of dentistry...

INVESTIGATIVE FINDINGS

The Board finds the following facts:[1]

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.

2. On or about August 10, 1988, the Respondent was initially licensed to practice dentistry in Maryland under License Number 9976.

3. On or about August 15, 1988, the Respondent also was also licensed to practice dentistry in the District of Columbia under License Number DEN5006, but he allowed that license to expire on or about October January 31, 2012.

4. At all times relevant to this Order, the Respondent practiced dentistry at a private practice location in Laurel, Maryland (the "Laurel Office"). The Respondent is a corporate director and co-owner of the Laurel Office.

5. On or about July 17, 2015, the Board received a complaint from an individual (the "Complainant") who was a patient of the Respondent from April 27, 2015 until May 28, 2015. Among other concerns, the Complainant noted that the Laurel Office had "sanitary issues."

6. The Complainant came to the Laurel Office after he was diagnosed with an infected tooth at another dental office. He was referred to another specialist for a root

[1] The statements describing the Respondent's conduct are intended to provide the Respondent with notice of the basis of the summary 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.

canal, but after checking with his dental insurance company, he chose to have the root canal performed at the Laurel Office because it accepted his insurance.

7. The Complainant called the Laurel Office on April 27, 2015, and was able to schedule an appointment for later that same day. The Complainant arrived fifteen minutes early for his appointment. However, he was not seen until long after his appointment time. Instead, he was made to wait for several hours in an overcrowded waiting area.

8. Eventually, the Complainant was ushered into a "cramped" room where he was asked to provide insurance and other personal/private information. A number of other patients were also present providing private information, which was easily overheard. The Complainant then was taken for x-rays in a "dirty" room. Subsequently, the Complainant reported that some of the dental implements used to treat him were "non-sterile."

9. Based on the Complaint, the Board initiated an investigation.

Investigation

10. On or about July 29, 2015, in furtherance of its investigation, the Board retained an independent expert in infection control protocols (the "Board Expert") to conduct an inspection of the Laurel Office.

11. On August 8, 2015, the Board Expert conducted an unannounced on-site inspection of the Laurel Office to determine whether it was in compliance with the Centers for Disease Control and Prevention guidelines for infection control in dental healthcare settings (the "CDC guidelines").[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 Board's statute, 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.

12. The Board Expert directly observed the conditions of the Laurel Office and the procedures employed by staff, including patient treatment and instrument preparation.

13. On August 11, 2015, the Board Expert issued a report of her inspection. Based upon the serious types and number of sterilization violations noted, the Board Expert concluded that the safety of the staff and patients was in jeopardy and that immediate action was required to rectify the situation.

14. In her report, the Board Expert noted seventeen (17) distinct violations of CDC guidelines at the Laurel Office, summarized below:

a. Missing Continuing Education certificates for completion of mandatory Infection control programs;

b. Hepatitis B vaccination records missing for 14 clinical operators;

c. Only 7 Certificates for Radiology submitted for 14 dental assistants;

d. Fire extinguishers improperly placed and being used for door stops;

e. No heavy utility gloves for handling contaminated instruments and chemicals;

f. Hand scrubbing contaminated instruments wearing thin exam gloves prior to placement in the ultrasonic cleaner;

g. Failure to cover nose, mouth or eyes while handling chemicals;

h. Staff not wearing safety shields when doing clinical procedures;

i. Storing opened sterilized instrument cassettes with no protective covers or bags;

j. Placing multiple surgical instruments in one bag with no separation or placement to insure sterility;

k. Storing sterile and non-sterile items together;

l. Removing instruments from the sterilizer prior to completion of the cycle rendering the bags wet and easily torn;

m. Absence of documented Dental Unit Waterline Policy;

n. Sharps containers located on the floor, allowing easy access for children or potential injury with contaminated sharps;

o. Wearing contaminated PPE out of clinical areas;

p. 214 weekly spore test violations listed for the Laurel Office's four sterilizers over a 3 year period; and

q. Repeated failures of the four sterilizers to appropriately sterilize instruments.

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.), the Board concludes that the public health, safety, and welfare imperatively require this emergency action of summary suspension.

ORDER

Based on the foregoing, it is this 10th day of September, 2015, by the Board hereby:

ORDERED that the Respondent's license to practice dentistry in the State of Maryland, under License Number 9976, 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 indicia of licensure 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. Code Ann., General Provisions, §§ 4-101 through 4-601 (Repl. Vol. 2014).

Ronald F. Moser, 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. Code Ann., State Gov't §§ 10-210 *et seq.*