IN THE MATTER OF	*	**BEFORE THE MARYLAND**
MOHAMMAD ALI TABATABAEEI-FATEMI, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 11720	*	**Case Number: 2018-213[1]**

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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 **MOHAMMAD ALI TABATABAEEI-FATEMI, D.D.S.** (the "Respondent"), License Number 11720, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under Md. Code Ann., State Gov't ("State Gov't") § 10-226(c) (2014 Repl. Vol.), finding that the public health, safety, or welfare imperatively requires 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: [2]

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[1] The allegations set forth in this order are strictly limited to the Board's investigation with respect to the Respondent's compliance with Centers for Disease Control and Prevention ("CDC") Guidelines in his dental practice. Case Number 2018-213 may include non-CDC related issues that the Board continues to investigate. The Board is not foreclosed from later bringing additional disciplinary charges against the Respondent.

[2] The statements regarding 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

I. LICENSING BACKGROUND

1. At all times relevant, the Respondent was and is licensed to practice dentistry in the State of Maryland. The Respondent was originally licensed to practice dentistry in Maryland on March 27, 1996, under License Number 11720. The Respondent's license is current through June 30, 2020.

2. At all times relevant, the Respondent practiced general dentistry as a sole-practitioner at a dental office in Gaithersburg, Maryland (the "Dental Office"). [3]

3. On or about April 19, 2018, the Board received a complaint from a former patient (the "Complainant") alleging, *inter alia,* that the Respondent used "unsanitary dental tools" in his practice of dentistry.

4. Based on the complaint, the Board initiated an investigation of the Respondent and his Dental Office.

II. DISCIPLINARY HISTORY

5. In or around October 2003, the Maryland Office of the Attorney General, Medicaid Fraud Control Unit, charged the Respondent in the Circuit Court for Baltimore City, *State of Maryland v. Mohammad Ali Tabatabaeei-Fatemi,* Criminal Case No. 20375014, with one (1) count of defrauding a state health plan ("Medicaid Fraud"), in violation of Md. Code Ann., Crim. Law ("Crim. Law") § 8-509. On November 18, 2003,

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description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

[3] To ensure confidentiality, the names of individuals, hospitals and healthcare facilities involved in this case are not disclosed in this document. The Respondent may obtain the identity of the referenced individuals or entities in this document by contacting the administrative prosecutor.

the Respondent pleaded guilty to Medicaid Fraud, in violation of Crim. Law § 8-509. On February 24, 2004, the Respondent appeared in the Circuit Court for Baltimore City, Maryland, and was sentenced to three years of incarceration, all of which was suspended, followed by three years of supervised probation with conditions that he pay restitution in the amount of twenty eight thousand three hundred twenty-nine dollars and fifteen cents ($28,329.15) and complete ninety-one and one half (91 ½) hours of community service.

6. Based on the criminal disposition, the Board, in 2004, charged the Respondent with being convicted or pleading guilty to a felony or a crime involving moral turpitude, in violation of Health Occ. § 4-315(a)(4). The Respondent resolved the Board's charges by entering a Consent Order, dated December 15, 2004, in which the Board made factual findings and legal conclusions that the Respondent pleaded guilty to and was convicted of a felony and a crime involving moral turpitude, in violation of Health Occ. § 4-315(a)(4). The Board suspended the Respondent's license to practice dentistry in Maryland for one (1) year with all but four (4) months stayed followed by two (2) years of probation with the condition that he perform one hundred (100) hours of *pro bono* dental services.

III. INFECTION CONTROL INSPECTION

7. Due to the Complainant's allegation of unsanitary dental instruments at the Respondent's Dental Office, on or about May 12, 2018, a Board-contracted infection control expert (the "Board Inspector") visited the Respondent's Dental Office and conducted an infection control inspection.

8. Initially, the Board Inspector noted that the Respondent was a sole-practitioner at a general dentistry practice. The Respondent employed a dental assistant, who was present during the inspection.

9. As part of the inspection, the Board Inspector utilized the Centers for Disease Control and Prevention Infection Prevention Checklist for Dental Settings.

10. During the inspection, the Board Inspector was able to directly observe patient treatment by the Respondent and his dental assistant.

11. Based on the inspection, the Board Inspector found the following CDC violations:

Section I: Policies and Practices

a. **Administrative Measures** – Although the Respondent produced a written infection control policy with certain sections specific to the practice, the infection control policy was not updated, and certain sections were missing. The Respondent also did not have a "Cover Your Cough" poster posted in the reception or practice area.

b. **Infection Prevention Education and Training** – The Respondent failed to maintain training log of personnel training (upon hire and annually) on infection prevention and bloodborne pathogens standard.

c. **Dental Health Care Personnel Safety** – The Respondent maintained exposure control plan specific to his Dental Office.

However, the section on OSHA Policy required update, and the section on Employee Training was missing the training log.

d. **Program Evaluation** – The Respondent failed to maintain policies and procedures for routine monitoring and evaluation for infection prevention.

e. **Hand Hygiene** – The Respondent failed to maintain personnel training log and posted protocol for hand hygiene.

f. **Personal Protective Equipment (PPE)** – Utility gloves were available but not used during instrument processing. Sterile surgical gloves were not available in the practice for surgical procedures.

g. **Respiratory Hygiene/Cough Etiquette** – The Respondent failed to maintain and post respiratory hygiene policies and procedures for personnel and patients. The "Cover Your Cough" poster was not posted or available.

h. **Sharps Safety** – The Respondent complied with CDC Guidelines on Policies and Practices for Sharps Safety.

i. **Safe Injection Practices** – The Respondent complied with CDC Guidelines on Policies and Practices for Safe Injection Practices.

j. **Sterilization and Disinfection of Patient-Care Items and Devices** – The Respondent failed to maintain maintenance log for equipment specific to manufacturer; maintenance log for Emergency Eye Wash

Station; maintenance log for spore testing; and processed sterilization pouches were not marked with date, time or load.

k. **Environmental Infection Prevention and Control** – The Respondent failed to utilize barriers on A/W syringe, HVE and SVE suction. The Respondent also failed to document periodic monitoring and evaluation of cleaning, disinfection and use of surface barriers.

l. **Dental Unit Water Quality** – The Respondent failed to maintain testing log for annual dental unit water testing. The dental units were connected to municipal water system.

Section II: Direct Observation of Personnel and Patient-Care Practices

m. **Performance of Hand Hygiene** – The Board inspector observed that the Respondent and/or his assistant failed to wash their hands or use hand sanitizer before and after gloving. She further observed that the Respondent and/or his assistant failed to use sterile surgical gloves during surgical procedures nor were they available for use.

n. **Use of Personal Protective Equipment (PPE)** – The Board Inspector observed that the Respondent changed into a new pair of examination gloves without washing his hands first; that he failed to change his mask after patient treatment; that he failed to use utility gloves during instrument processing, even though utility gloves were available; that he failed to use sterile surgical gloves during surgical

procedures; that he failed to wear protective disposable long sleeve jackets correctly; and that he failed to wear ear loop face masks correctly.

o. **Respiratory Hygiene/Cough Etiquette** – The Respondent failed to post "Cover Your Cough" poster for patients or staff to review.

p. **Sharps Safety** – The Respondent failed to maintain documentation of disposal of sharps containers.

q. **Safe Injection Practices** – The Respondent failed to maintain medication log for sedation medications and kept expired sedation medications in the refrigerator.

r. **Sterilization and Disinfection of Patient-Care Items and Devices** – The Respondent failed to date sterilization pouches after processing and failed to process hinged instruments in open position. The Respondent failed to maintain spore testing log. The implant drilling unit still had irrigation "cooling" tubing and sterile water bag attached. Surgical implant handpiece was still attached to the unit.

s. **Environmental Infection Prevention and Control** – The Respondent failed to utilize barriers for A/W syringe, HVE and SVE suction. The Respondent failed to change barrier on radiology exposure button after use. Biohazard medical waste container was placed in staff lounge area without a lid, instead of in the treatment

operatories. The Respondent also failed to maintain log of medical waste manifest for disposal.

t. **Dental Unit Water Quality** – The Respondent failed to maintain testing log for annual dental unit water testing. The dental units were connected to municipal water system. The implant drilling unit still had irrigation "cooling" tubing and sterile water bag attached. Surgical implant handpiece was still attached to the unit.

12. Based on her observations and inspection, the Board Inspector determined that the Respondent's dental practice at his Dental Office posed a risk to patient and staff safety.

CONCLUSIONS OF LAW

Based on the foregoing investigative findings, the Board concludes as a matter of law that there is a substantial likelihood that the Respondent poses a risk of harm to the public health, safety and welfare, which imperatively requires the immediate suspension of his license, pursuant to State Gov't § 10-226(c)(2) (2014 Repl. Vol.).

ORDER

Based on the foregoing investigative findings, it is, by a majority of a quorum of the Board considering this case, pursuant to authority granted to the Board by State Gov't § 10-226(c)(2) (2014 Repl. Vol.):

ORDERED that the Respondent's license to practice dentistry in the State of Maryland, License Number 11720, 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 but not to exceed thirty (30) days from the date of the Respondent's request, at which the Respondent will be given an opportunity to be heard as to why the Order for 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 of his license; 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 his original license, renewal certificates and wallet size license; and it is further

ORDERED that this document constitutes an order of the Board and is therefore a public document for purposes of public disclosure, as required by Md. Code Ann., Gen. Provisions §§ 4-101 *et seq.* (2014).

7/18/18
Date

Arthur C. Jee, D.M.D.
Board President
Maryland State Board of Dental Examiners

NOTICE OF HEARING

Upon the Board's receipt of a written request from the Respondent, a Show Cause Hearing will be held at the offices of the Maryland State 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 but not to exceed thirty (30) days from the Board's receipt of a written request for a 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 State Gov't §§ 10-201 *et seq.* (2014 Repl. Vol.).