IN THE MATTER OF	*	**BEFORE THE MARYLAND**
VIKASKUMAR PATEL, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 15616	*	**Case Number: 2018-218**

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CONSENT ORDER

On August 27, 2018, the Maryland State Board of Dental Examiners (the "Board") summarily suspended the license of **VIKASKUMAR PATEL, D.D.S.,** (the "Respondent"), License Number 15616, and charged him with violating the Maryland Dentistry Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 4-101 *et seq.* (2014 Repl. Vol.).

The Board charged the Respondent with violating the following provisions of the Act under Health Occ. § 4-315:

> (a) *License to practice dentistry* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may… 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; [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[.]

On September 19, 2018, a Case Resolution Conference was held before a committee of the Board. As a resolution of this matter, the Respondent agreed to enter this public Consent Order consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Board makes the following Findings of Fact:

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 July 11, 2014, under License Number 15616.

2. At all times relevant, the Respondent practiced general dentistry with another staff dentist ("Dentist A") [1] at a dental practice called Family Dental Care of Maple Lawn, located in Laurel, Maryland (the "Maple Lawn Practice").[2] The Maple Lawn Practice is owned by a professional corporation called Dental Professionals of Maryland, Gerald Awadzi, P.C. and managed by a dental services organization ("DSO").

3. On or about May 3, 2018, the Board received a complaint from the Howard County Health Department reporting that on or about April 23, 2018, it received information that several trash bags of biohazardous waste and patient dental charts from the Maple Lawn Practice were found inside a dumpster at a gas station close to the practice's location.

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[1] 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.

[2] The Respondent is an employee of Dental Professionals of Maryland, Gerald Awadzi, P.C. The Respondent is not an owner, associate partner, or independent contractor of Dental Professionals of Maryland, Gerald Awadzi, P.C., or any practice owned by Dental Professionals of Maryland, Gerald Awadzi, P.C.

4. Based on the complaint, the Board initiated an investigation of the Maple Lawn Practice and its dental practitioners.

II. INFECTION CONTROL INSPECTION

5. Due to allegations of improper disposal of biohazardous waste from the Maple Lawn Practice in the complaint, on or about May 15, 2018, a Board-contracted infection control expert (the "Board Inspector") and a Board investigator visited the Maple Lawn Practice for the purpose of conducting an infection control inspection.

6. The Board Inspector and the Board investigator arrived at the Maple Lawn Practice at approximate 9:00 a.m. and met with the practice manager of operation ("Employee A"). The Board Inspector and the Board investigator introduced themselves and explained the purpose of their visit. They confirmed that the Respondent and Dentist A were the only two dentists practicing at this location.

7. Initially, the Board Inspector noticed that a sign at the front of the practice displayed the name "Vikas Patel, DDS," but the name card that the Respondent handed to the Board Inspector had the name "Vikaskumar Patel, DDS."

8. At the start of the inspection at approximately 9:30 a.m., the Board Inspector noted the following individuals on the premises: Employee A, the Respondent, two registered dental hygienists, two dental assistants and three patients.

9. Prior to the start of the inspection, Employee A made several telephone calls to individuals affiliated with the Maple Lawn Practice. By 10:30 a.m., the following additional individuals arrived at the Maple Lawn Practice: two corporate representatives

from the DSO, one of whom was the Occupational and Health Administration ("OSHA") coordinator, another dental assistant and Dentist A.

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

11. During the inspection, the Board Inspector was able to directly observe patient treatment by the Respondent and other dental staff members.

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

Section I: Policies and Practices

a. **Administrative Measures** – The Respondent failed to: make available written infection prevention policies and procedures specific for the dental setting; reassess and update the policies and procedures at least annually; assign an individual trained in infection prevention the responsibility of coordinating the program; make available supplies necessary for adherence to Standard Precaution; and have a system for early detection and management of potentially infectious persons.

i. At approximately 9:30 a.m., upon request by the Board Inspector, the Respondent, Employee A and all other staff members were unable to produce any manuals that listed infection prevention procedures specific for the Maple Lawn Practice. The same request was made at approximately 10:30

a.m. to the DSO corporate representatives and Dentist A, but none was able to produce any written policies and procedures specific to the Maple Lawn Practice.

ii. None of the staff members, including the Respondent and Dentist A, or DSO corporate representatives were able to confirm or provide documents to demonstrate that infection prevention policies and procedures were reassessed at least annually.

iii. No staff member who was trained in infection prevention was assigned the responsibility for coordinating the program.

iv. The Maple Lawn Practice did not have supplies, such as disposable laboratory jackets, proper protective eyewear, or hi-quality utility gloves, necessary to adhere to Standard Precautions.

v. The Board Inspector did not observe any precaution posters at the Maple Lawn Practice. There were no signs at the entrance instructing patients on how to prevent spread of respiratory secretions. There were no masks available to patients with potential respiratory issues.

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 failed to provide documents to demonstrate: having an exposure control plan tailored to the specific requirements of the Maple Lawn Practice; training relevant staff members on the OSHA Blood Pathogen Standards; having available current CDC recommendations for immunization, evaluation and follow-up; having available Hepatitis B vaccination to relevant staff members; having available post-vaccination screening for Hepatitis B; having offered annual influenza vaccination to staff members; staff members receiving baseline tuberculosis screening; maintaining a log of needle-sticks and sharps injuries; having in place referral arrangements to qualified health care professionals for provision of preventive, medical and post-exposure management services; having post-exposure evaluation and follow-up subsequent to occupational exposure event; and maintain policies on contact between personnel having potentially transmissible conditions with patients.

d. **Program Evaluation** – The Respondent failed to provide documents to demonstrate: having available written policies and procedures for routine monitoring and evaluation of infection prevention and control program; and adhering with certain practices

such as immunizations, hand hygiene, sterilization monitoring, and proper use of personal protective equipment.

e. **Hand Hygiene** – The Respondent failed to provide documents to demonstrate that staff members were trained regarding appropriate indications for hand hygiene.

f. **Personal Protective Equipment (PPE)** – The Respondent failed to provide documents to demonstrate that staff members were trained on proper selection and use of PPE.

g. **Respiratory Hygiene/Cough Etiquette** – The Respondent failed to provide documents to demonstrate: having policies and procedures to contain respiratory secretions in people who have signs and symptoms of a respiratory infection; and staff members having received training on the importance of containing respiratory secretions.

    i. The Board Inspector did not observe any precaution posters at the Maple Lawn Practice. There were no signs at the entrance instructing patients on how to prevent spread of respiratory secretions. There were no masks available to patients with potential respiratory issues

h. **Sharps Safety** – The Respondent failed to provide documents to demonstrate: having available written policies, procedures and guidelines for exposure prevention and post-exposure management;

having staff member(s) identify, evaluate and select devices with engineered safety features at least annually.

i. **Safe Injection Practices** – The Respondent failed to provide documents to demonstrate having available written policies, procedures, and guidelines for safe injection practices.

j. **Sterilization and Disinfection of Patient-Care Items and Devices** – The Respondent failed to provide documents to demonstrate: having available written policies and procedures to ensure reusable instruments were cleaned and reprocessed appropriately; having available policies, procedures and manufacturer reprocessing instructions for reusable instruments; having appropriately trained staff member(s) responsible for reprocessing reusable instruments upon hire and at least annually; having available training and equipment to ensure proper use of PPE; performing and documenting routine maintenance for sterilization equipment; and having in place policies and procedures outlining dental setting response in the event of a reprocessing error or failure.

   i. For the autoclave, the Respondent maintained a rudimentary log sheet that was incomplete and prefilled. According to the log, spore testing was not done at least weekly.

ii. The Board Inspector observed processed sterilization pouches that were not dated and labeled as to which autoclave was used for the sterilization.

iii. The Board Inspector observed that the eyewash station was located at the sink where dirty instruments were washed.

k. **Environmental Infection Prevention and Control** – The Respondent failed to provide documents to demonstrate: having available written policies and procedures for routine cleaning and disinfection of environmental surfaces; staff members who perform environmental infection prevention procedures received job-specific training about infection prevention and control management upon hire and at least annually; having available training and equipment to staff members to ensure proper use of PPE; periodic monitoring and evaluation of cleaning, disinfection and use of surface barriers; and having in place procedures for decontamination of spills of blood or other body fluids.

l. **Dental Unit Water Quality** – The Respondent failed to provide documents to demonstrate: having in place policies and procedures for maintain dental unit water quality that met Environmental Protection Agency standards; having policies and procedures in place for using sterile water as coolant /irrigant when performing

surgical procedures; and having available written policies and procedures outlining response to a community boil-water advisory.

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

m. **Performance of Hand Hygiene** – The Board inspector observed the Respondent and/or other staff members failing to consistently perform hand hygiene before and after treating patients, before putting on gloves and after removing gloves. The Board Inspector further noted that he did not see a posting of hand hygiene protocol poster at the Maple Lawn Practice.

n. **Use of Personal Protective Equipment (PPE)** – The Board Inspector observed the Respondent and/or other staff members: not removing PPE before leaving work area; failing to perform hand hygiene after removing PPE; failing to change masks between patients; failing to wear mask during processing and sterilization of instruments; not having eye-shields on PPE; failing to wear puncture and chemical resistant utility gloves during cleaning; and failing to change visibly soiled protective clothing in between patients and after processing instruments.

o. **Respiratory Hygiene/Cough Etiquette** – The Board Inspector found that the Respondent failed to: post "Cover Your Cough" poster at the entrance; have available masks for symptomatic

persons; and have available segregated area for symptomatic persons.

p. **Sharps Safety** – The Board Inspector observed the Respondent and/or other staff members failing to consistently use engineering controls and work place controls for sharps to prevent injuries. The Board Inspector observed two sharps containers, one in the operatory and one in the processing area, that were difficult to access. The Board Inspector requested the Respondent and other staff members for documents demonstrating that sharps containers were properly disposed, but they were unable to provide such documents.

q. **Safe Injection Practices** – Based on the Board Inspector's observations, the Respondent and other staff members complied with CDC Guidelines on Safe Injection Practices.

r. **Sterilization and Disinfection of Patient-Care Items and Devices** – The Respondent failed to properly sterilize and disinfect patient-care items and devices or failed to ensure such actions were taken for reasons including:

i. The Board Inspector observed multiple patient-care items and devices, such as burs, bur blocks, XCP equipment and other instruments, that could not be verified as being properly sterilized.

ii. Staff members retrieved sterile packs for patient use despite the external indicators not having changed to the proper dark shade.

iii. The Board Inspector noticed that regular water was used for sterilization instead of distilled water.

iv. The instrument processing workflow pattern did not follow high contamination area to clean/sterile area.

v. The Board Inspector could not verify the type of solution used in the ultrasonic cleaner and how often the solution was changed.

vi. The Board Inspector further noticed that the sterile packs failed to contain labels indicating the sterilizer used, the cycle or load number, the date of sterilization, and when applicable, the expiration date.

vii. The Board Inspector noted that a folder labeled Spore Test Result was empty. A log near the autoclaves was prefilled and contain varying dates ranging from a week apart to a month apart. The Respondent, other staff members and the DSO corporate representatives were unable to provide documents to support that spore testing was performed at least weekly.

viii. The Board Inspector observed dental hand-pieces attached to lines in operatories that were not in use. These hand-pieces should be in sterile pouches if not in use.

s. **Environmental Infection Prevention and Control** – The Respondent failed to comply with CDC Guidelines on Environmental Infection Prevention and Control for reasons including:

i. The Board Inspector observed multiple examples of missing barrier protection on dental units, water lines, A/W syringes, HVE, SVE, connectors, computer keyboards/mouse and radiological exposure buttons. Non-sterile bib clips were on a bracket table along with sterile bags.

ii. The Board Inspector observed biohazardous waste cans placed next to regular waste cans. The Board Inspector found used examination gloves placed in the regular waste can.

iii. The Board Inspector was unable to verify that cleaners and disinfectants were used according manufacturer instructions.

iv. The Board Inspector was unable to find any large biohazardous waste boxes at the Maple Lawn Practice. The Respondent, other staff members and the DSO corporate representatives were unable to provide documents that

demonstrated proper pickup and disposal of biohazardous waste.

v. The Board Inspector observed clutter around every sink with patient education materials and instruments.

vi. The Board Inspector observed an uncovered portable oxygen/nitrous oxide cart covered in dust placed at a corner of the sterilization area.

t. **Dental Unit Water Quality** – The Respondent, other staff members and the DSO corporate representatives were unable to produce documents to demonstrate that waterline testing was ever performed. When asked, the Respondent, other staff members and the DSO corporate representatives were unable to confirm whether daily or weekly flushing of dental unit waterline was being performed.

13. Based on his observations and inspection, the Board Inspector determined that the Respondent's practice of dentistry at the Maple Lawn Practice under the current operating conditions posed a direct risk to the health of patients, employees and community at large.

14. As a result of the Board Inspector's findings, the Respondent proactively retained an infection control consultant to assist him with CDC policies and procedures. The Respondent's consultant has provided the Board with a favorable report of the Respondent's compliance with CDC Guidelines.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's failure to comply with CDC Guidelines in his practice of dentistry at the Maple Lawn Practice constitutes: behaving dishonorably or unprofessionally, or violating a professional code of ethics pertaining to the dentistry profession, in violation of Health Occ. § 4-315(a)(16); and except in an emergency life-threatening situation where it is not feasible or practicable, failing to comply with the Centers for Disease Control's guidelines on universal precautions, in violation of § 4-315(a)(28).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, by a majority of the Board considering this case:

ORDERED that the Board's *Order for Summary Suspension* of the Respondent's license to practice dentistry in the State of Maryland, issued on August 27, 2018, is hereby **TERMINATED**; and it is further

ORDERED that the Respondent is hereby **kEPRIMANDED,** and it is further

ORDERED that the Respondent is placed on **PROBATION** for a period of **TWO (2) YEARS**, subject to the following terms and conditions:

1. A Board-assigned inspector shall conduct an unannounced inspection within ten (10) business days of the date of this Consent Order in order to evaluate the Respondent and his staff regarding compliance with the Act and infection control guidelines. The Board-assigned inspector shall be provided with copies of the Board's file, the Consent Order, and any other documentation deemed relevant by the Board.

2. The Respondent shall provide to the Board-assigned inspector a schedule of his office's regular weekly hours of practice and promptly apprise the inspector of any changes.

3. During the probationary period, the Respondent shall be subject to quarterly unannounced onsite inspections by a Board-assigned inspector.

4. The Board-assigned inspector shall provide inspection reports to the Board within ten (10) business days of the date of each inspection and may consult the Board regarding the findings of the inspections.

5. The Respondent shall, at all times, practice dentistry in accordance with the Act, related regulations, and shall comply with CDC and Occupational Safety and Health Administration's ("OSHA") guidelines on infection control for dental healthcare settings.

6. Any non-compliance with the Maryland Dentistry Act, all related statutes and regulations, and CDC and OSHA guidelines shall constitute a violation of probation and of this Consent Order.

7. On or before the fifth day of each month, the Respondent shall provide to the Board a copy of his current patient appointment book for that month.

8. Within ninety (90) days, the Respondent shall pay a fine in the amount of **TWO THOUSAND FIVE-HUNDRED DOLLARS** ($2,500) by bank certified check or money order made payable to the Maryland Board of Dental Examiners.

9. Within three (3) months of the date of this Consent Order, the Respondent shall successfully complete the following Board-approved in-person courses: four (4) credit hour in infection control protocols and two (2) credit hour in professional ethics, neither of which may be applied toward his license renewal.

10. The Respondent may file a petition for early termination of his probation after one (1) year from the date of this Consent Order. After consideration of the petition, the Board, or a designated committee of the Board, may grant or deny such petition at its sole discretion.

AND IT IS FURTHER ORDERED that after the conclusion of the **TWO (2) YEAR** probationary period, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated, through an order of the Board, or a designated Board committee. The Board, or designated Board committee, may grant the termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints of similar nature; and it is further

ORDERED that if the Board has reason to believe that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be an evidentiary hearing before the Board. If there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before the Board; and it is further

ORDERED that after the appropriate hearing, if the Board determines that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice dentistry in Maryland. The Board may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent; and it is further

ORDERED that the Respondent shall at all times cooperate with the Board, any of its agents or employees, and with the Board-assigned inspector, in the monitoring,

supervision and investigation of the Respondent's compliance with the terms and conditions of this Consent Order

ORDERED that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Provisions §§ 4-101 *et seq.* (2014).

10/3/10
Date

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

CONSENT

I, Vikaskumar Patel, D.D.S., acknowledge that I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this

Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

7/19/18
Date

V. N. Patel
Vikaskumar Patel, D.D.S.
Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 19th day of September _____, 2018, before me, a Notary Public of the foregoing State and City/County personally appear Vikaskumar Patel, D.D.S., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notary seal.

Notary Public

My commission expires: 10/10/19