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| **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**[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 **VIKASKUMAR PATEL, D.D.S.** (the "Respondent"), License Number 15616, 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, and COMAR 10.44.07.22, finding a substantial likelihood that the Respondent poses a risk of harm to the public health, safety, or welfare.

## INVESTIGATIVE FINDINGS

The Board bases its action of the following findings: [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 2018-218 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 description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

## 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. The Respondent's license is current through June 30, 2020.

2. At all times relevant, the Respondent practiced general dentistry with another staff dentist ("Dentist A")[3] at a dental practice called Family Dental Care of Maple Lawn, located in Laurel, Maryland (the "Maple Lawn Practice"). 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.

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

[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.

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.

12. 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.

## 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 15616, 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 files a written request for a Show Cause Hearing but 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).

08/27/2018
Date

Arthur C. Lee, 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.).