IN THE MATTER OF	*	**BEFORE THE MARYLAND**
GREGORY C. FELTHOUSEN, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 10511	*	**Case Number: 2020-136**

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CONSENT ORDER

On May 21, 2020, the Maryland State Board of Dental Examiners (the "Board") summarily suspended the license of **GREGORY C. FELTHOUSEN, D.D.S.,** (the "Respondent"), License Number 10511, and charged him, under the Maryland Dentistry Act (the "Act"), codified at Md. Code Ann., Health Occ. ("Health Occ.") §§ 4-101 *et seq.* (2014 Repl. Vol. and 2019 Supp.).

Specifically, the Board charged the Respondent with violating the following provisions of the Act:

Health Occ. § 4-315. Denials, reprimands, probation, suspensions, and revocations – Grounds.

(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]

(30) 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 June 17, 2020, a Case Resolution Conference ("CRC") was held before a committee of the Board. Based on the CRC and subsequent negotiation, the Respondent agreed to enter into this Consent Order, which included 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 August 16, 1989, under License Number 10511. The Respondent's license is current through June 30, 2021.

2. At all times relevant, the Respondent was employed as a staff dentist by another licensed dentist ("Dentist A") who owned and operated a dental practice with locations in Easton and Salisbury (the "Salisbury Office"), Maryland. The Respondent practiced dentistry at the Salisbury Office, which he previously owned and sold to Dentist A in August 2019.

3. Soon after the Respondent sold his practice to Dentist A, he became concerned about Dentist A's apparent non-compliance with standards of care and the legal maintenance of patient records. He reported his concerns about the destruction of patient records to the Board on October 7, 2019.

4. Based on his concerns about maintenance of staff training on infection control, on November 14, 2019 Respondent and others from the staff attended a course on Practical Infection Control.

5. By November 27, 2019, the relationship with Dentist A had become sufficiently toxic that Respondent gave notice to Dentist A of termination of his professional services agreement, with request that he be allowed to finish care of patients currently underway. This request was met by letters from Dentist A's counsel on December 9, 2019 and December 31, 2019 refusing Respondent's attempted termination, threatening litigation and demanding withdrawal of Respondent's earlier report to the Board.

6. In early January, Respondent received a report from his staff that Dentist A had used single use materials on more than one patient. Respondent requested that the staff provide evidence to substantiate this report. At the same time, Respondent contacted his personal attorney, who wrote Dentist A's attorney in January 2020 about this issue.

7. In early February Respondent received the requested documentation of Dentist A's actions. He then confronted Dentist A's office manager and told him that a letter would be going to the Board about Dentist A's actions. Respondent and all of his former staff members were immediately terminated by Dentist A's office manager. Respondent then assisted his staff member in submitting a report of the actions to the Board.

II. COMPLAINT

8. On or about February 13, 2020, the Board received a complaint from a former employee (the "Complainant") at the Salisbury Office alleging, among other complaints, that Dentist A performed grafting procedures on multiple patients at different times using the same sterile bone and membrane grafting packet that was meant to be discarded after one-time use. The Complainant further alleged that Dentist A at times reused contaminated gloves during patient treatment.

9. Based on the complaint, the Board initiated an investigation of the Salisbury Office and its dental health care providers ("DHCP").

III. INFECTION CONTROL INSPECTION

10. Due to allegations of potential infection control issues at the Salisbury Office, on or about March 2, 2020, a Board-contracted infection control inspector (the "Board Inspector"), along with a Board investigator, visited the Salisbury Office and conducted an infection control inspection.

11. Present during the inspection were the following individuals: the Respondent, the office director (the "Office Director"), two dental hygienists, a dental radiation technologist/dental assistant, a dental assistant and a patient care coordinator. Dentist A was not present during the inspection.

12. As part of the inspection, the Board Inspector utilized the Centers for Disease Control and Prevention ("CDC")[1] Infection Prevention Checklist for Dental Settings.

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[1] 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 (the "CDC Guidelines") for

13. During the inspection, the Board Inspector was able to directly observe patient treatment by the DHCPs. He was complimentary of the Respondent's practices and told the Respondent he would make a good member of the Board. The Board investigator explained to the Respondent that they had been unable to conduct an inspection earlier because of staff shortages.

14. Based on the inspection, the Board Inspector made the following findings:

Section I: Policies and Practices

a. **Administrative Measures** – As a practicing dentist at the Salisbury Office, Dentist A failed to maintain on site any documented: written infection control policies and procedures specific to the Salisbury Office; annual reassessments of those policies and procedures; training on Infection Prevention/OSHA Bloodborne Pathogen; or utility gloves in the sterilization area. Dentist A maintained a partial system for early detection and management of potentially infectious persons at initial points of patient encounter. Dentist A posted precautions poster for patients and offered face masks for patients but failed to designate a separate area for patients with respiratory

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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 Bloodborne Pathogens (29 CFR 1910.1030). The only exception to this rule arises in an emergency which is life-threatening *and* where it is not feasible or practicable to comply with the guidelines.

symptoms and train staff on the importance of containing respiratory infection.

b. **Infection Prevention Education and Training** – As a practicing dentist at the Salisbury Office, Dentist A failed to ensure that a log of personnel training (upon hire, annually and new tasks or procedure) on infection prevention and bloodborne pathogens standards was maintained.

c. **Dental Health Care Personnel Safety** – Dentist A failed to maintain on site any documented: exposure control plan specific to the Salisbury Office; employee training on OSHA Bloodborne Pathogens Standard (upon hire and at least annually); current CDC recommendations and office-specific policies on immunization, evaluation and follow-up; availability of Hepatitis B vaccination; post-vaccination screening of Hepatitis B surface antibody; availability of annual influenza vaccination; baseline tuberculosis screening for all dental health care personnel; a log of needlesticks, sharps injuries and other exposure events; referral arrangements to qualified health care professionals; post-exposure evaluation and follow-up; or well-defined policies concerning contact of personnel with potentially transmittable conditions with patients.

d. **Program Evaluation** – Dentist A failed to maintain on site any documented policies and procedures on routine monitoring and

evaluation of infection prevention and control program, and adherence to certain practices such as immunization, hand hygiene, sterilization monitoring and proper use of Personal Protective Equipment.

e. **Hand Hygiene** – Dentist A failed to maintain on site any documented dental personnel training regarding appropriate indications for hand hygiene including handwashing, hand antisepsis and surgical hand antisepsis.

f. **Personal Protective Equipment (PPE)** – Dentist A failed to maintain documentation that dental personnel received training on proper selection and use of PPE.

g. **Respiratory Hygiene/Cough Etiquette** – As a practicing dentist at the Salisbury Office, Dentist A failed to maintain on site any documented policies/procedures and personnel training logs on containing respiratory secretion in people with signs and symptoms of respiratory infection. Dentist A also failed to make available hand sanitizer in the waiting area or provide separate space for persons with respiratory symptoms.

h. **Sharps Safety** – Dentist A failed to maintain on site any documented policies, procedures and guidelines for exposure prevention and post-exposure management. Dentist A failed to maintain documentation on identifying, evaluating and selecting devices with engineered

safety features at least annually or as they become available in the market.

i. **Safe Injection Practices** – Dentist A failed to maintain on site any documented policies, procedures and guidelines for safe-injection preparation and practices.

j. **Sterilization and Disinfection of Patient-Care Items and Devices** – Dentist A failed to maintain on site documentation, policies or procedures regarding: appropriate cleaning and processing of reusable instruments and devices; manufacturer's reprocessing instructions; upon hire and annual personnel training log on reprocessing of reusable instruments and devices; personnel training logs on appropriate use of PPE; maintenance logs on sterilization equipment; and responses in the event of a reprocessing error/failure. Dentist A had inconsistent information on spore testing.

k. **Environmental Infection Prevention and Control** – Dentist A failed to maintain on site any documented policies and procedures on: routine cleaning and disinfection of environmental surfaces; upon hire and annual personnel training about infection prevention and control management of clinical contact and housekeeping surfaces; personnel training logs on appropriate use of PPE; periodic monitoring and evaluations of use of surface barriers; and decontamination of spills or blood or other body fluid.

l. **Dental Unit Water Quality** – Dentist A failed to maintain on site any policies and procedures for: maintaining dental unit water quality; using sterile water as a coolant/irrigant when performing surgical procedures; and responding to a community boil-water advisory.

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

m. **Performance of Hand Hygiene** – Dentist A failed to ensure that DHCPs at the Salisbury Office consistently perform handwashing before putting on gloves and after removing gloves between treating patients.

n. **Use of Personal Protective Equipment (PPE)** – Dentist A failed to ensure that DHCPs at the Salisbury Office consistently perform handwashing before removing PPE. DHCPs also failed to remove PPE before leaving the sterilization/instrument processing area. Dentist A failed to have available utility gloves in the sterilization area.

o. **Respiratory Hygiene/Cough Etiquette** – Dentist A failed to make available face masks and separate waiting area for patients who may have respiratory symptoms.

p. **Sharps Safety** – Dentist A failed to place sharps containers in readily accessible areas of the operatories.

q. **Sterilization and Disinfection of Patient-Care Items and Devices** – Dentist A failed to: have available puncture and chemical resistant

utility gloves for manual cleaning; use a chemical indicator inside each sterilization package; label sterilization packages with sterilizer used, the cycle or load number, and the date of sterilization; and maintain logs for each sterilization cycle. Dentist A also failed to maintain consistent documentation on spore testing on site.

r. **Environmental Infection Prevention and Control** – Dentist A failed to consistently barrier-protect clinical contact surfaces such as radiologic exposure button, A/W syringes, HVE and SVE. Unopened sterile packs were placed on the same tray as used instruments. The Board Inspector also did not see an emergency medical kit, and the eye-wash station was not working properly. The medical waste box was placed at a poorly accessible area, and waste disposal manifest was poorly documented.

s. **Dental Unit Water Quality** – Dentist A failed to perform waterline testing and treatment to monitor dental water unit quality.

15. During the inspection, several staff members, including the Respondent, reported to the Board's investigator of having observed Dentist A transporting previously opened packages of membrane and grafting materials from his Easton Office to the Salisbury Office. They reported observing Dentist A using the membrane and grafting materials from the already opened packages on multiple patients at the Salisbury Office. Packages of membrane and grafting materials were meant for one-time use once the package is opened with the unused material discarded.

16. The Respondent offered to provide sworn testimony to the Board in support of the reports by himself and staff members and was told that would occur. He then wrote an additional report to the Board in April 2020 further documenting his concerns.

17. Based on the results of his inspection, the Board Inspector determined that the Salisbury Office was not in compliance with CDC Guidelines as set forth above, which posed a direct risk to patient safety.

18. Subsequent to the issuance of Charges, the Respondent informed the Board that he was not practicing dentistry and was uncertain whether he would practice dentistry in the future. The Respondent informed the Board that if he were to practice dentistry in the future, it would be in the form of teaching or consulting and would not be likely to entail any hands-on clinical treatment.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's continued employment in an office where Dentist A failed to comply with CDC Guidelines in his practice of dentistry at the Salisbury Office, violated § 4-315(a)(30), which prohibits, 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.

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 May 21, 2020, is **hereby TERMINATED** and his license is returned to active status; and it is further

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

ORDERED that the Respondent agrees to limit his practice to: (1) teaching and consulting, not to entail hands-on clinical treatment, except in an emergency, if encountered during teaching or consulting; (2) supervision of dental hygienist examinations, without clinical treatment; and (3) not being a manager, a proprietor, or a conductor of or an operator in any place in which a dental service or dental operation is performed intraorally; and it is further

ORDERED that the Respondent may petition the Board in the future to have the terms and conditions of this Consent Order terminated should he wish to resume clinical practice; 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).

8/05/2020
Date

Francis X. McLaughlin, Jr.
Executive Director
Maryland State Board of Dental Examiners

CONSENT

I, Gregory C. Felthousen, D.D.S., M.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 voluntarily and without reservation, after having an opportunity to consult with counsel, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

7/16/20
Date

Gregory C. Felthousen, D.D.S., M.S.
Gregory C. Felthousen, D.D.S., M.S.
The Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF WICOMICO

I HEREBY CERTIFY that on this 16TH day of JULY _____, 2020, before me, a Notary Public of the foregoing State and City/County personally appear Gregory C. Felthousen, D.D.S., M.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.

Joan Coleen Sheridan
Notary Public

JOAN COLEEN SHERIDAN NOTARY PUBLIC WICOMICO COUNTY, MD

My commission expires: 6/14/2024

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July 20, 2020

Francis X. McLaughlin, Jr.
Executive Director
Maryland State Board of Dental Examiners
Spring Grove Hospital Center
Benjamin Rush Building
55 Wade Avenue/Tulip Drive
Catonsville, MD 21228

Re: Gregory C. Felthousen, D.D.S.
License Number: 10511
Case Number: 2020-136

Dear Mr. McLaughlin:

Enclosed please find two original copies of the Consent Order approved by the Board in this matter. When they have been executed on behalf of the Board, please return an original to Dr. Felthousen and a copy to me.

When you return the executed Consent Order, please include Dr. Felthousen's license, which was surrendered to the Board in compliance with its previous Order of Summary Suspension.

Very truly yours,

M. Natalie McSherry

M. Natalie McSherry

MNM/mnm
cc: K.F. Michael Kao, AAG, via electronic mail
Grant Gerber, AAG, via electronic mail
Gregory Felthousen, D.D.S., via electronic mail