IN THE MATTER OF	*	BEFORE THE MARYLAND
BRYNNE A. REECE, D.D.S.	*	STATE BOARD OF
Respondent	*	DENTAL EXAMINERS
License Number: 15141	*	Case Number: 2019-141

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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 **BRYNNE A. REECE, D.D.S.** (the "Respondent"), License Number 15141, 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

The Board bases its action on the following findings: [1]

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 September 6, 2011, under License Number 15141. The Respondent's license is current through June 30, 2020.

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[1] 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.

2. At all times relevant, the Respondent was employed as a staff dentist at a dental office located in Bowie, Maryland (the "Dental Office").[2]

II. COMPLAINT

3. On or about April 22, 2019, the Board received a complaint referral from the Maryland Department of Labor ("DLLR"), Licensing and Regulation, Occupational Safety and Health. The referral was regarding a complaint filed with DLLR on June 12, 2018, by a staff member (the "Complainant") at the Dental Office alleging that the owner of the Dental Office ("Dentist A") failed to wash his hands between treating patients and allowed an assistant to treat patients without wearing personal protective equipment ("PPE").

4. Based on the complaint referral, the Board initiated an investigation of Dentist A, the Dental Office and its staff members.

III. INFECTION CONTROL INSPECTION

5. Due to allegations of unsanitary dental practice at the Dental Office, on or about April 26, 2019, a Board-contracted infection control expert (the "Board Inspector"), along with a Board investigator, visited the Dental Office and conducted an infection control inspection.

6. Present during the inspection were the Respondent, the office manager, two dental assistants and a receptionist. The owner, Dentist A, was not present.

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[2] 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.

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

8. During the inspection, the Board Inspector was able to directly observe patient treatment by the Respondent and the dental assistants.

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

Section I: Policies and Practices

a. **Administrative Measures** – The Dental Office had a Maryland Occupational Safety and Health ("MOSH") manual, but the manual failed to contain written infection control policies specific to the Dental Office. Moreover, the MOSH manual was not updated, not organized and missing certain documents. The Board's "We Take Precautions for You" poster was posted in the instrument processing room and not visible to patients.

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

c. **Dental Health Care Personnel Safety** – The Dental Office failed to maintain required documentation on specific personnel safety plans

and policies. Moreover, the Dental Office failed to maintain a Needle Stick Injury Log.

d. **Program Evaluation** – The Dental Office failed to maintain required documentation on specific program evaluations.

e. **Hand Hygiene** – The Dental Office failed to maintain required documentation on specific hand hygiene protocols. There was no posting of hand hygiene protocols in patient treatment areas.

f. **Personal Protective Equipment (PPE)** – The Dental Office failed to maintain required documentation on proper training for and use of PPE.

g. **Respiratory Hygiene/Cough Etiquette** – The Dental Office failed to maintain required documentation on specific respiratory hygiene policies and procedures for personnel and patients. The "Cover Your Cough" poster was not posted in patient waiting area.

h. **Sharps Safety** – The Dental Office failed to maintain required documentation on Policies and Practices for Sharps Safety.

i. **Safe Injection Practices** – The Dental Office failed to maintain documentation on Policies and Practices for Safe Injection Practices.

j. **Sterilization and Disinfection of Patient-Care Items and Devices** – The Dental Office failed to maintain required documentation on sterilization and disinfection process, such as specific protocols to

address instruments that failed spore testing. Moreover, processing area did not adhere to the "single loop" processing concept.

k. **Environmental Infection Prevention and Control** – The Dental Office failed to maintain required documentation on specific environmental infection prevention and control policies and procedures.

l. **Dental Unit Water Quality** – The Dental Office failed to maintain required documentation on specific dental unit water quality policies and procedures.

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

m. **Performance of Hand Hygiene** – The Board inspector observed the Respondent and/or her assistant failing to wash their hands or use hand sanitizer before and after gloving. The positioning of dental equipment compromised the ease of access to the sink in patient treatment area.

n. **Use of Personal Protective Equipment (PPE)** – The Board Inspector observed the Respondent and/or her assistant failing to wear masks and safety glasses in a correct manner. The Respondent and/or her assistant wore cloth lab jackets or short sleeve scrub shirts that they were required to launder themselves. The Board Inspector did not observe any sterile gloves being available for surgical procedures.

o. **Respiratory Hygiene/Cough Etiquette** – The Board Inspector did not observe posting of "Cover Your Cough" poster or tissues at the patient waiting area.

p. **Sharps Safety** – The Board Inspector found the Respondent and her assistant to be in compliance with sharps safety protocols.

q. **Safe Injection Practices** – The Board Inspector observed preloaded aspirating syringes placed on prepared instrument trays in preparation of patient treatment.

r. **Sterilization and Disinfection of Patient-Care Items and Devices** – The Board Inspector found the Respondent and/or her assistant failing to seal processed instruments in a consistent manner. She also found that processed instrument packaging failed to identify the date the instruments were processed, and which sterilizer was used. Endodontic files and rotary files were stored with open access in the static area of the treatment operatory.

s. **Environmental Infection Prevention and Control** – The Board Inspector found the Respondent and/or her assistant failing to change gloves and perform hand hygiene after transporting contaminated instruments. HVE/SVE, A/W handpieces were not protected with barriers.

t. **Dental Unit Water Quality** – The Board Inspector found that the dental handpieces were flushed, suction treatment and waterline treatment were performed after treatment.

12. Based on her observations and inspection, the Board Inspector determined that the Respondent, as a practicing dentist at the Dental Office, failed to comply with CDC Guidelines as set forth above, which 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's failure to comply with CDC Guidelines poses a risk of harm to the public health, safety and welfare, which imperatively requires the immediate suspension of her 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 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 15141, 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

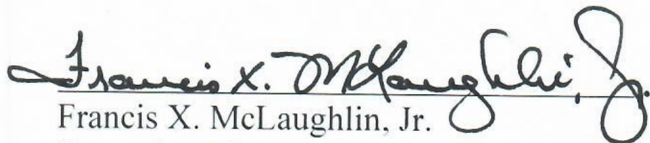
request, at which the Respondent will be given an opportunity to be heard as to why the Order for Summary Suspension should not continue; and it is further

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 her 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).

July 9, 2019
Date



Francis X. McLaughlin, Jr.
Executive Director
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.).