IN THE MATTER OF	*	BEFORE THE MARYLAND
DAVID LEWIS, D.D.S.	*	STATE BOARD OF
Respondent	*	DENTAL EXAMINERS
License Number: 6523	*	Case No.: 2015-163

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE DENTISTRY

The State Board of Dental Examiners (the "Board") hereby **SUMMARILY SUSPENDS** the license of **DAVID LEWIS, D.D.S.** (the "Respondent"), License Number **6523**, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under Md. Code Ann., State Gov't II § 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:[1]

A. Background

1. At all times relevant to this Order for Summary Suspension (the "Order"), the Respondent was licensed to practice dentistry in the State of Maryland. The

[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.

Respondent initially received his license to practice dentistry on December 16, 1977. The Respondent's current license expires on June 30, 2015.

2. At all times relevant to this Order, the Respondent operated a general dental practice in Rockville, Maryland. The Respondent is a solo practitioner who practices general dentistry and employs one or more dental assistants.

3. On March 19, 2015, the Board received a complaint from a patient who received treatment from the Respondent, hereinafter identified as "Patient A." Patient A alleged various health and safety concerns, including the following: the Respondent's office was unsanitary and unclean; had an unpleasant odor; dental instruments were not in autoclave bags; the Respondent dipped the mirrors in a blue liquid; the Respondent wore gloves, but between cleanings he washed his hands with the gloves on.

4. Upon review of the complaint, the Board initiated an investigation. On or about April 6, 2015, the Board assigned the case to an independent infection control expert (the "Board Expert") to conduct an inspection of the Respondent's dental office (the "office").

5. On or about April 7, 2015, the Board Expert conducted an unannounced inspection of the Respondent's office to determine whether the Respondent was in compliance with the Centers for Disease Control and Prevention ("CDC")[2] guidelines on universal precautions.

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[2] The CDC is a federal agency dedicated to designing protocols to prevent the spread of disease. The CDC has issued guidelines for 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 set forth more involved standards for infection control. Under the Maryland Dentistry Act, Md. Code Ann., Health Occ. I § 4-315(30), all dentists are required to comply with the CDC guidelines, which incorporate by reference the Occupational Safety and Health

6. The Board received an inspection report from the Board Expert on or about April 9, 2015, which noted numerous violations of the CDC guidelines. The report concluded that:

> the infection control practices in the facility do not meet expected standards. There is a question as to if any spore testing is conducted in the facility. The majority of patient care instruments in the facility are left open and unbagged in operatory drawers for patient use. Those items that are in sterilization bags are undated, lack internal indicators and do not identify which autoclave they were sterilized in.

7. A summary of the findings from the report is set forth *infra.*

B. Board Expert Report

8. On or about April 7, 2015, the Board Expert arrived at the Respondent's office in Rockville, Maryland for an unannounced, on-site inspection.

9. At the time of the inspection the Respondent and two support staff persons were present.

10. The Board Expert noted over 50 violations in his report that required further corrective action, including, but not limited to the following violations:

(a) Respondent was observed using a cloth towel to dry his washed hands rather than available disposable towels. Staff advised that the towels were laundered weekly;

(b) A defogger (blue liquid) was used on mirrors prior to usage. Staff advised that the defogger is changed daily in a common dish in each operatory;

(c) Mirrors are not kept in sterilization bags and are left open in operatory drawers for usage;

(d) The office is outdated, cluttered, and dirty;

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: 1) life-threatening; and (2) where it is not feasible or practicable to comply with the guidelines.

(e) Operatories are carpeted and have multiple pieces of machinery that appear to be broken, unused, and unclean;

(f) Multiple unsterilized instruments were left in operatory drawers including high speed and low speed hand pieces;

(g) Protection barriers were not used on dental care units and radiograph units;

(h) Office staff could not produce any written records of spore tests, biohazard removal, exposure control or infection control policies or procedures; and

(i) Board Expert observed multiple examples of plastic instruments being cold sterilized;

(j) Dental instruments were found in sterilization bags, lacked internal indicators and there were no notations as to which autoclave instruments were sterilized in; and

(k) There were shelves and drawers of expired products with evidence that the products and equipment had been out of use for quite some time

11. The Board Expert noted in his report that the observed infection control violations create a high risk for patient injury.

12. The Respondent's actions as described herein, is a violation of Md. Code Ann., Health Occ. I § 4-315 (30), which requires compliance with the CDC guidelines.

13. The Respondent's inability to follow the CDC guidelines on universal precautions poses an imminent risk of harm to the health, safety and welfare of the public, which imperatively requires the suspension of his license.

CONCLUSIONS OF LAW

Based on the foregoing investigative facts, the Board concludes that the Respondent constitutes a danger to the public and that the public health, safety or

welfare imperatively require emergency action in this case, pursuant to Md. Code Ann., State Gov't II § 10-226(c)(2) (2014 Repl. Vol.).

ORDER

Based on the foregoing findings, it is this 6th day of May, 2015, by a majority vote of a quorum of the State Board of Dental Examiners, by authority granted to the Board by Md. Code Ann., State Gov't II § 10-226(c)(2) (2014 Repl. Vol.), it is hereby:

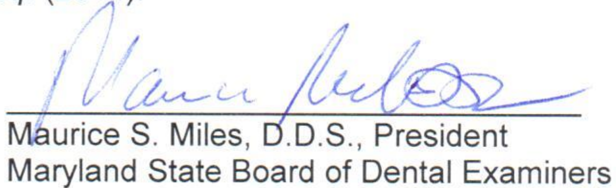
ORDERED that the Respondent's license to practice dentistry in the State of Maryland, under **License Number 6523**, is hereby **SUMMARILY SUSPENDED**; and it is further

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; and it is further

ORDERED that upon service of this Order for Summary Suspension, the Respondent shall immediately surrender to the Board all licenses to practice dentistry issued by the Board that are in his possession, including but not limited to the original license, renewal certificates and wallet size license; and it is further

ORDERED that this document constitutes a Final Order of the Board and is therefore a public document for purposes of public disclosure, as required by Md. Code Ann., General Provisions §§ 4-104 *et seq.* (2014).



Maurice S. Miles, D.D.S., President
Maryland State Board of Dental Examiners

NOTICE OF HEARING

A Show Cause Hearing will be held at the offices of the Maryland 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 Md. Code Ann., State Gov't II §§ 10-201 *et seq.*