IN THE MATTER OF	*	**BEFORE THE MARYLAND**
ARDEN BRONSTEIN D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 10602	*	**Case Number: 2013-228**

* * * * * * * * * * * * *

CONSENT ORDER

Procedural Background

On September 20, 2013, the Maryland State Board of Dental Examiners (the "Board") issued and served on **ARDEN BRONSTEIN, D.D.S** ("Respondent"), license number 10602, an Order for **SUMMARY SUSPENSION** of the Respondent's license to practice dentistry under Md. St. Gov't. Code Ann. § 10-226(c)(2)(2009 Repl. Vol.) The Board concluded that the public health, safety and welfare imperatively required emergency action based on the Respondent's violations of the Maryland Dentistry Act, Md. Health Occ. ("H.O.") Code Ann. § 4-315(a) as follows:

> (a) *License to practice dentistry.* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may deny a general license to practice dentistry...reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the ... licensee:
>
> (6) Practices dentistry in a professionally incompetent manner or in a grossly incompetent manner;
>
> (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 ["CDC"] guidelines on universal precautions...

On October 2, 2013 the Respondent appeared before a quorum of the Board to show cause why the Order for Summary Suspension should not be continued. Following presentation by both parties, the Board voted to uphold and continue the summary suspension of the Respondent's license. The Board scheduled a Case Resolution Conference Committee (the "CRC") for October 16, 2013 to provide the parties an opportunity to discuss a potential resolution of the Order for Summary Suspension. The Respondent voluntarily elected to waive the issuance of charges arising from the same circumstances. Following the CRC, the parties agreed to enter into this Consent Order as a means of resolving the Order for Summary Suspension and Charges.[1]

FINDINGS OF FACT

A. Background

1. At all times relevant to the Order for Summary Suspension (the "Order"), the Respondent was licensed to practice dentistry in the State of Maryland. The Respondent was initially licensed to practice dentistry in Maryland on or about September 20, 1990, under License Number 10602.

2. At all times relevant to this Order, the Respondent operated a solo, general dental practice in Hyattsville, Maryland. He employed one or more dental assistants.

[1] The Administrative Prosecutor and the Respondent, through counsel, have agreed that this Consent Order would obviate the need for filing Charges arising out of the same circumstances. This Consent Order does not affect or waive the Board's right to investigate allegations or file charges arising from a different complaint.

3. On or about May 21, 2013, the Board received a complaint from a former patient (the "Patient") alleging infection control violations, unprofessional conduct, harassment, intimidation, and deceptive billing practices.

4. In his complaint, the Patient expressed concerns about the Respondent's professional competence, demeanor and "unhygienic approach" to dentistry. Specifically, the Patient alleged that during his initial visit on December 21, 2012, the Respondent approached "[his] mouth with the same dirty gloves he used on another patient." When requested to remove his contaminated gloves, the Patient reported that the Respondent discarded his gloves and applied a small amount of hand sanitizer instead of washing his hands.

5. Following its review of the complaint, the Board initiated an investigation. On or about June 27, 2013, the Board retained an independent infection control expert ("the Board Expert") to conduct an inspection of the Respondent's dental office.

6. On August 1, 2013, the Board Expert conducted an unannounced onsite inspection of the Respondent's office to determine whether the Respondent was in compliance with the Maryland Dentistry Act (the "Act") and the Centers for Disease Control ("CDC")[2] guidelines on universal precautions. The Board expert found systemic and widespread CDC violations throughout the inspection. The Board Expert concluded that the "cleaning, disinfection, sterilization and infection control practices of [the Respondent's] office are unacceptable".

[2] 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 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 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 Blood borne 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.

B. Board Expert's opinions

7. A report of the Board Expert's findings was issued on August 2, 2013. The Board Expert noted that the Respondent's waiting room and reception area were tidy and reasonably well maintained and that his business office was well staffed and reasonably uncluttered.

8. The Respondent's office housed five (5) dental operatories, of which three (3) were used to treat patients. There was also a sterilization room, lunch room and a lavatory.

9. The Board expert found:

> [t]he equipment, while serviceable, appeared dirty and not well maintained. Upon inspecting the dental operatories and all clinical/sterilization areas as well as directly observing treatment being performed, I found that the complaints of . . . [the Patient] . . . were well founded. There were multiple and significant breaches in infection control identified in this inspection and patients treated in his office have been put at risk for transmission for infectious disease(s).
>
> * * *
>
> Based on the inspection of August 1, 2013 it is my opinion that it is unsafe for patients to undergo dental treatment in the office of Arden Bronstein D.D.S.

10. Among other things, the Board Expert concluded:

(a) The Respondent's office's Exposure Control Plan was incomplete and outdated, with the last documented update in 2003. The office manual that details proper infection prevention procedures was missing; nonetheless, the Respondent maintained continuing education certificates[3] verifying that he was fully aware and had been repeatedly instructed on the principles of infection control requirements;

[3] The Respondent provided documentation that he had successfully completed several infection control courses given by the Board Expert.

(b) Drawers and cabinets housing instruments, containers used to store expendables, and x-ray heads and bodies, all contained accumulated dust, dirt and debris, which evidenced a prolonged and "serious breach in infection control" and "significant risk of cross contamination";

(c) "[F]ilthy" Burs were stored in "dirty blocks" with visible fingerprints evidencing contaminated gloves/hands. "This is a clear indication [of] a lack of cleaning and sterilization" that poses a "significant risk of cross contamination" and "[r]euse of these burs is a threat to patient health and safety";

(d) The design of the sterilization area was substandard, leading to serious deficiencies in cleaning and sterilization. Dirty and clean instruments were in close proximity to one another. The ultrasonic cleaning device was available but instead of using it, the Respondent and his staff were observed hand washing contaminated instruments. "The assistant took the instruments into the sterilization area and scrubbed them by hand", left the instruments in the sink while she disposed of the expendables, disinfected the tray for future use, while using the same pair of gloves worn during the previous patient's treatment;

(e) Many instruments were housed in torn or open bags, some containing debris. None were labeled or dated. There was evidence that food was being consumed in the sterilization area;

(f) Each operatory contained unlabeled and uncapped syringes. This created an unacceptable risk of injury, cross contamination and inadvertent administration of unnecessary and improper medication. Upon direct observation of the Respondent's administration of a mandibular block in preparation for an extraction, the Respondent was observed re-capping a needle by hand, and repeatedly cross contaminating the patient's mouth and the hand control to the Respondent's dental chair. At no time during this observation did the Respondent or his staff ever change their gloves;

(g) Multiple working surfaces were dirty and littered with particles, dust, debris and unidentifiable spots that may have been blood or other splatter from previous patients. There was no visible evidence of surface disinfection in patient treatment areas. Although there was a small spray bottle of a surface disinfectant in the sterilization area, it was evident from the accumulation of debris and stains that no effective surface disinfection had been performed "for a considerable period of time";

(h) High, low and ultrasonic handpieces were affixed in each operatory with barriers attached, but the "barriers were more for show than function as they appeared well used and obviously not changed between patients". There were no replacement handpieces or covers on any of the dials or surfaces of the ultrasonic units. Ultrasonic tips were covered with sterilization bags, many of which were open, rendering the tips non-sterile;

(i) As the inspection proceeded, it became more and more apparent that the Respondent's office "fundamentally lacked standard operating procedures related to asepsis, infection control, and sterilization", and that the Respondent did "little or nothing to prevent cross-contamination.

C. Respondent's response to Board action

11. On or about August 5, 2013, Board staff formally requested that the Respondent provide a response to the Patient's complaint. The Respondent provided a written response, dated August 19, 2013. With respect to the infection control aspect of the Patient's complaint, the Respondent acknowledged that the Patient requested that he change his gloves prior to treatment. The Respondent stated that he had already washed his hands and had changed his gloves in a different operatory prior to entering the Patient's treatment room. When requested to change his gloves, he used hand sanitizer "because the last time I had used soap and I wanted to change the method of hand cleaning".

12. The Board's investigation revealed a pervasive and dangerous pattern of infection control violations which included the use of contaminated gloves. Based on the direct observations of the Board Expert, the Board found the Respondent's explanation that he had previously changed his gloves and washed his hands prior to entering the Patient's treatment room, not credible.

13. Following notice of the Order for Summary Suspension, the Respondent implemented safety and infection control protocols consistent with CDC guidelines. He further retained the services of an infection control consultant (the "Respondent's Expert") to conduct an inspection of the Respondent's offices. On September 25, 2013, the Respondent's Expert issued a report stating that at the time of the inspection (September 24, 2013), she found no violations of the Act or CDC guidelines. The Respondent's Expert noted that Respondent and his office staff had made corrections to infection control protocols and appeared to be invested in providing care that met or exceeded infection control standards.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that at the time of the issuance of the Order for Summary Suspension, the Respondent constituted an imminent threat to the public, and that the public health, safety or welfare imperatively required emergency action in this case, pursuant to Md. State Govt. Code Ann. § 10-226(c)(2)(2009 Repl. Vol.)

The Board further concludes as a matter of law that the Respondent, practiced dentistry in a professionally incompetent manner or in a grossly incompetent manner in violation of H.O. §4-315(a)(6); behaved dishonorably or unprofessionally, or violated a professional code of ethics pertaining to the dentistry profession, in violation of H.O. § 4-315(a)(16); and except in an emergency or life threatening situation where it is not feasible or practicable, failed to comply with Centers for Disease Control's guidelines on universal precautions in violation of H.O. § 4-315(a)(28).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 16th day of October 2013, by a majority of the quorum of the Board, hereby

ORDERED that upon the Board's receipt of documentation that the Respondent has formally retained the services of an independent Board approved CDC consultant and that the consultant has issued a favorable report substantiating that the Respondent and his office staff understand CDC and OSHA guidelines and are in full compliance, the Respondent may petition the Board for a **STAY** of the **Order of Summary Suspension** of the Respondent's license to practice dentistry issued on September 20, 2013 and continued on October 2, 2013, and it is further

ORDERED that upon the Board's **STAY** of the Order of Summary Suspension, the Respondent's license to practice dentistry is hereby **SUSPENDED** for a period of **TWO (2) YEARS, IMMEDIATELY STAYED**; and it is further

ORDERED that the Respondent shall be placed on **PROBATION** for a period of **THREE (3) YEARS** from the date of the Board's Order for Reinstatement under the following terms and conditions:

1. The Board-approved consultant shall be present for one (1) full day of patient care within seven (7) days after his license is reinstated to conduct an unannounced inspection, in order to evaluate the Respondent and his staff regarding compliance with the Act and infection control guidelines. If necessary, the consultant shall train the Respondent and his staff in the proper implementation of infection control protocols. The consultant shall be provided with copies of the Board file, this Consent Order, all prior inspections and any and all documentation deemed relevant by the Board.

2. On or before the fifth day of each month, the Respondent shall provide to the Board a listing of his regularly scheduled days and hours for patient care.

3. The Respondent shall be subject to monthly, unannounced onsite

inspections by the Board approved consultant, during the first six (6) months of his three (3) year probationary period. If there are no documented violations noted by the consultant during the initial six (6) month period of probation, the Respondent shall thereafter be subject to unannounced, quarterly onsite inspections for eighteen (18) months. If there are no documented violations noted by the consultant, the Respondent shall be subject to two (2) unannounced, onsite inspections during the third year of his probationary period.

4. The consultant or Board approved agent shall provide reports to the Board within ten (10) days of the date of each inspection and may consult with the Board regarding the findings of the inspections. A finding by the Board indicating that the Respondent or his practice is not in compliance with the CDC guidelines shall constitute a violation of this Order and may, in the Board's discretion, be grounds for summarily suspending the Respondent's license. In the event that the Respondent's license is suspended under this provision, he shall be afforded a Show Cause Hearing before the Board to show cause why his license should not be suspended.

5. In the Board's discretion, the Respondent may also be subject to random, unannounced inspections at any time during the probationary period. A finding by the Board indicating that the Respondent or his practice is not in compliance with the CDC guidelines shall constitute a violation of this Order and may, in the Board's discretion, be grounds for summarily suspending the Respondent's license. In the event that the Respondent's license is suspended under this provision, he shall be afforded a Show Cause Hearing before the Board to show cause why his license should not be suspended.

6. Respondent shall, at all times, practice dentistry in accordance with the Act and further comply with CDC guidelines, including Occupational Safety and Health Administration's ("OSHA") for dental healthcare settings.

7. At any time during the period of probation, if the Board makes a finding that Respondent is not in compliance with CDC and OSHA guidelines or the Act, the Respondent shall have the opportunity to correct the infractions within seven (7) days and shall be subject to a repeat inspection within seven (7) days.

AND IT IS FURTHER ORDERED that the Respondent shall complete all continuing education requirements for renewal of his license, including but not limited to infection control requirements. No part of the training or education that the Respondent

receives in order to comply with this Consent Order shall be applied to his required continuing education credits, and it is further

ORDERED that the Respondent shall at all times cooperate with the Board, any of its agents or employees, and with his consultant, in the monitoring, supervision and investigation of the Respondent's compliance with the terms and conditions of this Consent Order, and it is further

ORDERED that the Respondent shall be responsible for all costs incurred under this Consent Order; and it is further

ORDERED that after a minimum of three (3) years from the effective date of reinstatement of his license, the Respondent may submit a written petition to the Board requesting termination of probation without conditions or restrictions whatsoever. After consideration of the petition, the probation may be terminated through an order of the Board. The Board shall grant termination if Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending investigations or outstanding complaints related to the charges; and be it further

ORDERED that if Respondent violates any of the terms or conditions of this Consent Order, the Board, in its discretion, after notice and an opportunity for a show cause hearing before the Board, or opportunity for an evidentiary hearing before an Administrative Law Judge at the Office of Administrative Hearings if there is a genuine dispute as to the underlying material facts, may impose any sanction which the Board may have imposed in this case under §§ 4-315 and 4-317 of the Dental Practice Act, including an additional probationary term and conditions of probation, reprimand, suspension, revocation and/or a monetary penalty, said violation of probation being

circumstances. I waive any right to contest the Findings of Fact and Conclusions of Law and I waive my right to a full evidentiary hearing, as set forth above, and any right to appeal this Consent Order or any adverse ruling of the Board that might have followed any such hearing.

I sign this Consent Order voluntarily, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

10/16/13
Date

Arden Bronstein
Arden Bronstein, D.D.S.
Respondent

Read and approved:

Anne Marie McGinley
Anne Marie McGinley, Esquire
Attorney for the Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF BALTIMORE

I HEREBY CERTIFY that on this 16 day of October, 2013 before me, a Notary Public of the State and County aforesaid, personally appeared before me Arden Bronstein, D.D.S. License Number 10602, and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Sandra A Sage
Notary Public

My commission expires: 10/10/15

proved by a preponderance of the evidence; and be it further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-601 *et seq.* (2009 Repl. Vol.)

10/16/17
Date

Ngoc Q. Chu, D.D.S.
President
Maryland State Board of Dental Examiners

CONSENT

I, Arden Bronstein D.D.S., License No. 10602, by affixing my signature hereto, acknowledge that I have consulted with counsel, Anne Marie McGinley, Esquire, and knowingly and voluntarily elected to enter 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 am aware that I am entitled to a formal evidentiary hearing, pursuant to Md. Health Occ. Code Ann. § 4-318 (2009 Repl. Vol. & 2013 Supp.) and Md. State Gov't Code Ann §§ 10-201 *et seq.* (2009 Repl. Vol. & 2013 Supp.).

I accept the validity and enforceability of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have 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 as provided by law. I am waiving those procedural and substantive protections.

I voluntarily enter into and agree to abide by the terms and conditions set forth herein as a resolution of the Order of Summary Suspension issued against me. I further agree that I waive my right to have Charges filed against me arising from the same