IN THE MATTER OF	*	**BEFORE THE MARYLAND**
FREDRICK D. CLARK, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 10125	*	**Case No.: 2014-272**

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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 **FREDRICK D. CLARK, D.D.S.** (the "Respondent"), License Number **10125**, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under Md. Code Ann., State Gov't § 10-226(c) (2009 Repl. Vol. & 2013 Supp.), concluding 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 Respondent initially received his license to practice dentistry on December 16, 1987.

[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 to this Order, the Respondent operated a general dental practice in Oxon Hill, Maryland. The Respondent is a solo practitioner who practices general dentistry and employs one or more dental assistants.

3. On June 11, 2014, the Board received a complaint alleging various health and safety concerns. Among other things, the complaint alleged unsanitary office conditions and asserted that the Respondent "falls asleep while trying to complete a procedure."

4. Upon review of the complaint, the Board initiated an investigation. On June 11, 2014, the Board retained an independent infection control expert (the "Board Expert") to conduct an inspection of the Respondent's dental office (the "office"). Two inspections were conducted on separate dates.

5. On June 16, 2014, 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. However, the Respondent was not present and the Board Expert was able to complete only a limited inspection under constrained conditions.

6. The Board Expert issued a report on June 17, 2014, which noted nineteen (19) separate violations of the CDC guidelines. The report concluded that "[c]ontaminated instruments and supplies were noted throughout the office" and

[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. § 4-315(28), all dentists are required to comply with the CDC guidelines, which incorporate by reference the 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: 1) life-threatening; and (2) where it is not feasible or practicable to comply with the guidelines.

recommended a follow-up inspection "to determine the level of compliance with other CDC, OSHA, EPA and MSBDE recommendations and regulations."

7. On June 23, 2014, the Board Expert conducted a second inspection, at which time she noted twenty-seven (27) violations. The Board Expert, who was accompanied by an investigator from the Board (the "Board Investigator"), performed the inspection in the Respondent's presence.

8. A summary of the findings from both reports is set forth *infra*.

B. Investigative Findings

9. At approximately 9:00 a.m. on June 16, 2014, the Board Expert arrived at the Respondent's office for an unannounced, on-site inspection.

10. The Respondent was not present at the office, but the office manager was working at the front desk. When the Board Expert explained the reason for the visit, the office manager contacted the Respondent via telephone and alerted him to the Board Expert's presence.

11. The Board Expert then spoke with the Respondent over the telephone, and he reluctantly agreed to allow the inspection. The Board Expert then handed the telephone back to the office manager, who proceeded to have a hushed conversation with the Respondent while still keeping the Board Expert in the waiting room.

12. Shortly after the office manager ended the telephone call with the Respondent, she quickly went back to the clinical area, still without granting the Board Expert access for the inspection, and after a short period of time, returned to the front desk. The office manager then informed the Board Expert that she had been instructed to prohibit the inspection in the Respondent's absence.

13. The Board Expert then explained that she would be required to notify the Board that she had not been granted access to perform the inspection, after which the office manager permitted the inspection to commence.

14. The Respondent's office housed five (5) operatories, one (1) dental laboratory ("lab"), one (1) lounge area, one (1) waiting room, and one (1) personal office space.

15. The Board Expert noted nineteen (19) separate violations in her report. Among other things, the Board Expert concluded the following:

(a) Neither surface disinfectant nor hand sanitizer were present in the lab; the sink and countertops in the lab were covered with dental plaster; two pieces of lab equipment were found on the floor; and the sink in the sterilization area of the lab contained contaminated rubber bowls, impression trays, glass slabs, and spatulas;

(b) The office contained expired medications and dental supplies, including Formo Cresol[3] (expiration date of December 20, 2010) and temporary dental cement (expiration year of 2011);

(c) General safety concerns existed throughout the office, including an expired fire extinguisher (expiration date of October 14, 2008), a lack of posted exit plans, and a lack of safety covers on the electrical outlets;

(d) Contaminated gloves, x-ray covers, patient bibs, and cotton rolls were noted in the regular trash;

(e) Non-sterilized equipment and supplies were found throughout the office, including:

i. A collection of dental burs[4] laying in the bottom of a plastic container;

ii. Dental burs, dentures, and miscellaneous items mounted on a bur block[5] with cement and dental material clearly evident;

[3] A compound consisting of formaldehyde, cresol, glycerin, and water used in the removal of tissues inside of the tooth and during root canal therapy.
[4] A type of cutter used in a handpiece for cutting hard tissue such as tooth or bone.

iii. A bur block that was not contained within a closed bag indicating sterility;

iv. Several burs crusted with dental material;

v. Several syringes with composite material with the tips still attached;

vi. A dental handpiece on a tray with no evidence of sterility;

vii. Heat sterilizable air/water syringe tips that lacked barriers on the handles and did not show evidence of sterility;

viii. Gross contamination and crusted material on an air/water syringe tip and handle;

ix. Contaminated instruments and supplies lying in the sink and on countertops in the sterilization area;

(f) Sharps containers were noted on the floor and accessible to children without any evidence of a sharps security system;

(g) Unlabeled chemicals were noted in most clinical areas.

16. The Board Expert noted that the Respondent's office manager abruptly ended the inspection by saying she had to lock up the office and leave.

17. The Board Expert recommended a follow-up inspection to determine the level of compliance with other CDC, OSHA, EPA, and MSBDE recommendations and guidelines.

18. On June 23, 2014, the Board Expert returned to the office for a second unannounced inspection. The Board Expert, who was accompanied by the Board Investigator, performed the inspection in the Respondent's presence.

19. During the inspection, the Board Expert noted a total of twenty-seven (27) violations. In addition to the violations noted from the previous inspection, the Board Expert noted the following:

[5] A cube-shaped block with holes in it of varying sizes, designed to store various-sized burs.

(a) The Respondent failed to wear protective eyewear when treating patients;

(b) The Respondent failed to wear a mask when treating patients and also wore the same mask when treating different patients;

(c) The Respondent failed to close his lab coat when treating patients;

(d) The dental assistant failed to wear a lab coat, protective eyewear, or a mask;

(e) Patients were not offered protective eyewear;

(f) The dental chairs were in extremely poor condition, split, punctured, and cracked, with the lining material protruding;

(g) Water stains, rust stains, dirt, and other soil was noted on clinical floors;

(h) In one operatory, a sterilizer bag containing a dental handpiece was found torn open (i.e. no longer sterilized);

(i) The Respondent admitted that spore testing for sterilizers had been conducted monthly and not weekly as required by CDC guidelines;

(j) The office contained expired Oraqix[6] (expiration month of May, 2012) and expired Fluoride[7] (expiration year of 2008);

(k) The biohazard box in the sterilization area was overflowing with waste materials.

20. On July 14, 2014, the Respondent sent an e-mail to the Board Investigator wherein he provided a host of "personal and real life issues" that "influenced [his] ability to be focused on the many numerous requirements of compliance." The Respondent included a litany of examples, including several health-related issues. He further stated that the Board's investigation presented a "huge obstacle to [his]...mental well-being and simple survival."

[6] An anesthetic gel that is applied to the treatment site without the use of a needle and anesthetizes the site within approximately 30 seconds.
[7] Fluoride treatment involves application of Fluoride to the teeth in the form a gel, foam or varnish, with the intention of preventing tooth decay and cavities.

21. On July 16, 2014, the Respondent sent a second e-mail to the Board Investigator wherein he provided additional reasons for his inability to "remain in compliance with federal HIPPA, CDC, or State Infection Control regulations, and loss of malpractice insurance." The Respondent stated that "...at this point I am nearly unable to continue to practice due to the destruction of my business...."

22. The Respondent's continued inability to follow the CDC guidelines on universal precautions, particularly after having been notified via telephone of the Board Expert's investigation and inspection on June 16, 2014, 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. State Gov't Code Ann. § 10-226(c)(2) (2009 Repl. Vol. & 2013 Supp.).

ORDER

Based on the foregoing findings, it is this 11th day of August, 2014, 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 § 10-226(c)(2) (2009 Repl. Vol. & 2013 Supp.), it is hereby:

ORDERED that the Respondent's license to practice dentistry in the State of Maryland, under License Number 10125, 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., State Gov't § 10-617(h)(2)(vi) (2009 Repl. Vol. & 2013 Supp.).

Maurice Miles DDS

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 requeState The Board shall conduct an evidentiary hearing under the contested case provisions of Md. Code Ann., State Gov't §§ 10-210 *et seq.*