IN THE MATTER OF	*	**BEFORE THE**
MAURY J. FECHTER, D.D.S.	*	**STATE BOARD OF**
RESPONDENT	*	**DENTAL EXAMINERS**
License Number: 5494	*	**Case Number: 2013-126**

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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 **MAURY J. FECHTER D.D.S.** (the "Respondent"), License Number **5494**, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under Md. St. Gov't Code Ann. § 10-226(c)(2009 Repl. Vol.), concluding that the public health, safety and welfare imperatively require 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 the Board, including the circumstances 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 was initially licensed to practice dentistry in Maryland on or about September 7, 1973 under License Number 5494. The Respondent was previously licensed to practice

[1] The statements describing the Respondent's conduct are intended to provide the Respondent with notice of the basis of the summary 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.

dentistry in the New Jersey but allowed that license to expire on or about October 31, 1977. He was also licensed to practice dentistry in Delaware but allowed that license to expire on or about June 30, 1976.

2. At all times relevant to this Order, the Respondent operated as a solo practitioner, practicing general dentistry at three (3) private practice locations in the greater Baltimore, Maryland area.

3. On or about March 1, 2013, the Board received a complaint from the parent ("the Complainant") whose son had been a former patient of the Respondent from August 2, 2006 - January 25, 2013.

4. The Complainant alleged that prior to his last visit on January 25, 2013, her son had always been treated at the Respondent's Glenmore, Maryland office ("Office A"). On the visit in question, the Complainant was asked to bring her son to the Baltimore office ("Office B").

5. Upon arrival, the Complainant observed that Office B had no central heating, was "unkempt" and "very dirty". During her son's routine prophylaxis and evaluation of mouth sores, the Complainant was "shocked by the condition of not only the office but also the exam room". She "couldn't believe her eyes" and expressed concern in her complaint that the instruments used in her son's mouth were not sterile.

6. Following its review of the complaint, the Board initiated an investigation. As part of its investigation, on or about April 12, 2013, the Board retained an independent infection control expert ("the Board Expert") to conduct an inspection of Office B.

7. On June 28, 2013, the Board Expert conducted an unannounced on-site inspection of Office B to determine whether the Respondent was in compliance with the

Maryland Dentistry Act (the "Act") and the Centers for Disease Control ("CDC")[2] guidelines for infection control in dental health-care settings. The Board Expert's evaluation and analysis was based on direct observations of patient treatment and instrument preparation, as well as discussions with the Respondent, his dental assistant(s) and receptionist.

8. The Board Expert issued a report on August 27, 2013, concluding that the general condition of Office B was dirty and unsanitary and that there was no evidence of routine sanitation. The Board Expert found twenty-eight (28) distinct violations of CDC guidelines for infection control.

9. On or about October 8, 2013, the Respondent notified the Board that he had closed Office B because someone "had stolen his air conditioning unit". He also stated that as a result of the theft, he was contemplating selling Office B.

10. The Board's investigation revealed that the Respondent maintained two other locations in the greater Baltimore area. In early November 2013, the Board requested that the Board Expert conduct inspections of the Respondent's other locations, Offices A and C.

11. On November 12, 2013 the Board Expert conducted an unannounced on-site inspection of Office C ("Perry Hall") to determine whether the Respondent was in compliance with the Act and CDC guidelines for infection control in dental health-care settings. The Board Expert's evaluation and analysis was based on direct observations of patient treatment and instrument preparation as well as discussions with the Respondent, his dental assistant(s) and receptionist.

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[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.

12. On November 14, 2013 the Board Expert conducted an unannounced, on-site inspection of Office A to determine whether the Respondent was in compliance with the Act and CDC guidelines for infection control in dental health-care settings. The Board Expert's evaluation and analysis was based on direct observations of patient treatment and instrument preparation as well as discussions with the Respondent, his dental assistant(s) and receptionist.

13. In her report issued on November 16, 2013 pertaining to Office A, the Board Expert concluded that the Respondent's ongoing accumulation of damaged dental equipment, use of unsterile instruments and absence of regular janitorial services resulted in a failure to maintain "a basic clean and sanitary facility in which to provide health services". She further concluded that the Respondent failed to implement and apply infection control protocols (mandated since 1994), resulting in serious risk to the health and safety of his patients and employees. A detailed summary of the Board Expert's findings regarding Office A is set forth *infra*.

14. In her report issued on November 19, 2013 pertaining to Office C, the Board Expert concluded that multiple, serious violations were directly observed and identified. Again, the Respondent failed to maintain "a basic clean and sanitary facility in which to provide health services". Further, the Board Expert noted that basic concepts of infection control protocols..."mandated for two (2) decades... are not applied in this facility". A detailed summary of the Board Expert's findings regarding Office C is set forth *infra*.

B. Reports of Board Expert

Office A

15. The Board Expert found that the general office condition was dirty and unsanitary with layers of accumulated dust, dirt and debris. There was no evidence of

routine environmental sanitation. In addition, the countertops of Respondent's three (3) treatment rooms, his dental lab and his sterilization room were all cluttered with unnecessary equipment, supplies and used instruments, preventing access to surfaces requiring routine disinfection.

16. The Board expert evaluated the Respondent's Heath and Safety Program. The Respondent was unable to produce necessary and required documentation of his Exposure Control Plan, employee training records, Hepatitis B vaccination records and post exposure forms. Despite his assurance to the Board Expert during her November 12, 2013 inspection of Office C, that all Health and Safety Program records for the entire practice were housed and available at Office A, the Respondent failed to provide written records, for annual safety evaluation, employee training records for the preceding three (3) years, or Hepatitis B vaccination records for himself and his staff.

17. The Respondent was observed handling paper products, charts and storage drawers while wearing contaminated gloves. These materials cannot be de-contaminated nor was any attempt made to employ disinfection techniques following his handling.

18. Although he was observed treating multiple patients, some of whose procedures produced blood and fluid splatter, the Respondent did not wash his hands "even once during the entire evaluation despite donning and removing treatment gloves multiple times."

19. Available utility gloves were torn and unusable.

20. The Respondent did not wear eye protection during treatment nor did he offer it to patients or employees.

21. The Respondent wore a mask hanging from one (1) ear and required prompting to place and remove the mask as appropriate.

22. The design of the sterilization area was substandard, leading to serious deficiencies in cleaning and sterilization. The sterilization area lacked a distinct and well-organized "clean" and "dirty" separation. Required sterilization of critical and semi-critical instruments including hand instruments, dental handpieces, endodontic files/reamers and burs, could not be verified.

23. The Board Expert observed handpieces and disposable tips for air/water syringes left in place on a dental unit bracket tray. The disposable tips were reused. Applicator tips were left on resin and syringes. Contaminated tips were used on multiple patients.

24. Office spore testing was not adequately or properly performed to verify efficacy of the autoclave. Hand written records provided for a limited time frame were incomplete and questionable as they were contradicted by controlled, objective testing obtained in October 2013 from a certified testing agency.

25. There was no routine maintenance or treatment of the dental unit waterlines thereby exposing every patient to potential biofilm contamination.

26. Food and dental supplies were improperly stored in a refrigerator that was housed in the sterilization room.

27. Numerous dental supplies including anesthetic needles and medications were expired. Expiration dates ranged from 2005-2013.

28. Birex surface disinfectant in an undated spray bottle, was allegedly used to disinfect surfaces. Once activated, Birex has a maximum shelf life of 14 days.

29. Office A lacked the requisite waste removal documentation evidencing certified, routine waste removal during the preceding three (3) years. Medical waste containers were overfilled and located in areas exposed to patients. The Board Expert

observed a sealed box of medical waste with visible evidence of water damage, thereby suggesting that timely disposal had not occurred.

30. Red sharps containers were overfilled with used needles and other sharps, beyond the fill line. Intact puncture resistant containers must be closed and sealed once the contents reach the visible fill line to avoid injuries and/or cross contamination to patients or employees.

31. The Respondent was unable to readily locate his CPR resuscitator mask. If necessary, neither the Respondent nor his staff had the ability to perform CPR without the risk of disease transmission.

32. Emergency medical supplies were not available and there was no designated eyewash station in the event of an eye injury or exposure incident.

33. Dental equipment was in a state of disrepair. Among other things, Operatory #3 had a broken cuspidor and water dispenser that leaked water onto the floor. Further, the dental unit in Operatory #2 had barrier shields used as a make-shift patch. Multiple safety hazards were also noted.

34. The Board's investigation revealed that a portion of the Respondent's office was sub-let to a tenant allegedly operating a massage therapy business. The Board Expert noted that the Respondent "seemed unconcerned that the arrangement allowed access to his office space including patient records." Confidentiality of dental records was potentially compromised through the Respondent's failure to preserve the privacy of his patient's health care information.

Office C

35. The Board Expert observed that the general condition of Office C was dirty and unsanitary. Carpeting used in the clinical areas including operatories/treatment rooms,

precluded routine cleaning and disinfection following splatter of blood and/or saliva. Countertops of the dental lab, treatment rooms and sterilization area were covered with dirt, debris, equipment, supplies and used instruments. Thorough infection control, disinfection and sanitation were seriously compromised.

36. The Board Expert noted during her inspection of Office C that the autoclave sat precariously on a sagging, damaged countertop, with exposed particleboard partially covered with duct tape. Dirt, debris, loose instruments and dental materials had been placed on top of and on either side of the autoclave. The poorly supported countertop combined with the exposed spongy surface enhanced the risk of potential disease transmission from organism absorption. There was also a risk of potential collapse and damage to the autoclave.

37. The Board Expert further found that the dental units in Operatory # 1 and 3 were in disrepair. She observed treatment supplies falling from the brackets onto the floor. The Respondent retrieved the supplies from the contaminated floor and returned them to patient care. Bloodstains were observed on the bracket tray and support arms of the dental unit in Operatory #1.

38. The Board Expert observed in her inspection of Office C, identical or substantially similar violations of the Act and CDC guidelines as found during her inspection of Office A. With respect to Office C, Investigative Findings, Para. #s 16-32, *supra,* are incorporated herein by reference.

39. In addition to the Investigative Finding Para. # 23, *supra,* spore test capsules, disinfectants and dental supplies were also expired. Expiration dates ranged from 2004-2013.

C. **Summary of Violations**

40. Based on the Investigative Findings that reveal a pervasive and dangerous pattern of violations under the Act and CDC guidelines, the Board has a basis to charge the Respondent with committing prohibited acts as set forth under H.O. § 4-315. Specifically, the Board finds that the Respondent violated one or more of the following subsections of H.O. § 4-315(a):

> (6) Practices dentistry in a professionally incompetent manner or in a grossly incompetent manner;
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> (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 guidelines on universal precautions[.]

CONCLUSIONS OF LAW

Based on the foregoing investigative Findings, 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.).

ORDER

Based on the foregoing findings, it is this 23rd day of December, 2013, by a majority vote of a quorum of the State Board of Dental Examiners, by authority granted to the Board by Md. St. Govt. Code Ann. § 10-226(c)(2) (2009 Repl. Vol.), it is hereby:

ORDERED that the Respondent's license to practice dentistry in the State of Maryland, under License Number 5494, 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, not to exceed thirty (30) days from the Board's receipt, at which the Respondent will be given an opportunity to be heard as to why the Order the 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. State Govt. Code Ann. § 10-617(h) (2009 Repl. Vol.).

Ngoc Quang Chu, 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, not to exceed thirty (30) days, following the Board's receipt of a written request for 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 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. State Gov't Code Ann. §§ 10-210 *et seq.*