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

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

FINAL ORDER

On or about September 29, 2014, the Maryland State Board of Dental Examiners (the "Board") charged **MAURY J. FECHTER, D.D.S.** (the "Respondent"), License Number 5494, with violating his Consent Order, dated May 21, 2014 (the "Consent Order") by serving on him a *Notice of Violation of Consent Order* under the Maryland Dentistry Act (the "Act"), codified at Md. Code Ann., Health Occ. ('H.O.") §§ 4-101 et seq. (2009 Repl. Vol & 2013 Supp.), and pursuant to the compliance provision of the Consent Order, which provides in relevant part the following:

> **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 proved by a preponderance of the evidence;

Specifically, the Board charged that the Respondent had violated the following probationary terms and conditions of the Consent Order:

> The 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.

In accompanying correspondence, the Board notified the Respondent of his opportunity to request a hearing on the charges in the Notice of Violation of Consent

Order, and the possibility that the Board would issue a final order in this case if he failed to make such request. Nevertheless, the Respondent failed to request a hearing. Thus, for the reasons set forth below, the Board issues this Final Order.

FINDINGS OF FACT

The Board finds the following:

Background

1. The Respondent was initially licensed to practice dentistry in Maryland on or about September 7, 1973, under license number 5494. His license is current through June 30, 2016.

2. On December 23, 2013, after an investigation including an on-site inspection of the Respondent's practice, the Board issued and served on the Respondent an *Order for Summary Suspension of the Respondent's License to Practice Dentistry* under the authority of Md. Code Ann., State Gov't § 10-226(c)(2) (2009), concluding that the public health, safety and welfare imperatively required emergency action based on the Respondent's violations of the Centers for Disease Control's ["CDC"] guidelines on universal precautions[1] and the following provisions of the Act:

> (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:

[1] 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 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 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.

(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;

. . .

(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[.]

3. On or about January 7, 2014, the Respondent affirmatively waived his right to appear before a quorum of the Board to show cause why the Order for Summary Suspension should not be upheld and continued.

4. On May 21, 2014, the Respondent entered into a Consent Order with the Board in order to resolve the Order for Summary Suspension and potential Charges stemming from his violations of the Act.

5. Among other terms, the Consent Order called for the Respondent's dental practice to be inspected at intervals after it reopened.

June 10, 2014 Inspection

6. On or about June 10, 2014, pursuant to the terms of the Consent Order, the Respondent reopened his office located at 8817 Belair Road, Baltimore, Maryland 21236 (called "Office C" in the Consent Order).

7. That same day, also pursuant to the terms of the Consent Order, a Board-approved inspector (the "CDC Inspector") conducted the first of three on-site inspections of the Respondent's dental practice and compliance with CDC guidelines.

8. In her report on the June 10, 2014 inspection, the CDC Inspector noted the following deficiencies:

a. Improper closure of lab coat;

b. Treatment of a patient while wearing the same mask worn during treatment of a previous patient;

c. Failure to provide protective eyewear for patients during routine procedures or during use of an ultraviolet (UV) curing light;

d. Cross-contamination caused by improperly wearing contaminated gloves when searching through a cabinet for equipment and supplies;

e. Failure to ensure proper waterline management by flushing the waterlines between patients; and

f. Failure to maintain equipment in good operating condition, including:

   i. a dental chair that could not recline, causing difficulties with visibility and access to patients' mouths;

   ii. air pressure equipment malfunction;

   iii. a major waterline leak causing water to run from the lines onto the unit, chair, and floor; and

   iv. a non-functional x-ray processor.

9. The Respondent was made aware of all of the deficiencies and advised to correct them.

June 20, 2014 Inspection

10. On or about June 20, 2014, the CDC Inspector conducted another inspection of the Respondent's practice. By this date, the Respondent had hired and was working with a dental assistant (the "Assistant").

11. In her report on the June 20, 2014 inspection, the CDC Inspector noted the following deficiencies:

a. Failure to war safety glasses;

b. Failure to provide safety eyewear for patients;

c. Cross-contamination caused by retrieving a cuspidor dropped on the floor and presenting to a patient without disinfection;

d. Water leak in operatory; and

e. A non-functional x-ray processor.

12. The Respondent was made aware of all of the deficiencies and advised to correct them.

July 23, 2014 Inspection

13. On or about July 23, 2014, the CDC Inspector conducted another inspection of the Respondent's practice.

14. At this time, the Assistant was working both the reception desk and assisting with dental treatment and post-treatment operatory cleanup. Because of this unsettled arrangement, several problems arose. For example, after patient treatment, the Respondent attempted to clean up an operatory himself, handling contaminated supplies and equipment with his bare hands. During patient treatment, the Assistant moved back and forth between the front desk and the operatory, which lead to her working the front desk while wearing her lab coat, her protective eyewear on her head and mask in her pocket. In addition, the Respondent wrote a prescription at the front desk while wearing his mask hanging off his ear.

15. This arrangement caused the CDC Inspector to note in her report that there had been a "regression for the practice" because "with the dental assistant working both positions infection control violations have increased in the practice."

16. The CDC Inspector also wrote that "a new, and very dangerous sharps management practice was observed today by both Dr. Fechter and his assistant." The Respondent recapped a contaminated needle using a two-handed technique, and his assistant removed a contaminated needle from a syringe manually, even though needle recapping devices were available.

17. During this inspection, the CDC Inspector was also able to inspect the Respondent's compliance with spore testing protocols. When the CDC Inspector requested copies of spore testing records, no results were available for June 17, 2014, and the results from June 26, 2014 indicated that the Respondent's sterilizer had failed. The Respondent indicated that these results were the consequence of a paperwork issue involving the spore testing contractor that had since been corrected.

18. The CDC Inspector also found in the Respondent's sterilization area a tub of metal impression trays that were not sterilized and had dried impression material on them. The Respondent indicated that they were in the process of being sterilized.

19. In her report, the CDC Inspector noted the following deficiencies:

a. Removal of contaminated supplies with bare hands;

b. Failure to initially provide protective eyewear to a patient;

c. Continuing non-functionality of automatic X-ray processor;

d. Failure to maintain regular records of successful spore-testing;

e. Cross-contamination by failure to doff contaminated protective equipment before moving to front desk area;

f. Use of high-risk two-handed needle recapping technique; and

g. Seating a patient in a contaminated chair.

20. In summary, the CDC Inspector concluded that, "The newly developed CDC infection control policies have not been integrated into the practice policies of the office long enough to be firmly established, therefore problems are beginning to resurface."

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's failure to comply with the CDC guidelines for dental healthcare settings, as described above, constitutes a violation of the probationary terms and conditions of the Consent Order.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is by a majority of the Board considering this case:

ORDERED that the Respondent's license to practice dentistry in the State of Maryland, license no. 5494, is hereby **REVOKED;** and it is further

ORDERED that this is a Final Order and as such is a **PUBLIC** document pursuant to Md. Code Ann., General Provisions, § 4-101 *et seq.* (2014).

NOTICE OF RIGHT TO APPEAL

Pursuant to Md. Code Ann., Health Occ. § 4-319, the Respondent has the right to take a direct judicial appeal. Any appeal shall be filed within thirty (30) days from the date of this Final Order and shall be made as provided for judicial review of a final

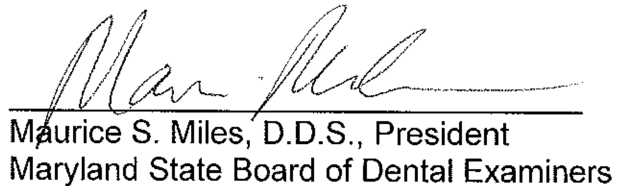
decision in the Maryland Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222; and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If the Respondent files an appeal, the Board is a party and should be served with the court's process at the following address:

Laurie Sheffield-James, Executive Director
Maryland State Board of Dental Examiners
Benjamin Rush Building
55 Wade Avenue/Tulip Drive
Baltimore, Maryland 21228

At that point, the Administrative Prosecutor is no longer a party to this case and need not be served or copied.

12/17/2014
Date



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