IN THE MATTER OF	*	BEFORE THE
NASSER MORADI, D.D.S.	*	STATE BOARD OF
RESPONDENT	*	DENTAL EXAMINERS
License Number: 4719	*	Case Number: 2013-101

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CONSENT ORDER

PROCEDURAL BACKGROUND

On September 18, 2013, the State Board of Dental Examiners (the "Board") issued and served on **NASSER MORADI, D.D.S.** (the "Respondent"), License Number 4719, an **ORDER FOR SUMMARY SUSPENSION,** in which it summarily suspended the Respondent's license to practice dentistry in the State of Maryland. The Board took 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 based on the Respondent's violations of the Maryland Dentistry Act, Md. Health Occ. Code Ann. ("H.O.") § 4-315(a) as follows:

> (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 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 (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

1. At all times relevant to this Order for Summary Suspension and this Consent Order (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 August 11, 1969, under License Number 4719.

2. At all times relevant to this Order, the Respondent operated a general dental practice in Elkton, Maryland (the "Elkton office"). The Respondent is a solo practitioner and does not employ any dental assistants.

3. The Board initiated an investigation of the Respondent after reviewing a complaint from one of his former patients (the "Patient"). On or about November 1, 2012, the Patient, then a man in his mid-fifties, sought dental treatment from the Respondent at his Elkton office. On this date, the Respondent extracted tooth number (#) 31.

4. In his complaint, the Patient expressed concerns about the condition of the Respondent's office and the treatment the Respondent provided to him. The Patient alleged that the Respondent's office was unsanitary and that the office dental equipment was not in working order. The Patient stated that during the extraction, the

[1] The Administrative Prosecutor and the Respondent have agreed that this Consent Order would obviate the need for filing Charges 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.

Respondent asked him to spit into a dirty trashcan instead of the cuspidor that was adjacent to the dental chair. The Patient reported that he went to his previous dentist two days later and was given antibiotics.

5. As part of its investigation, the Board ordered an inspection of the Respondent's Elkton office.

6. On March 21, 2013, an independent Board infection control consultant ("Board expert # 1") conducted an unannounced 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. Board expert # 1 found systemic and widespread CDC violations during the inspection.

7. The Board subsequently contacted the Respondent, who stated that he corrected the violations in question.

8. The Board then ordered a second inspection to determine the condition of the Respondent's office. On or about June 4, 2013, a second independent Board infection control consultant ("Board expert # 2") conducted a follow-up inspection of the Respondent's office and determined that many of the violations Board expert # 1 identified were still uncorrected. Board expert # 2 found several deficiencies in the condition of the Respondent's office.

9. A summary of these findings is set forth *infra*.

Office inspection, dated March 21, 2013

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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.

10. On March 21, 2013, Board expert # 1 conducted an infection control inspection of the Respondent's Elkton office. At the time of the inspection, the Respondent was in the office but did not have any patients scheduled for treatment. As a result, Expert # 1 did not observe the Respondent provide any dental treatment to any patients. The Respondent reportedly does not employ any dental hygienists, assistants or other personnel to assist him in his practice.

11. The Respondent's office consists of a waiting room, a business area, a lavatory, three dental operatories, of which two were used to treat patients (a third is used for radiographs alone), and a private office.

12. Board expert # 1 issued a report, dated March 21, 2013, in which he stated,

> [t]he equipment, while serviceable, appeared dirty and not well maintained. Upon inspecting these clinical areas, I found that the complaints of . . . [the Patient] . . . were well founded. There were multiple and significant breaches in the standard of care for infection control identified in this inspection.
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> * * *
>
> The cleaning, disinfection and sterilization practices of this office are below the standards of care. Based on the inspection of March 21, 2013, it is my opinion that it is unsafe for patients to undergo dental treatment in the office of Nasser Moradi, DDS.

13. Board expert # 1 made findings that included but were not limited to the following:

(a) The Respondent's office lacks an Exposure Control Plan or office manual that details the proper infection prevention procedures;

(b) Operatories lacked new barriers and items were cross-contaminated during procedures. Single use barriers were re-used. The few barriers on the light handles and headrest were soiled from multiple and repeated use;

(c) Instrument tray surfaces were unclean and contained dust, dirt and patient debris on almost every surface. The bracket tray surfaces were unclean and contained dust, dirt and patient debris on almost every surface. The tray covers were crumpled and dirty and indicated that they had not been changed in a considerable period of time. Used instruments were left opened on the trays;

(d) Almost every working surface was unclean and littered with particles, dust, debris and unidentifiable spots that may be blood or other splatter from previous patients. There was little evidence of surface disinfection. The one wipe-style container that was located in one of the working operatories contained wipes that were "bone dry," and it was "obvious that this has been the case for a considerable period of time";

(e) There was no treatment of the dental unit waterlines exposing patients to potential biofilm contamination;

(f) High, low and ultrasonic handpieces were left set up on bracket trays in each treatment room with barriers attached, but the barriers were "well used and obviously not changed between patients"; There was a bur housed in a handpiece that had debris in its flutes;

(g) There was no alcohol-based hand rub available and there were sinks in the treatment rooms to facilitate hand washing;

(h) Disposable facemasks were hanging in operatories and re-used;

(i) Clean laboratory coats were not available. The office had one laboratory coat, which was soiled and draped over a sofa in the dentist's office space;

(j) The surfaces of the dental laboratory had not been cleaned and contained debris and used film packets. There was no device or provision for cleaning contaminated instruments;

(k) The office did not have a tabletop ultrasonic cleaner, nor was there a place or device where instrument cleaning could be performed. The autoclave was small and stuffed in an operatory directly adjacent to patient care items facilitating the potential for significant cross contamination. "The dentist, when questioned, had no fundamental knowledge of the principles of cleaning and sterilization";

(l) The two operatories contained local anesthesia devices with syringes that were not wrapped or properly sterilized;

(m) The office contained a pack of burs that indicate that they were not sterilized. Other burs were in bur blocks that were dirty and were not verifiably sterilized. The bur flutes were often contaminated with debris and tooth fragments. A floss container had evidence of blood/debris on it;

(n) The operatories contained three way syringes that had not been cleaned. The syringes had dirt and patient debris present on the tubing and bracket tray. The surface was scratched, making it difficult to clean and disinfect. The three way tips of both devices were dirty and had not been changed;

(o) Instrument packs were unsealed and/or were torn open, exposing the instruments within the packs to potential contamination;

(p) Instruments were found unwrapped in several drawers; and

(q) Processed and unprocessed instrument packs were mixed together.

Respondent's response to the Patient's Complaint and Report of Board expert # 1

14. Board representatives subsequently contacted the Respondent and requested that he provide a response to the Patient's complaint and Board expert # 1's inspection report.

15. The Respondent provided a written response, dated April 12, 2013. With respect to the Patient's complaint, the Respondent acknowledged that when the Patient requested to spit into the dental bowl, he directed him to spit into a trash can, claiming he did not want to contaminate the bowl further. The Respondent also stated that he could not retrieve the Patient's dental radiograph, speculating that he either gave it to the Patient or could not locate it.

16. With respect to Board expert # 1's report, the Respondent stated, "[m]y office was not as neat and clean right then. Some of the criticisms were correct and some were not."

Office inspection, dated June 4, 2013

17. On or about June 4, 2013, Board expert # 2 conducted a follow-up, unannounced inspection of the Respondent's Elkton office. No patients were present at the time of the inspection.

18. Board expert # 2 issued a report, dated June 10, 2013, in which she found that the Respondent failed to correct the overwhelming majority of the deficiencies Expert # 1 identified during his March 21, 2013, inspection.

19. Board expert # 2 identified the following uncorrected deficiencies:

(a) With respect to barriers and cross-contamination, there were no barriers on the headrests and when interviewed, the Respondent was not clear about his frequency of use of barriers;

(b) With respect to surface cleanliness and accessibility for cleaning, (i) available disinfecting wipes were dry and had an expiration date of 2010; and (ii) there remained excessive storage on countertops precluding access to clean and disinfect;

(c) With respect to handpiece sterilization, (i) all handpieces were not verifiably sterilized; (ii) multiple high speed handpieces were in single bags, with some of the bags open and with other bags that were without activated process monitors; and (iii) some slow speed handpieces were left on bracket trays;

(d) With respect to alcohol hand rub, no alcohol hand rub was available. The only sinks on the premises were in the bathroom and the alcove that was being prepared as a sterilization area, both of which were not conveniently available to any treatment rooms;

(e) With respect to the sterilization area, (i) the new sterilization area the Respondent was planning was not yet operational; (ii) a clean and dirty area was not established; (iii) the autoclave was on a counter in the main treatment room; (iv) an area to debride and package instruments was not available; and (v) instruments were not consistently bagged and verifiably sterilized;

(f) With respect to use of packaged instruments, (i) the Respondent noted that he was colorblind and could not clearly distinguish the activated process monitors; and (ii) some loose instruments and torn bags of instruments were stored in storage drawers;

(g) With respect to the presence of unbagged instruments, unbagged instruments were present in drawers and clinical areas;

(h) With respect to the presence of medical waste, (i) gloves and other intra-orally used items were found to be discarded in routine trashcans; and (ii) medical waste manifests were not available to indicate at least three years of appropriate disposal; and

(i) With respect to compliance with CDC guidelines, the Respondent had "significant lapses in compliance with CDCGICHCS" [Centers for Disease Control Guidelines for Infection Control in Dental Health-Care Settings].

20. Board expert # 2 identified the following CDCGICHCS violations in the Respondent's office:

(a) Dental handpieces were not consistently and verifiably sterilized;

(b) The Respondent is unable to consistently identify sterilized packaging;

(c) Due to poor access to hand washing facilities and/or hand sanitizers, hand washing cannot be conveniently performed before and after patient care;

(d) Personal protective equipment in the form of utility gloves is not available when preparing instruments for sterilization;

(e) Instruments are not properly processed after use;

(f) The Respondent's office lacked a well-organized sterilization area with distinct clean and dirty areas;

(g) The Respondent's office lacks consistent, verifiable sterilization of all re-usable intra-oral instruments, specifically slow speed handpieces, some high-speed handpieces, burs, and hand instruments;

(h) The Respondent's office contains expired products, such as surface disinfectants that expired in 2010;

(i) Expired anesthetic carpules and dental materials are in treatment areas;

(j) The Respondent did not establish a dental unit waterline maintenance policy;

(k) The Respondent's office lacks proper disposal of medical waste. At least three years of records should be available for waste manifests showing regular medical waste removal and/or safe processing;

(l) The Respondent's office does not have a CPR resuscitator mask available; and

(m) The Respondent's office does not have medical emergency supplies available.

CONCLUSIONS OF LAW

Based on the foregoing investigative facts, the Board concludes as a matter of law that at the time of the issuance of the Order for Summary Suspension, the Respondent constituted 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.).

The Board further concludes as a matter of law that the Respondent: Practices dentistry in a professionally incompetent manner or in a grossly incompetent manner, in violation of H.O. § 4-315(a)(6); Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession. in violation of H.O. § 4-315(a)(16); and 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, in violation of H.O. § 4-315(a)(28).

ORDER

Based on the foregoing findings, it is this 6th day of November, 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 FOR SUMMARY SUSPENSION** of the Respondent's license to practice dentistry issued on September 18, 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. The Respondent shall, at all times, practice dentistry in accordance with the Act, related regulations, 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 the 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

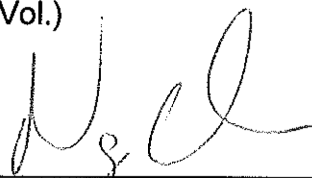
ORDERED that the Respondent shall at all times cooperate with the Board, any of its agents or employees, and with his consultant, in the monitoring, supervision and investigation of the Respondent's compliance with the terms and conditions of this Consent Order, and it is further

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 further conditions or restrictions. After consideration of the petition, the probation may be terminated through an order of the Board. The Board shall grant termination if the 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 it is further

ORDERED that if the 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, may impose any sanction which the Board may have imposed in this case under §§ 4-315 and 4-317 of the Maryland Dentistry 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; and it is 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.)



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

CONSENT

I, Nasser Moradi, D.D.S., acknowledge that I have been advised of my right to be represented by counsel in this case, and after having been so advised, have knowingly and voluntarily waived my right to be represented by counsel in this case. By this Consent, I agree and accept to be bound by this Consent Order and its conditions and

restrictions. I waive any rights I may have had to contest the Findings of Fact and Conclusions of Law.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had 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 acknowledge the legal authority and the jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I also affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing.

I sign this Consent Order after having had an opportunity to consult with counsel, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order. I voluntarily sign this Order, and understand its meaning and effect.

10-22-13
Date

Nasser Moradi, D.D.S.
Respondent

NOTARY

STATE OF Md.
CITY/COUNTY OF: Cecil

I HEREBY CERTIFY that on this 22d day of October, 2013, before me, a Notary Public of the State and County aforesaid, personally appeared Nasser Moradi, D.D.S., 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.

Notary Public

My commission expires: 1-6-14