IN THE MATTER OF	*	**BEFORE THE**
ERNEST J. COLVIN, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 4553	*	**Case Number: 2007-120**

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FINAL PRE-CHARGE CONSENT ORDER

Based on information received and a subsequent investigation by the State Board of Dental Examiners (the "Board"), on December 12, 2006, the Board voted an intent to summarily suspend the license of Ernest Colvin, D.D.S. (the "Respondent"), license number 4553, based on violations of the Maryland Dentistry Act (the "Act"), Md. Health Occ. Ann. § 4-101, et seq., (2005 Repl. Vol. and 2006 Supp.).

The pertinent provisions of § 4-315 provide:

> (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, a limited license to practice dentistry or a teacher's license to practice dentistry to any applicant, reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the applicant or licensee:
>
> (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 January 17, 2007, the Board offered the Respondent an opportunity to Show Cause why his license should not be summarily suspended. As a result of improvements in his practice, and, as a result of negotiations with the Office of the Attorney General, by Roberta Gill, Assistant Attorney General, Administrative Prosecutor, the Respondent, by

Gerald A. Smith, Esq., and the Board, the parties agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law, and Order, in lieu of signing the Summary Suspension Order or issuing charges under its Act.

FINDINGS OF FACT

BACKGROUND

1. At all times relevant hereto, the Respondent was licensed to practice dentistry in Maryland. The Respondent was first licensed on November 13, 1968. The Respondent's license expires June 30, 2007.

2. At all times relevant hereto, the Respondent maintained an office in Baltimore City, Maryland, where he was the sole dentist.

3. Prior to this occasion, the Respondent had been the subject of two Consent Orders, one dated February 6, 2002 for allowing unauthorized persons to perform functions for which a license is needed. That Order suspended the Respondent's license for over a month, followed by three years probation with conditions, including, but not limited to, taking the law examination and paying a $2500 fine. The other is dated May 12, 1989 and resulted in the Respondent's taking the law examination and paying a $500 fine, for allowing an unauthorized person to practice dentistry.

4. The Centers for Disease Control ("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/or dental staff to and from the patients.

5. 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 that incorporate by reference the Occupational Safety and Health Administration's ("OSHA") final rule on Occupational Exposure to Bloodborne Pathogens (29 CFR 1910.1030).

6. 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.

7. Based on a written complaint to the Board, on November 9, 2006, two Board investigators visited and inspected the Respondent's dental office. When the investigators informed the Respondent that they were there about CDC violations in the office, the Respondent asked, "[w]hat is CDC?" Thereafter, one investigator informed the Respondent what the initials stood for and told him that they would be observing patient treatment and the sterilization process.

INVESTIGATIVE FINDINGS

8. The investigators observed the following:

A. The Respondent was wearing a long-sleeved lab coat that was completely soiled and contained splattered blood all over it.[1]

B. The Respondent proceeded to treat the first patient (Patient A)[2] in Operatory #2. The Respondent was assisted by KB, who is not licensed,

1 The Respondent explained that he sends his lab coats to a dry cleaner, which returns them cleaned, though stained.
2 Patient and employees' names are confidential.

certified or otherwise authorized by the Board to perform any expanded duties. Both the Respondent and KB grabbed a pair of gloves out of an open box of gloves, located over the sink, which was located in the middle of Operatories ##1 and 2. Neither the Respondent nor KB washed their hands before gloving. The Respondent anesthetized Patient A, who was having an extraction performed. The Respondent recapped the needle using both hands. Once Patient A was anesthetized, the Respondent and KB removed their gloves, discarded them in the red biohazard bag located in the Operatory, and exited the Operatory without washing their hands.

C. The Respondent and KB then grabbed a pair of gloves from the open box and entered Operatory #1, where Patient B was seated in the dental chair. Neither the Respondent nor KB washed their hands prior to gloving. The Respondent anesthetized Patient B, who was having extractions performed, recapping the needle using both hands. Once again, the Respondent and KB removed the gloves and discarded them in the red biohazard bag. Thereafter, the Respondent and KB regloved with new gloves and reentered Operatory # 2 to begin the extraction on Patient A, failing to wash their hands prior to regloving.

D. The Respondent extracted Patient A's tooth, while KB performed suctioning. The Respondent wore a mask and his prescription glasses, with no side shields; KB wore a mask and no eyewear at all. The

Respondent failed to wear sterile gloves, as required for a surgical procedure.

E. After completing the extraction on Patient A, the Respondent and KB removed their gloves and discarded them in the biohazard trash bag. They then grabbed another pair of gloves and re-gloved without washing their hands. The Respondent and KB reentered Operatory #1 to begin the extractions on Patient B.

F. While this was taking place, Dental Assistant QB, who is licensed by the Board as a Dental Radiation Technologist, started to break down and sterilize Operatory #2. QB removed all contaminated plastic barriers and discarded them in the biohazard bag. She then sprayed all potentially contaminated areas with Cavicide spray, which is EPA-regulated. QB did not, however, spray the dental stool used by the Respondent or the dental buttons on the chair. QB then flushed the valves on the suction line for approximately 30 seconds and removed the hand piece. QB then carried all of the contaminated dental instruments, including the hand piece, to the sterilization room located several feet away from the Operatory, put on heavy gloves and placed the contaminated instruments inside of a bucket containing bleach water. Several minutes later, QB removed the instruments from the bleach water and scrubbed them in the sink, using soap and water. QB then placed the instruments into the cold sterilizer, after which she bagged them and placed them in the autoclave.

G. QB informed the investigators that the autoclave is preset at 250 degrees and runs for 30 minutes. She opened the autoclave and investigators observed the inside to have three trays, one on each level. The trays contained bagged instruments piled neatly and not overloaded. QB explained that she places two sterilization strips inside on the autoclave during the cycle, one on top and one on the bottom. QB advised that she then placed the strip inside of an envelope addressed to a company that performs the weekly spore testing.

H. QB further explained that the arrow indicator on the outside of the bag begins as a light pink and, once the bag is autoclaved, the indicator changes to a dark brown. The investigator counted 20 bags atop the counter next to the autoclave with dental instruments inside and asked QB if they had been autoclaved yet, to which QB replied "yes". The investigator observed 9 of those 20 with a light pink arrow on the outside; once notified of this, QB pulled those bags out and indicated that she would autoclave them again.

I. Upon being shown where the autoclaved instruments are placed, the investigators began sorting through the bags to look at the arrow on the outside and, once again, observed that at least half of the bags in the drawers displayed a light pink arrow, while the other half displayed a dark brown arrow.

J. While the Respondent completed the extractions on Patient B, the investigators observed KB twice retrieve items from a drawer located

inside the operatory to hand to the Respondent, using contaminated gloves as she grabbed the door handle. After which, the Respondent and KB removed their gloves and disposed of them in the biohazard bag and exited Operatory #1 without washing their hands after degloving.

K. The Respondent and KB then walked into Operatory #4, where a male patient, Patient C, was seated in the dental chair. The Respondent and KB failed yet again to wash their hands prior to gloving. The Respondent anesthetized Patient C and recapped using the two-hand method. The Respondent and KB left the operatory to wait for the patient to become numb; they failed to wash their hands after degloving.

L. The Investigators observed QB break down and sterilize Operatory #1 after Patient B was dismissed. QB removed all protective plastic barriers from the tray, overhead light handles and dental chair and wiped them down with Cavicide Spray. She then placed new coverings on the equipment, but failed to sterilize the dental stool, chair buttons and metal handles on the drawer that KB retrieved items out of. QB flushed the water line for approximately 30 seconds.

M. The Respondent and KB then returned to Operatory #4 to complete the extractions on Patient C. They failed to wash their hands prior to gloving and proceeded with the extractions. Afterwards, the Respondent and KB degloved, discarded them in the appropriate container and exited Operatory #4 without washing their hands.

9. In summary, the Respondent failed to: wash his hands prior to gloving and after degloving during the treatment of several patients receiving extractions; change into a clean-looking lab coat; wear surgical gloves during extractions; wear side shields during the extractions; change his mask during patient treatment when all patients were receiving extractions; recap needles correctly; and, wear protective eyewear for each patient. In addition, the Respondent had one failed spore test on July 7, 2006. Furthermore, KB failed to: wear eye protection while assisting the Respondent; wash her hands before and after gloving; and, change her mask between patient treatments. Also, QB failed to sterilize the dental stool, dental chair buttons and the metal drawer handles or properly check the autoclaved instruments.

10. On January 16, 2007, Christine Wisnom, R.N., Nurse Consultant, who is approved by the Board to instruct, inspect and make recommendations on compliance with CDC requirements, visited the Respondent's office for four hours, observing the Respondent and his staff and made recommendations, many of which the Respondent immediately complied with. Some of the observations noted by the inspectors had already been complied with, such as the Respondent's use of a disposable lab coat and his assistant wearing a mask and goggles and washing her hands before and after gloving/de-gloving. Ms. Wisnom's report is attached hereto and made a part hereof as Pre-Charge Consent Order, Exhibits 1A, B and C.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the Board finds that Respondent violated Md. Health Occ. Code Ann. § 4-315 (a) (28).

ORDER

Based on the foregoing Findings of Fact, Conclusions of Law and agreement of the parties, it is this 7th day of February, 2007, by a majority of a quorum of the Board,

ORDERED that the Respondent is hereby **REPRIMANDED;** and the Respondent's license to practice dentistry is hereby placed on **PROBATION** for one year, subject to the following conditions:

1. Ms. Wisnom, or any other Board-approved consultant, shall be present in the Respondent's office on a quarterly basis to ensure that the Respondent is complying with the CDC guidelines and the Act and that all employees and practitioners in his office are in compliance; Ms. Wisnom may also provide training to the Respondent and his staff;
2. After each such visit, Ms. Wisnom shall provide reports to the Board within ten days of the date of the inspection and may consult with the Board regarding the findings of the inspections.
3. 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 immediately 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 as to why his license should not be suspended or should not have been suspended;

4. The Respondent shall also be subject to random, unannounced inspections by the Board or its representative(s), 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 immediately 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 as to why his license should not be suspended or should not have been suspended;
5. The Respondent shall complete all required continuing education courses required for renewal of his license. No part of the training or education he receives or provides in compliance with this Order shall be applied to his required continuing education credits;
6. The Respondent shall comply with the Maryland Dentistry Act, including CDC guidelines and Occupational Safety and Health Administration's ("OSHA") final rule on Occupational Exposure to Bloodborne Pathogens (29 CFR 1910.1030); 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, with regard to monitoring, supervision and investigation of the Respondent's compliance with the terms and conditions of this Consent Order; and be it further

ORDERED that the Consent Order is effective as of the date of its signing by the Board; and be it

ORDERED that, should the Board receive a report that the Respondent has substantially violated the Act or if the Respondent violates any conditions of this Order or of Probation, after providing the Respondent with notice and an opportunity for a hearing, the Board may take further disciplinary action against the Respondent, including suspension or revocation. The burden of proof for any action brought against the Respondent as a result of a breach of the conditions of the Order or of Probation shall be on the Respondent to demonstrate compliance with the Order or conditions; and be it

ORDERED that, at the end of the Probationary period, the Respondent may petition the Board to be reinstated without any conditions or restrictions on his license, provided that he can demonstrate compliance with the conditions of this Order. Should the Respondent fail to demonstrate compliance, the Board may impose additional terms and conditions of Probation, as it deems necessary; and be it further

ORDERED that for purposes of public disclosure, as permitted by Md. State Gov't. Code Ann. §10-617(h) (2004 Repl. Vol. and 2006 Supp.), this document consists of the contents of the foregoing Findings of Fact, Conclusions of Law and Order and that the Board may also disclose same to any national reporting data bank that it is mandated to report to.

James P. Goldsmith, D.M.D., President
State Board of Dental Examiners

CONSENT OF ERNEST J. COLVIN, D.D.S.

I, Ernest J. Colvin, by affixing my signature hereto, acknowledge that:

1. I am represented by an attorney, Gerald Smith, and have been advised by him of the legal implication of signing this Consent Order;

2. I am aware that, without my consent, my license to practice dentistry in this State cannot be limited except pursuant to the provisions of § 4-315 of the Act and the Administrative Procedure Act (APA) Md. State Govt. Code Ann. §10-201, et seq., (2004 Repl. Vol. and 2006 Supp.).

3. I am aware that I am entitled to a formal evidentiary hearing before the Board.

By this Consent Order, I hereby consent and admit to the foregoing Findings of Fact, Conclusions of Law and Order, provided the Board adopts the foregoing Consent Order in its entirety. By doing so, I waive my right to a formal hearing as set forth in § 4-318 of the Act and §10-201, et seq., of the APA, and any right to appeal as set forth in § 4-319 of the Act and §10-201, et seq., of the APA. I acknowledge that my failure to abide by the conditions set forth in this Order, and following proper procedures, I may suffer disciplinary action, possibly including revocation, against my license to practice dentistry in the State of Maryland.

1-31-07
Date

Ernest J. Colvin, D.D.S.

STATE OF Maryland

CITY/COUNTY OF Baltimore :

I HEREBY CERTIFY that on this 31st day of January, 2007, before me, Tungia D. Williamson (Print Name) a Notary Public of the foregoing State and (City/County), personally appeared Ernest J. Colvin, D.D.S., License No.4553, and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed, and the statements made herein are true and correct.

AS WITNESSETH my hand and notarial seal.

Tungia D. Williamson
Notary Public

TUNGIA D. WILLIAMSON
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires September 21, 2008

My Commission Expires: _____