IN THE MATTER OF	*	**BEFORE THE MARYLAND**
WALTER D. SOLOMON, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 7983	*	**Case Number: 2010-291**

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

CONSENT ORDER

Procedural Background

On November 21, 2011, the Maryland State Board of Dental Examiners (the "Board") charged Walter D. Solomon, D.D.S ("Respondent"), (D.O.B. 7/03/1952) license number 7983, under the Maryland Dentistry Act, Md. Health Occ. ("H.O.") Code Ann. §§ 4-101 *et seq.* (2009 Repl. Vol. & Supp. 2010) pursuant to H.O. § 4-315(a). The pertinent provisions of H.O. § 4-315(a), and those under which these charges are brought, are as follows:

> (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:
>
> > (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 guidelines on universal precautions[;].

On December 21, 2011, the Respondent appeared before a Case Resolution Conference committee (the "CRC") of the Board to discuss the pending charges and the

potential resolution of the pending charges. Following the CRC, the parties agreed to enter into this Consent Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law and Order, with the terms and conditions set forth below.

FINDINGS OF FACT

I. Background

1. At all times relevant hereto, the Respondent was and is a dentist licensed to practice dentistry in the State of Maryland. The Respondent initially was licensed on September 20, 1982. The Respondent last renewed his license on or about June 2011, which will expire on June 30, 2013.

2. At all times relevant hereto, the Respondent maintained an office for the practice of dentistry at 7518 Belair Road, Baltimore, MD 21236. The Respondent is a solo practitioner and has one employee, a receptionist/dental assistant.

3. Previously, on April 27, 1995, pursuant to a Board decision to defer issuing an Order for Summary Suspension of Respondent's license, the Respondent executed an "Agreement to Surrender" his license and agreement to enter a contract with the Maryland Committee for Rehabilitation of Dentists.

4. On June 5, 1996, following petition by the Respondent for reinstatement of his license, the Respondent entered into a Consent Order with the Board whereby the Respondent's license was reinstated and he was placed on probation for a period of five years under conditions that he remain under a treatment contract and that he not dispense or prescribe any controlled dangerous substances in Maryland.

5. On February 3, 1999, following petition by the Respondent for permission to prescribed schedule II, III, and IV medications, the Board in an Amended Consent Order,

granted the request provided that he use numbered triplicate-copy prescription pads and that he forward copies of these prescriptions to the Board on a quarterly basis.

6. On July 21, 2004, the Respondent entered into a Consent Order with the Board to resolve new charges of obtaining a fee by fraud, professional incompetence, unprofessional conduct, false report, submission of third party claim which is misleading or deceptive, waiver of copayment, and overbilling. The Respondent's license was suspended for one year, with all but one month stayed, and the Respondent was placed on probation for three years with conditions that he complete the Dental Stimulated Clinical Exercise, comply with all course work recommendations made by the Board, complete courses in risk management, record keeping, billing and coding, oral radiology, endodontics, and restorative dentistry. The Respondent was also required to have a clinical practice reviewer to monitor his practice of dentistry.

7. On November 21, 2007, the Board issued an Order of Termination of Probation restoring the Respondent's license without restrictions or conditions.

II. Complaint and Investigation

8. On or about April 30, 2010, the Board received a complaint from a former patient of the Respondent, Patient A,[1] regarding the Respondent's infection control procedures. Patient A alleged that when she saw the Respondent for a root canal:

a. His office was messy and dirty;

b. He often dropped "utensils" on the ground, picked them back up, and used them;

c. During the procedure, he took an x-ray and "after he placed the equipment in my mouth he rinsed it under water;" and

[1] In order to protect patient privacy and the confidentiality of health care records, patient names are not contained in this document but may revealed to the Respondent by contacting the Administrative Prosecutor.

d. "He did not use gloves or a face mask while working on me."

9. Patient A did not return to the Respondent.

10. The Board opened the case for investigation.

11. On June 21, 2010, an independent Board consultant in infection control (the "Board expert") conducted an unannounced inspection of the Respondent's office to determine whether the Respondent was in compliance with the Dental Practice Act and the Centers for Disease Control[2] ("CDC") Guidelines for Infection Control in Dental Health-Care Settings -2003. The Board expert interviewed the Respondent and his receptionist/dental assistant, inspected the office, requested written documentation and written protocols, and observed patient care. The Board expert photographed relevant areas of the Respondent's office.

12. Following her comprehensive inspection and review, the Board expert requested that the Respondent provide documents that were not provided on the date of the inspection. On June 29, 2010, the Respondent submitted some of the requested documents.

13. On August 20, 2011, based upon her inspection, as well as her review of the documents received from the Respondent, the Board expert submitted a written report to the Board finding numerous violations of CDC guidelines, as delineated herein.

III. Findings Based on Board Expert's Inspection

A. Description of Office

[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.

14. The Respondent is the sole occupant of a freestanding residential type building in a commercial area. The waiting room is clean and well appointed.

15. There are five operatories, only one of which is used for patient treatment, and a laboratory/darkroom/ instrument sterilization room. One of the operatories is used for storage and instrument debridement and bagging.

16. The operatory that is used for patient treatment contains a working dental unit, x-ray equipment, cabinets with counter top, and a sink.

17. The Respondent stores packaged medical waste in the basement.

18. The reception and business area were neat and clean.

19. The Respondent has a receptionist/dental assistant, who he hired in June 2008.

B. <u>Written Protocols, Recordkeeping and Posters</u>

20. On the date of inspection, the Respondent did not have a written health and safety program manual, including initial and annual employee health and safety training records, employee Hepatitis B vaccination records, employee post exposure forms, and an annual safety program evaluation.

21. The Respondent subsequently submitted a handwritten statement from his receptionist/dental assistant, dated June 29, 2010, stating that she had been offered a free Hepatitis B vaccination but declined it. This statement does not comply with the language required by the federal regulations in regard to declination of Hepatitis B Vaccination.[3]

22. The Respondent did not have infection control continuing education (CEU) certificates for himself at the time of the inspection. The Respondent subsequently

[3]See, Hepatitis B Vaccination Declination, Bloodbourne Pathogen Standard 29 CFR Part 1910.1030, which describing the risk associated with declining the vaccination.

submitted CEUs for 2001, 2007 and 2010; however the Respondent did not submit certificates for the previous five years.

23. The Respondent did not have annual training records for his current or previous employees at the time of the inspection.

24. The Respondent subsequently submitted a training record for his current receptionist/dental assistant for 2010. The Respondent did not submit records from time of hire or annual training records for previous employees.

25. The Respondent did not have, and did not submit, any Hepatitis B vaccination records for previous employees. It is mandated that Hepatitis B records be maintained for at-risk employees for the term of employment plus thirty years.

26. The Respondent's medical history form does not ask specific questions about HIV/AIDS, Hepatitis B, Hepatitis C, TB, blood transfusions, and transplants.

27. The Respondent did not post the required "We Take Precautions for You" poster.

28. The Respondent's Maryland Department of the Environment Radiation Machine Facility Registration was expired on February 28, 2010. The Respondent subsequently submitted a "Radiation Machine Facility Registration" renewal form, dated June 23, 2010.

C. <u>Standard Precautions and Personal Protective Equipment</u>

29. The Respondent did not have alcohol hand sanitizer as well as soap and water readily available in the laboratory or the instrument prep rooms where potentially contaminated items are handled. Hand sanitizer was available in the sole treatment operatory.

30. The Respondent had treatment gloves which he wore. The Respondent did not have any utility gloves in the instrument prep room.

31. The Respondent had masks in the operatory. The Respondent did not have masks available in the laboratory or the instrument prep room.

32. Lab coats and eye shields were not available or worn in the clinical areas such as the operatory, laboratory, and instrument prep room.

33. The Respondent did not have a protocol for rinsing the eyes after an exposure incident or eye injury. The Respondent did not have an eyewash station.

D. Sterilization Protocol

34. The Respondent did not remove reusable dental hand pieces and other air driven devices from the dental unit for multiple patients. All reusable intra-oral devices must be verifiably sterilized after use and remain in sealed sterilization bags or cassettes with activated process monitors until ready for use.

35. The Respondent's sterilization bags had process monitors that could only be activated by steam autoclaves or chemiclaves but not by the dry heat Steri-dent that the Respondent used; therefore instrument processing could not be verified.

36. At the time of the inspection, the Respondent did not have documentation of weekly spore testing of autoclaves used in the office nor was he able to provide it subsequent to the inspection.

E. Operatory/Treatment Room Disinfection and Cross Contamination Prevention

37. The Respondent used the countertops in the operatory for storage and unwrapped instruments. Re-usable instruments stored in the drawers were not consistently sealed in intact sterilization bags. Bagged items did not have activated process monitors.

38. During patient procedures, the Respondent accessed containers on the operatory countertop while wearing gloves used for patient care, risking opportunities to cause cross contamination.

39. The Respondent performed surface decontamination of light handles, countertops, cuspidor, and other exposed equipment after patient care; however it was not sufficient because he could not adequately access the surfaces being decontaminated.

40. The Respondent kept large containers of "Golden Grain" alcohol, Clorox bleach, and Listerine stored together on the countertop of the operatory making it difficult to decontaminate the surface and mixing toxic hazardous ingredients with consumables. The Respondent had a non-approved anesthetic in the operatory.

41. Various surface disinfectants were available on top of a mobile cart along with assorted patient care items, with the potential for chemical contamination of intra-oral items.

42. The Respondent transported dental Instruments from the operatory to the sterilization area after patient treatment with tray cover paper as a carrier, instead of using a tray or container, with the potential for percutaneous injuries.

F. <u>Sharps Management and Regulated/biohazardous Waste Disposal</u>

43. The CDC guidelines require dental health care facilities to "...dispose of medical waste regularly to avoid accumulation."

44. The Respondent improperly disposed of biohazardous trash in a trashcan lined with a white bag instead using a red bag, a fluid resistant container, or sharps container.

45. The Respondent does not have a protocol whereby all disposable items that are saturated with blood or saliva, and/or caked with dried blood, will be disposed in the regulated biohazardous waste container.

46. The Respondent did not have any medical waste disposal manifests from 1992 to 2010, verifying pick up and disposal of medical waste. The Respondent stored the medical waste in the basement of the facility in containers which had signs of water damage and were not intact with the potential for cross contamination with anyone handling materials in the basement.

47. After the inspection, the Respondent submitted a service contract with a medical waste company, dated June 23, 2010.

48. The Respondent's red sharps containers in the operatory and sterilization preparation areas were overfilled with used needles and the containers were cracked, with the potential of injury with contaminated sharps.

G. <u>Laboratory/Sterilization Room</u>

49. The Respondent did not have a laboratory protocol for disinfection and isolation of used patient impressions, dental stone models, and crowns and bridges to prevent cross contamination. These items were on shelves and the countertop as well as in drawers in the laboratory area.

50. Instruments are prepared in a non-functioning operatory used as an instrument prep room and transferred to the laboratory/sterilization room. There are not distinct "clean" and "dirty" areas designated in either room. Paint cans were stored on the floor in the instrument prep area.

51. The sink in the laboratory/sterilization room was covered in rust.

H. **Radiation Safety**

52. The Respondent's Maryland Department of the Environment Radiation Machine Facility Registration expired on February 28, 2010.

53. The Respondent subsequently submitted a "Radiation Machine Facility Registration" renewal form, dated June 23, 2010.

I. **First Aid and Emergency Procedures**

54. The Respondent did not have an emergency evacuation plan posted in the office or available for review.

55. The Respondent does not have a written policy for managing Occupations Exposure to bloodbourne pathogens. The dental assistant was not aware of what steps should be taken and where an employee should go for counseling and testing after an exposure incident, possibly resulting in delay in appropriate care.

56. The Respondent had a CPR mask available in the treatment operatory. The Respondent did not have oxygen and basic medical supplies. After the inspection, the Respondent submitted invoices for an "epi" pen, injectable diphenhydramine, and a portable oxygen tank.

57. The Respondent did not have first aide supplies for managing occupational exposure other than two bottles of hydrogen peroxide which had expired on April 1997.

J. **Summary of Findings Based on Board Expert's Inspection**

58. At the time of the initial inspection on June 21, 2010 the following serious violations to the Occupational Exposure to Bloodborne Pathogens Standard [COMAR 9.12.31] and Guidelines for Infection Control in Dental Health-Care Settings, referenced in the Universal Infection Control Precautions Standard [COMAR 10.52.11], were noted.

a. Office lacked a written Exposure Control Plan;

b. Office lacked written policy to manage Occupational Exposures;

c. Office lacked written records for annual safety evaluation, employee training [at least initially and annually thereafter], weekly spore testing of sterilizer, and medical waste manifests showing regular medical waste removal. At least three years of each of these records should be available;

d. Office lacked Hepatitis B vaccination or declination records for all at risk employees maintained for the term of employment plus thirty [30] years;

e. Office lacked Confidential Employee Medical records for any employee experiencing an occupational exposure and maintained for the term of employment plus thirty [30] years;

f. Office lacked adequate hand washing facilities in the instrument prep and lab/sterilization rooms;

g. Office lacked adequate access to personal protective equipment, including eye protection, masks, and long sleeve gowns/lab coats;

h. Office lacked consistent, verifiable sterilization of all re-usable intra-oral instruments including hand pieces, burs, hand instruments, syringes, and endodontic armamentarium;

i. Cross-contamination opportunities exist due to poor access to environmental surfaces and the bulk storage of medicaments and materials in treatment area;

j. Office lacks effective engineering controls to prevent cross contamination of dental laboratory casts, impressions and appliances;

k. Office lacks effective engineering and work practice controls to reduce opportunities for percutaneous injury due to contaminated instrument transport in paper carriers, as well as overfilled, and unsealed sharps containers.

l. Office lacks safe storage of medical waste and timely removal of it by certified medical waste haulers;

m. Radiation Machine Facility Registration is expired;

n. Emergency Evacuation plan is not posted;

o. First aid supplies for employee accidents are not readily available; and

p. Medical emergency supplies are incomplete.

IV. Findings Based on Board Investigator's Inspection

59. On August 10, 2010, an investigator for the Board made an unannounced inspection of the Respondent's office. He reviewed the Board expert's report with the

Respondent.

A. Written Protocols, Recordkeeping and Posters

60. The poster from the MDE for radiation exposure and a poster for needle stick exposure were displayed.

61. The "We Take Precautions for You" poster was not displayed.

B. Treatment Room Disinfection and Cross Contamination Prevention

62. All instruments stored in the drawers were insecure bags.

63. Clorox bleach and Golden Grain alcohol were located on the bottom shelf of a cart in the operatory.

64. Purell sanitizers were mounted on the wall in the operatory.

65. Eye protection with side shields was present.

66. The countertops remained cluttered.

67. Short sleeve lab coats were in use instead of the required long sleeve coats.

C. Sterilization Protocol

68. A Steri-Dent heat sterilizer was in use. Heavy duty gloves and eye protection with side shield was in the room.

69. There were no records of spore testing being done.

D. Sharps Management and Regulated Bio-Hazardous Waste Disposal

70. Bio-hazard containers were located throughout the office.

71. The Respondent provided the investigator with a receipt of June 23, 2010 from a biomedical waste removal company for collection of two 30 gallon boxes and one case of medical bags; and a receipt of June 28, 2010 for a 30 gallon box and large sharps.

72. Sharps containers were present and at acceptable levels.

E. Laboratory/Sterilization Area

73. The sink was covered with rust.

74. The Respondent had not implemented a protocol for case disinfection and isolation to prevent cross contamination.

75. The Respondent did not maintain a clear distinction between clean and dirty areas.

76. The Respondent was using fixer and developer without a controlled timing process to reduce the need for re-take of x-rays.[4]

F. First Aid and Emergency Procedures

77. The Respondent had oxygen available in the operatory.

78. The Respondent has an emergency medical kit, including an "epi" pen and injectable diphenhydramine, which he purchased after the inspection by the Board expert.

V. Summary of Findings Based on Board Investigator's Inspection

79. At the time of the inspection by the Board's investigator, Respondent had corrected some, but not all, of the sixteen (16) deficiencies enumerated by the Board expert in paragraph 58 above.

VI. Summary of Findings

79. The Respondent's conduct as delineated above is evidence of:

a. Practicing dentistry in a professionally incompetent or grossly incompetent manner in violation of H.O. § 4-315(a)(6);

b. Behaving dishonorably or unprofessionally, or violating a professional code of ethics pertaining to the dentistry profession, in violation of H.O. § 4-315(a)(16); and

[4] The Board expert on her inspection observed in the Respondent's office a nonfunctional automatic processor for radiographs.

c. Failing to comply with Centers for Disease Control's guidelines on universal precautions in violation of H.O. § 4-315(a)(28).

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that Respondent practiced 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 of Fact and Conclusions of Law, it is this 25th day of JANUARY 2012, by a majority of the quorum of the Board, hereby

ORDERED that effective January 20, 2012, Respondent's license to practice dentistry is **SUSPENDED** for one (1) year with all but **thirty (30) days stayed**; and it is further

ORDERED that during the thirty (30) day suspension, Respondent's practice shall be inspected by a Board-approved CDC inspector who shall be provided with a copy of all orders in this case, including this Consent Order, and all documentation pertinent to the investigation, including the report of the Board expert of June 21, 2010; and be it further

ORDERED that Respondent's practice shall not reopen and the suspension will not be lifted without the approval of the CDC inspector; and be it further

ORDERED that after the suspension is lifted, Respondent shall be placed on **Probation** for a minimum of **two (2) years** from the date the Suspension is lifted under the following terms and conditions:

1. Within four (4) months of the date the Suspension is lifted, Respondent's a Board-approved consultant shall conduct an unannounced inspection to re-evaluate his current dental office for compliance with CDC guidelines and to train Respondent and each employee of the office in applying the CDC guidelines to the dental practice;

2. The consultant shall be present in the Respondent's office for at least one (1) full day of patient care and one (1) additional day during the first year of probation, to ensure that Respondent is complying with the CDC guidelines and the Act, and that all employees in the office are in compliance;

3. Respondent shall provide to the Board, on or before the fifth (5^{th}) day of each month, a listing of his regularly scheduled days and hours for patient care;

4. Respondent shall be subject to a minimum of four (4) inspections by the consultant, or other Board-approved agent, during his probationary period the last three being unannounced inspections. Respondent shall request that the consultant provide reports to the Board, within ten (10) days of the date of the inspection. The consultant may consult with the Board regarding the findings of the inspections;

5. Based on unannounced inspections, if the Board makes a finding that Respondent is not in compliance with CDC guidelines, it shall constitute a violation of this Consent Order, and it may, in the Board's discretion, be grounds for immediately suspending Respondent's license. In the event that 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.

6. Respondent shall complete all required continuing education courses required for renewal of his license. No part of the training or education that he receives in compliance with this Consent Order shall be applied to his required continuing education credits;

7. Respondent shall comply with CDC guidelines, including Occupational Safety and Health Administration's ("OSHA") for dental healthcare settings;

8. Respondent shall be responsible for all costs associated with fulfilling the terms of the Consent Order;

9. Respondent shall practice according to the Maryland Dentistry Act and in accordance with all applicable laws; and be it further

ORDERED that any violation of the terms or conditions of this Consent Order shall be deemed a violation of this Consent Order; and be it further

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; and be it further

ORDERED that after a minimum of two (2) years of probation, Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board. The Board will grant the termination if Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and be it 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. & 2011 Supp.)

25 January 2012
Date

T. Earl Flanagan, Jr., D.D.S.
President
Maryland State Board of Dental Examiners

CONSENT

I, Walter D. Solomon, D.D.S., License No. 7983, by affixing my signature hereto, acknowledge that:

1. I have consulted with counsel, Michael May, Esquire, and knowingly and voluntarily elected to enter into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.
2. I am aware that I am entitled to a formal evidentiary hearing, pursuant to Md. Health Occ. Code Ann. § 4-318 (2009 Repl. Vol. & 2011 Supp.) and Md. State Gov't Code Ann §§ 10-201 *et seq.* (2009 Repl. Vol. & 2011 Supp.).
3. I acknowledge the validity and enforceability of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have 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 am waiving those procedural and substantive protections.
4. I voluntarily enter into and agree to abide by the terms and conditions set forth herein as a resolution of the Charges against me. I waive any right to contest the Findings of Fact and Conclusions of Law and I waive my right to a full evidentiary hearing, as set forth above, and any right to appeal this Consent Order or any adverse ruling of the Board that might have followed any such hearing.

5. I sign this Consent Order voluntarily, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

1/13/12
Date

Walter D. Solomon, D.D.S.
Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF

I HEREBY CERTIFY that on this 13 day of January, ~~2011~~ 2012 before me, a Notary Public of the State and County aforesaid, personally appeared Walter D. Solomon, D.D.S. License number 7983, 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.

Janice M. Meisel
Notary Public

My commission expires: 9/28/12