IN THE MATTER OF	*	BEFORE THE MARYLAND
ULYSSES S. MARTIN, D.D.S.	*	STATE BOARD OF
RESPONDENT	*	DENTAL EXAMINERS
License Number: 9713	*	Case Number: 2014-128

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

CONSENT ORDER

On March 6, 2014, the Maryland State Board of Dental Examiners (the "Board") charged **ULYSSES S. MARTIN, D.D.S.** (the "Respondent"), License Number 9713, under the Maryland Dentistry Act (the "Act"), Md. Code Ann., Health Occ. ('H.O.") §§ 4-101 et seq. (2009 Repl. Vol & 2013 Supp.) 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:

(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 ["CDC"] guidelines on universal precautions...

The pertinent regulations under Md. Code Regs. 10.44.23.01 include:

A. A dentist...may not engage in unprofessional or dishonorable conduct.

B. The following shall constitute unprofessional or dishonorable conduct in the practice of dentistry...:

(8) Committing any other unprofessional or dishonorable act or omission in the practice of dentistry...

On April 16, 2014, the Respondent appeared before a Case Resolution Conference Committee ("CRC") to discuss the pending charges and a potential resolution of the charges. Following the CRC, the parties agreed to enter into this Consent Order as a means of resolving this matter.

FINDINGS OF FACT

The Board finds:

1. At all times relevant to these Charges, 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 June 26, 1987, under License Number 9713.

2. At all times relevant to this Order, the Respondent operated a general dental practice in Lanham, Maryland (the "Lanham 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 Internal Revenue Service Officers (the "IRS Officers"). On or about December 17, 2013, the IRS Officers visited the Respondent's Lanham office for the purpose of seizing his assets.

4. On or about December 17, 2013, the IRS Officers contacted the Board by telephone and expressed concern about the state of the Respondent's office, specifically, that they had observed unsanitary conditions. One IRS Officer subsequently sent an e-mail to the Board that included pictures of the Respondent's office attached.

5. On or about December 18, 2013, the Board approved an unannounced inspection of the Respondent's Lanham office.

6. On or about December 20, 2013, a Dental Compliance Officer ("Compliance Officer") conducted an unannounced CDC inspection of the Respondent's Lanham office to determine whether the Respondent was in compliance with the Act and the Centers for Disease Control ("CDC")[1] guidelines on universal precautions. The Compliance Officer found systemic and widespread CDC violations during the inspection.

7. By letter dated December 27, 2013, the Board notified the Respondent of the results of its inspection, and requested a response to the alleged violations and identification of corrective measures to be taken by Respondent.

8. On or about January 6, 2014, the Board received the Respondent's response. The Respondent identified and addressed each area of non-compliance identified by the Compliance Officer, including actions taken to correct each violation.

9. On or about January 14, 2014, a second CDC inspection was done by a dentist retained by the Board as a CDC expert ("CDC expert") to determine the condition of the Respondent's office. The CDC expert concluded that the Respondent had corrected many of the CDC violations and was making a good faith effort to correct infection control and regulatory compliance issues identified by the first CDC inspection.

[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.

The CDC expert recommended counseling and education may be of particular help in assisting the Respondent with these issues.

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

Office inspection, dated December 20, 2013

11. At the time of the Compliance Officer's inspection, the Respondent was not present at the office. As a result, the Compliance Officer 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 clinical practice.

12. The Compliance Officer noted that the Respondent's office consists of a waiting room, a receptionist's desk, a lavatory, and three dental operatories. One operatory ("Operatory 1") is primarily used to treat patients, a second ("Operatory 2") is used for storage, and the third ("Operatory 3") is used as a laboratory/darkroom and an office/storage room, and is rarely used for patients.

13. The Compliance Officer completed a report, dated December 23, 2013, in which the Compliance Officer found in part:

> Throughout the preliminary inspection, multiple Centers for Disease Control Guidelines for Dental Offices (CDC) violations were noted. The severity level of these infractions provides an unsafe environment for the rendering of dental care.
>
> ...
>
> This office poses a severe safety and infection control hazard and places the public at substantial risk for imminent harm.

14. The Compliance Officer's findings included but were not limited to the following:

(a) The reception desk was cluttered with office materials;

(b) Operatory 1 was thoroughly cluttered with boxes, large plastic bags, equipment and papers, which made it extremely difficult to completely access the room. Bio-hazardous waste was stored in this room in a large blue trashcan, closed with a lid and lined with a red bag. The lid completely sealed the can, so once closed with gloves, there was no other receptacle in which to place the contaminated Personal Protective Equipment (PPE);

(c) In Operatory 2, multiple items were on countertops, handpiece motors were engaged on the bracket table, the headrest cover was in place on the dental chair, but the chair itself was stained and no other protective barriers were noted. Loose instruments and x-ray film were noted on instrument tray. Hoses to dental units were encased in dirt and dust. The drawers contained expired Carboxylate[2] cement and Temrex[3] in addition to un-bagged instruments.

(d) Operatory 3 contained an air water syringe with metal syringe tip in place, the countertops were partially cluttered, some equipment was stained or rusted, no barriers were in place, and the curing light cord was taped and fraying of the cord was evident;

(e) The laboratory was cluttered and dirty, and multiple pillows were placed around the compressor. Papers were intermingled with study models, tools, and instruments. The vibrator was encased in cement and an impression tray containing dried impression material was on the countertop. Dental spatulas and knives were in the same container as ink pens and scissors. A used earloop mask was in the room and the lathe was covered with particulate matter with papers on top. Damaged and soiled boxes were in the room, the sink area was dirty and contained particles of cement, and x-ray film covers and foil were in a box and on the floor. In addition, the lid to the automatic processor was open and contained two open containers with liquid, indicating that film is processed through hand dipping. The containers were surrounded by soiled paper; and

(f) The office/storage room was also used as a staff eating area, and had clutter throughout. Numerous expired dental materials were found on the shelves. The emergency kit contained multiple expired

[2]Carboxylate is a brand of dental cement. Dental cements are hard, brittle materials formed by mixing powder and liquid together. Dental cements are used for a variety of dental and orthodontic applications, including use as luting agents, pulp-protecting agents or cavity-lining material, as well as inlays, crowns, bridges, laminate veneers, and orthodontic fixed appliances.
[3]Temrex is a brand of dental cement. *See* Footnote 1.

items, and multiple loose dental instruments and loose single use disposable items were disarrayed in various drawers. A disposable applicator with brush tip attached was also in a drawer.

15. At the time of the December 20, 2013 inspection, the Respondent's receptionist was unable to provide bi-hazardous waste manifests. The office was also unable to provide documentation of staff training, evidence of negative dosimetry testing for six months, current radiation facility registration, post exposure protocol, or weekly spore testing results.

Respondent's response to Compliance Officer's December 20, 2013 inspection

16. The Respondent submitted a written response to the Board dated December 30, 2013, and received by the Board on January 6, 2014. The Respondent stated he had experienced health issues, which led to his incapacitation for two months and he had only returned to work late September 2013. In response to the December 20, 2013 inspection conducted by the Compliance Officer, the Respondent provided information and detailed remedial steps taken, including but not limited to the following:

(a) Operatory 1 is a non-patient contact area which is used solely for storage and is inaccessible to any patients and remains out of patients' line of sight. An additional receptacle was also placed in the Operatory 1 for contaminated PPE;

(b) The dental chair in Operatory 2 has minor staining on the leather, but the stains are ingrained and cannot be removed. Protective barriers normally cover the saliva ejector, air-water syringe, and instrument trays. Hoses to dental units were thoroughly cleaned, all expired items in the drawers have been discarded, and unbagged instruments in drawers have been bagged or placed in closed containers. Loose applicators with syringe tips have been discarded, countertops with paper and baseplate sheet are not normally present and have been removed;

(c) A barrier was placed in the last operatory and the fraying cord has been removed and discarded;

(d) In the hallway, the x-ray unit with documents in the seat and floor was cleared, and the oxygen tank is operational and hallway carpet holes have been covered. Disposable instruments present have also been discarded;

(e) The laboratory/darkroom has been cleaned, but minimal clutter remains due to space limitations. The pillows that were acting as a sound guard for the compressor have been eliminated, and paper has been removed from study models, tools, and instruments. The vibrator was cleaned, an impression tray has been cleaned, dental spatulas and knives have been placed in separate containers from ink pens and scissors, and the lathe has been cleansed and papers discarded from the top. The x-ray film covers and foil have been placed in plastic bags, and soiled paper has been removed and changed daily; and

(f) In the storage room/office, expired dental materials have been removed from shelves and discarded, and the emergency kit has been stocked with non-expired items that are now correctly stored. Multiple loose dental instruments have been bagged or placed in closed containers and disposable items, including disposable applicator with brush tip in drawer, have been discarded.

17. The Respondent also stated in his response that all areas of requested documentation had been forwarded to the Compliance Officer. Respondent attached many of these documents to the response itself. In addition, Respondent stated, "[a]reas of concern and corrective measures have been addressed."

Office inspection, dated January 14, 2014

18. On or about January 14, 2014, the CDC expert conducted a follow-up, unannounced inspection of the Respondent's office. Patients were present at the time of the inspection.

19. The CDC expert completed a report, dated January 16, 2014. The CDC expert made findings including, but not limited to, the following:

(a) The initial impression of the reception area is neat and tidy. The clinic area is equipped with 1970's era dental units, which show

some wear but are in generally good repair without visible dust or dirt accumulation;

(b) With respect to Operatory 1, the door was closed. The lid for designated Medical waste container had been cleaned to remove accumulated dust, an additional trash receptacle was available, and the volume of stored items precluded entry and any further use of the room;

(c) With respect to Operatory 2, the upholstery of the dental chair was intact, and clean headrest barriers were used for each patient. Surface disinfection of chair was performed without prompts from the evaluator. Additionally, protective barriers covered saliva ejector, air water syringe, and instrument tray, and the hoses to dental units had been thoroughly clean. No expired items were found in treatment rooms, lab, storage area, or sterilization area. However, not all reusable devices were verifiably sterilized and open bags were found in multiple drawers and unbagged instruments were on trays for future patient use. All other previously identified problems were confirmed corrected;

(d) With respect to Operatory 3, it was confirmed that no patients were seen in this operatory and the materials on hand suggested use as described by the Respondent;

(e) With respect to the sterilization area, the panoramic x-ray unit had been cleared, the oxygen tank was operational, hallway carpet holes were repaired, and the clinic area was free of visible dust and dirt accumulation. All instruments had been bagged, but bags were not all kept sealed until point of use[4];

(f) With respect to the laboratory/darkroom, all deficiencies had been corrected; and

(g) With respect to the storage room, all deficiencies had been corrected, and while there was massive clutter in the storage room, no patient care or treatment items were found in the area.

20. The CDC expert identified the following CDC violations in the Respondent's office:

[4]After discussion with the evaluator, the Respondent acknowledged understanding that all reusable devices were to remain verifiably sterilized until point of use and initiated steps to immediately correct the situation. All other deficiencies in the sterilization room had been corrected.

(a) All reusable instruments were not verifiably sterilized, but Respondent took immediate steps to correct the condition; and

(b) Dental Unit Waterline maintenance protocol and Baseline testing were not adequately established.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent failed to comply with Centers for Disease Control's guidelines on universal precautions, in violation of H.O. § 4-315(a)(28). The Board agrees to dismiss the charges under H.O. § 4-315(a)(16).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 7TH day of MAY, 2014, by a majority of the quorum of the Board, hereby

ORDERED that the Respondent is **REPRIMANDED**; and it is further

ORDERED that the Respondent shall be placed on **PROBATION** for a **MINIMUM PERIOD OF TWO (2) YEARS** from the date of the execution of this Consent Order and until the Respondent fully and satisfactorily complies with the following terms and conditions:

1. Within **THREE (3) MONTHS** from the date of this Order, the Respondent shall retain a Board-approved consultant who shall conduct an unannounced inspection to evaluate his current dental office for compliance with CDC guidelines and shall train the Respondent and his office staff in the proper implementation of CDC guidelines. 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. The Respondent shall be subject to a minimum of two (2) additional unannounced inspections by the Board approved consultant, during his two (2) year probationary period. The second inspection shall be conducted not later than one (1) year after the execution of this Order. The third inspection shall be conducted no later than twenty-three (23)

months after the execution of this Order. Based upon the results of these inspections, the Board, in its discretion, may order additional inspections or may extend the probationary period;

3. The Respondent shall request that the consultant provide reports to the Board, within ten (10) days of the date of each inspection. The consultant may consult with the Board regarding the findings of the inspections;

4. All inspections shall be unannounced and shall be conducted during a full day of patient care and shall be designed to ensure that the Respondent and all office staff, is complying with the CDC guidelines and the Act;

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

6. At any time during the period of probation, if the Board makes a finding that the Respondent is not in compliance with CDC 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 thirty (30) days; and it is further

ORDERED that the Respondent shall successfully complete at his own expense a Board-approved infection control course no later than six (6) months from the date of the Consent Order. The course shall not be applied to his required continuing education credits required for continued licensure; and it is further

ORDERED that after a minimum of **TWO (2) YEARS OF PROBATION**, the 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 may grant termination only if the 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 it is further

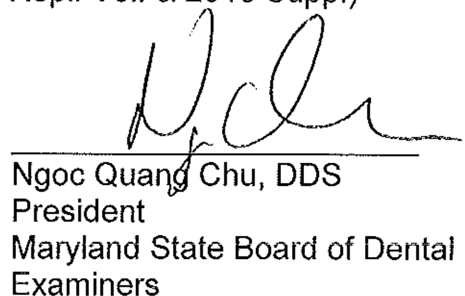
ORDERED that the Respondent shall at all times cooperate with the Board, any of its agents or employees, and with his consultant, in the monitoring, supervision and

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 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, 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 Maryland Dental Practice Act, including an additional probationary term and conditions of probation, reprimand, suspension, revocation and/or a monetary penalty, said violation 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. & 2013 Supp.)



5/7/14
Date

Ngoc Quang Chu, DDS
President
Maryland State Board of Dental Examiners

CONSENT

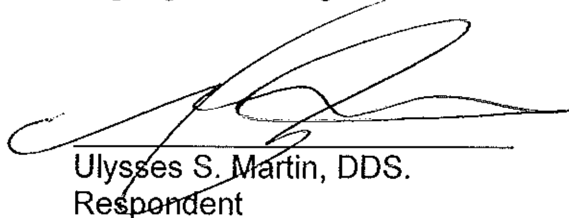
I, Ulysses S. Martin, DDS, acknowledge that I am representing myself in these proceedings. I have been advised of my right to be represented by the attorney of my choice throughout proceedings before the Board, including the right to counsel with an

attorney prior to signing this Consent Order. I have knowingly, willfully and intelligently waived my right to be represented by an attorney before entering 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.

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 provided by law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that I might have filed after any such hearing.

I sign this Consent Order after knowingly, willfully and intelligently waiving my right to be represented by an attorney, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

4/24/14
Date



Ulysses S. Martin, DDS.
Respondent

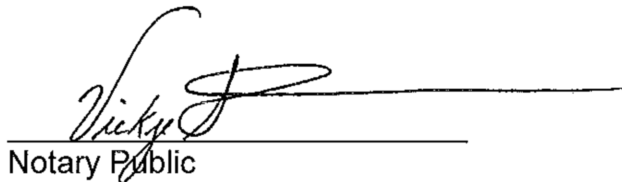
STATE OF Maryland

CITY/COUNTY OF Temple Hills / Prince Georges

I HEREBY CERTIFY that on this 24th day of April 2014, before me, a Notary Public of the foregoing State and City/County, Ulysses S. Martin, DDS

personally appeared, and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.



Notary Public

My Commission expires: 9/9/16