IN THE MATTER OF	*	**BEFORE THE MARYLAND**
ALICIA H. ROBERTSON, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 9636	*	**Case Number: 2018-015**

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE DENTISTRY

The Maryland State Board of Dental Examiners (the "Board") hereby **SUMMARILY SUSPENDS** the license of **ALICIA H. ROBERTSON, D.D.S.** (the "Respondent"), License Number 9636, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under Md. Code Ann., State Gov't II § 10-226(c)(2014 Repl. Vol.), finding that the public health, safety, or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

Based on information received by, and made known to the Board, and the investigatory information obtained by, received by and made known to and available to the Board, including the instances described below, the Board has reason to believe that the following facts are true: [1]

I. BACKGROUND

1. At all times relevant, the Respondent was and is licensed to practice dentistry in the State of Maryland. The Respondent was originally licensed to practice

[1] The statements regarding the Respondent's conduct are intended to provide the Respondent with notice of the basis of the suspension. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

dentistry in Maryland on February 18, 1988, under License Number 9636. The Respondent's license is current through June 30, 2018.

2. At all times relevant, the Respondent practiced dentistry at two locations in Maryland, one in Riverdale ("Practice A")[2] and a second in Silver Spring. The Respondent owned both practice locations and employed another dentist ("Dentist A") to provide dental services at Practice A.

II. DISCIPLINARY HISTORY

3. In or around 2003, based on an investigation of a complaint filed by a former dental associate, the Board issued disciplinary charges against the Respondent under Case Number 2003-071 for failing to comply with infection control guidelines of the Centers for Disease Control and Prevention ("CDC Guidelines") and permitting a dental assistant, who was not a licensed dental radiation technologist, to take radiographs of patients.

4. The Respondent resolved the Board's disciplinary charges by entering into a Consent Order (the "Consent Order"), dated March 3, 2004, in which the Board concluded that the Respondent: practiced dentistry in a professionally or grossly incompetent manner, in violation of Md. Code Ann., Health Occ. § 4-315(a)(6)(2000 Repl. Vol.); permitted an unauthorized individual to practice dentistry, in violation of § 4-315(a)(11); behaved dishonorably or unprofessionally, in violation of § 4-315(a)(16); violated regulations adopted by the Board, in violation of § 4-315(a)(18); and failed to comply with CDC Guidelines, in violation of § 4-315(a)(28).

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[2] To ensure confidentiality, the names of individuals, hospitals and healthcare facilities involved in this case are not disclosed in this document. The Respondent may obtain the identity of the referenced individuals or entities in this document by contacting the administrative prosecutor.

5. Pursuant to the Consent Order, the Board suspended the Respondent's dental license for a period of thirty (30) days with all but seven (7) business days stayed and placed her on probation for a period of two (2) years subject to certain terms and conditions, including but not limited to: quarterly CDC inspections; passing the Maryland Law Examination; performing 40 hours of *pro bono* dental care; and pay a fine of $1,250.00.

6. The Respondent successfully complied with the terms and conditions of the Consent Order, and the Board terminated her probation by order, dated June 27, 2006.

III. CURRENT COMPLAINT

7. On or about July 21, 2017, the Board received a complaint from a patient (the "Complainant") against Practice A. In the complaint, the Complainant stated that during a dental visit, on or about June 5, 2017, he observed human hair on the floor and exposed wiring from the base of the dental lamp in the examination room. The Complainant further stated that a male dentist, who wore a mask and never spoke to the Complainant during the visit, probed his gum for some time. Afterward, a receptionist handed the Complainant a sheet of paper, which stated that he needed deep cleaning, had four cavities and needed two root canal treatments. On or about July 18, 2017, the Complainant saw another dentist, who, after examining him, stated that the Complainant did not need any of the treatments Practice A recommended.

8. After receiving the complaint, the Board initiated an investigation of Practice A and the Respondent.

IV. CDC INSPECTION

9. Due to the Complainant's allegation of unsanitary condition at Practice A, on or about August 15, 2017, a Board-contracted infection control expert (the "Board Inspector"), along with two infection control trainees, went to Practice A to conduct an infection control inspection. Present during the inspection were Dentist A, two dental radiation technologists and a receptionist. The Board Inspector observed one patient in treatment operatory and other patients in the reception area. The Respondent was not present during the inspection.

10. The layout of Practice A includes three treatment operatories, an instrument processing area, a reception area, a patient waiting area, a playroom for children, a consultation/meeting room and staff lounge.

11. During inspection of the instrument processing area, the Board Inspector noted that the positioning of the various processing equipment failed to follow a single loop sequence, which may lead to cross contamination. Next to the autoclave, the Board Inspector observed "Cold Sterile" solution in a glass container, which was not labeled to indicate the solution activation date or the type of solution contained. The Board Inspector also observed a Birex spray bottle that failed to display the date when the solution was mixed or filled. Finally, the Board Inspector observed processed equipment in sterilization pouches that were inconsistently sealed, appeared to be wet inside and outside and failed to display the date the equipment was processed.

12. During the inspection of the three treatment operatories, the Board Inspector initially noted that only two of the operatories had faucets and sinks. In one of the operatories, the Board Inspector observed rotary instrument blocks on a counter

that were not in sterilization pouches and had visible contaminates on the blocks and rotary burs. The Board Inspector also noted the absence of protection on headrests for the dental chairs and the air/water syringe. The Board Inspector next inspected operatory drawers, which contained single-use items that were not bagged and reusable instruments in sterilization pouches that were inconsistently sealed and failed to display the processing date. The Board Inspector also noted that two of the operatories shared an x-ray imaging unit that did not have a barrier in place for the tube head. The Board Inspector further noted that two of the operatory chairs had self-contained water bottles, while a third chair was connected to the municipal water system.

13. During the inspection of the staff lounge, the Board Inspector observed used personal protective equipment ("PPE") placed on a coat rack next to laundered PPE. The Board Inspector found an expired oxygen tank stored in a closet. There were two refrigerators present one of which contained tooth whitening materials and an open bottle of water.

14. The Board Inspector was able to observe patient treatment by Dentist A and an assistant. The Board Inspector observed that Dentist A failed to adhere to safe injection practices. The Board Inspector observed Dentist A handing an uncapped syringe to his assistant, who transported it to the sharps container. The Board Inspector also observed Dentist A using an x-ray machine on a patient even though the tube head had no barrier protection. The Board Inspector observed an assistant using non-hospital grade disinfectant wipes to clean operatory counters. The Board Inspector also observed Dentist A treating a patient wearing prescription eyewear without side shields.

Finally, the Board Inspector noted Dentist A and the assistant failed to use hand sanitizer after removing their gloves.

15. The Board Inspector asked the receptionist to produce documentation of required administrative measures. The receptionist produced an "Office Policy" revised in 2017, an outdated ADA Infection Control Manual and a commercially produced Infection Control Manual not specific to Practice A. After further questioning, the receptionist was unable to produce documentation of equipment maintenance, biohazard waste removal, or weekly spore testing.

16. Based on her inspection, the Board Inspector found that the Respondent's and Dentist A's maintenance of Practice A posed a "significant infection control risk to the patient population that receives treatment at this location." The Board Inspector concluded,

> The office performs non verifiable infection control process with regard to instrument packaging, management, sterilization and surface disinfection. There is a risk due [to] not following hand hygiene practices and the lack of documentation in the performance of spore testing and dating of sterilization package. The office lacks specific protocols of written documentation for equipment and waterline maintenance.

17. In her inspection report, the Board Inspector found the following violations of the CDC Guidelines:

a. No practice-specific Infection Control Policy;

b. No baseline waterline testing;

c. No documentation of maintenance of self-contained water bottle/lines;

d. No posted policy for hand hygiene;

e. No weekly biological monitoring logs;

f. No documentation monitoring biohazard waste removal;

g. No maintenance logs for equipment "eye wash station";

h. No maintenance logs for equipment;

i. Inconsistent sterilization of critical instruments;

j. Inconsistent management of stored instruments;

k. Inconsistent handling of PPE;

l. Inconsistent use of PPE;

m. No labeling of "dated" disinfectant Birex;

n. No labeling of "Cold Sterile"; and

o. Inappropriate handling of sharps.

CONCLUSIONS OF LAW

Based on the foregoing investigative findings, the Board concludes as a matter of law that there is a substantial likelihood that the Respondent poses a risk of harm to the public health, safety and welfare, which imperatively requires the immediate suspension of her license, pursuant to Md. Code Ann., State Gov't II § 10-226(c)(2)(2014 Repl. Vol.).

ORDER

Based on the foregoing investigative findings, it is, by a majority of a quorum of the Board considering this case, pursuant to authority granted to the Board by Md. Code Ann., State Gov't II, § 10-226(c)(2)(2014 Repl. Vol.):

ORDERED that the Respondent's license to practice dentistry in the State of Maryland, License Number 9636, is hereby **SUMMARILY SUSPENDED**; and it is further

ORDERED that upon the Board's receipt of a written request from the Respondent, a Show Cause Hearing shall be scheduled at the Board's next regularly scheduled meeting but not to exceed thirty (30) days from the date of the Respondent's request, at which the Respondent will be given an opportunity to be heard as to why the Order for Summary Suspension should not continue; and it is further

ORDERED that if the Respondent fails to request a Show Cause Hearing or files a written request for a Show Cause Hearing and fails to appear, the Board shall uphold and continue the Summary Suspension of her license; and it is further

ORDERED that upon service of this Order for Summary Suspension, the Respondent shall immediately surrender to the Board all indicia of licensure to practice dentistry issued by the Board that are in her possession, including but not limited to her original license, renewal certificates and wallet size license; and it is further

ORDERED that this document constitutes an order of the Board and is therefore a public document for purposes of public disclosure, as required by Md. Code Ann., Gen. Provisions §§ 4-101 *et seq.* (2014).

10/4/17
Date

Arthur C. Jee, D.M.D.
President
MD State Board of Dental Examiners

NOTICE OF HEARING

Upon the Board's receipt of a written request from the Respondent, a Show Cause Hearing will be held at the offices of the Maryland State Board of Dental

Examiners, Spring Grove Hospital Center, Benjamin Rush Building, 55 Wade Avenue, Catonsville, Maryland 21228. The Show Cause Hearing will be scheduled for the Board's next regularly scheduled meeting but not to exceed thirty (30) days from the Board's receipt of a written request for a hearing filed by the Respondent.

At the conclusion of the Show Cause Hearing held before the Board, the Respondent, if dissatisfied with the result of the hearing, may, within ten (10) days, file a written request for an evidentiary hearing. Unless otherwise agreed to by the parties, the Board shall provide a hearing within forty-five (45) days of the Respondent's written request. The Board shall conduct an evidentiary hearing under the contested case provisions of Md. Code Ann., State Gov't II, §§ 10-201 *et seq.* (2014 Repl. Vol.).