IN THE MATTER OF	*	**BEFORE THE MARYLAND**
NEENA S. JOSHI, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 15785	*	**Case Number: 2018-161**

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

AMENDED ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE DENTISTRY

The Maryland State Board of Dental Examiners (the "Board") hereby **SUMMARILY SUSPENDS** the license of **NEENA S. JOSHI, D.D.S.** (the "Respondent"), License Number 15785, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under: Md. Code Regs. ("COMAR") 10.44.07.22, determining that there is a substantial likelihood that the Respondent poses a risk of harm to the public health, safety, or welfare; and Md. Code Ann., State Gov't § 10-226(c)(2) (2014 Repl. Vol. & 2017 Supp.), concluding that the public health, safety and welfare imperatively require emergency action.

INVESTIGATIVE FINDINGS

The Board bases its action on the following findings:[1]

1. At all times relevant hereto, the Respondent was licensed to practice dentistry in the State of Maryland. The Respondent was initially licensed on April 23, 2015. Her license is current through June 30, 2019.

---

[1] The statements regarding the Respondent's conduct identified herein are intended to provide the Respondent with reasonable notice of the asserted facts. 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.

2. At all times relevant hereto, the Respondent maintained an office for the private practice of dentistry located at 1900 East Northern Parkway, Suite 103, Baltimore, MD 21239 (the "Office").

Complaint

3. On or about February 1, 2018, the Board received a complaint (the "Complaint") from an individual (the "Complainant") who identified herself as a former patient of the Respondent.

4. In the Complaint, the Complainant indicated dissatisfaction with the Respondent's clinical care and alleged that the Respondent was not failing to follow proper hand hygiene protocols.

5. Based on the Complaint, the Board initiated an investigation regarding the Respondent's compliance with CDC guidelines. [2]

6. In furtherance of the investigation, the Board assigned an expert in infection control protocols (the "CDC Expert") to conduct an inspection of the Office.

Office Inspection

7. On or about October 9, 2018, the CDC Expert, accompanied by a Board investigator, conducted an inspection of the Office to determine whether the Respondent was complying with the CDC guidelines.

---

[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 (the "CDC 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 Bloodborne Pathogens (29 CFR 1910.1030). The only exception to this rule arises in an emergency which is life-threatening *and* where it is not feasible or practicable to comply with the guidelines.

Expert Report

8. Following the inspection, the CDC Expert completed a report (the "Expert Report") regarding the Respondent's compliance with CDC Guidelines at the Office.

9. In the Expert Report, the CDC Expert noted numerous violations of the CDC Guidelines in a wide range of areas, specifically as outlined below:

Section I: Policies and Practices

- **I.1 Administrative Measures** – No written policies of any kind available
  - Incomplete autoclave spore test logs
  - Indication of positive growth/ineffective sterilization but no policy on how to remediate
  - No log available on maintenance of equipment /type of maintenance performed
- **I.3 Dental Health Care Personnel Safety** – Office is non-compliant with an exposure control plan tailored to the specific facility
  - No employee records provided for review
  - No written policy regarding CDC recommendations for immunizations, evaluation, and follow-ups
  - Incomplete Hepatitis B Immunization and/or post-vaccination screening documentation for three (3) current employees
  - No documentation of Hepatitis B, MMR, Varicella, Tdap and/or baseline for Tuberculosis for all current staff
  - No written policy concerning contact of personnel with patients when personnel have potentially transmissible conditions
- **I.4 Program Evaluation** – No training or program evaluations for practice, monitoring or feedback available
  - No expiration date on oxygen tank
  - Emergency kit missing multiple medications
- **I.5 Hand Hygiene** – No written policy for hand hygiene

- Limited alcohol based cleaners available
- Several dispensers to hold alcohol cleaner present but non-operational

- **I.6 Personal Protective Equipment (PPE)** – No training log or protocol regarding PPE provided
  - No side shields on Rx glasses used
  - No protective glasses for patient
- **I.7 Respiratory Hygiene/Cough Etiquette** – No policy or procedures available
  - No training log, policy or protocol to document processes for symptomatic staff or patients
  - No masks in reception area
- **I.8 Sharps Safety** – No written policies or guidelines for prevention
- **I.9 Safe Injection Practices** – No written policies, procedures or guidelines available
- **I.10 Sterilization and Disinfection of Patient Care Items and Devices** - No written policies or procedures available for instrument and device maintenance, sterilization or training
  - No device or equipment maintenance logs
- **I.11 Environmental Infection Prevention and Control** – No documentation logs of training for DHCP upon hire, when procedures/policies change, or annually
  - No masks with shields or side shields available
- **I.12 Dental Unity Water Quality** – No written policies, procedures, guidelines or training logs available for maintaining dental water line quality
  - No documentation on frequency or test results
  - No policies and procedures for potential community boil-water advisory

Section II: Direct Observation of Personnel and Patient-Care Practices

- **II.2 Personal Protective Equipment (PPE) is Used Correctly** – Utility gloves not used while processing dirty instruments
  - Eye protection without side shields

- Patient not wearing protective eyewear

- **II.3 Respiratory Hygiene/Cough Etiquette** – No observation of cough etiquette or symptomatic patients
    - No documentation of cough etiquette training
- **II.4 Sharps Safety** – No direct observation of engineering and work practice controls
    - Sharps containers above the full line
- **II.6 Sterilization and Disinfection of Patient Care Items and Devices** – Sterilization area was cluttered, disjointed, and impacting flow from dirty to decontaminated to sterile
    - No use of utility gloves for handling of dirty instruments
    - No secondary indicators used
    - Sterilized instruments stored in peel packs without date of run, machine type, or cycle information
    - No equipment maintenance log
    - Multiple occurrences of failed spore test results
    - Multiple occurrences of spore testing that exceeded weekly testing
    - No information on follow-up or remediation of failed spore tests or explanation for inconsistent spore testing
    - Inability to determine which instruments may have been affected from incomplete sterilization due to undated packs
    - CaviCide lid left open after use, potentially drying out the next wipe
- **II.7 Environmental Infection Prevention and Control** – Inconsistent utilization of surface barriers
    - Disinfectant product stored next to mouthwash
    - Expired anesthetic in operatories available for use
    - Outdated dental materials stored in refrigerator
    - Dirty water remained in bucket in sterilization area
- **II.8 Dental Unit Water Quality** – No documentation of waterline quality management or maintenance of water lines

10. The Expert concluded that based on the violations of the CDC Guidelines found during the CDC Inspection, in particular those listed below, there exists a potential risk to patient and staff safety at the Office:

1) Failed spore test results on 05/16/18, 05/18/18, 05/29/18, 06/05/18, 06/13/18, and 06/19/18 with no indication of follow-up or remediation;

2) Inconsistent time periods between spore tests (07/02/18 – 07/31/18) with no documentation to address discrepancy in weekly timing of spore test;

3) No indication of control spore test results or control usage in documentation;

4) No equipment maintenance log for autoclave or dental waterlines maintained to indicate compliance;

5) No sterilizer run cycle log available;

6) Storage of expired materials and medications;

7) No eye wash station;

8) No customized CDC manual or training log for staff on infection control or blood borne pathogens; and

9) Inconsistent barrier protection.

CONCLUSIONS OF LAW

Based on the foregoing Investigative Findings, and pursuant to its authority under Md. Code Ann., State Gov't § 10-226(c)(2) (2014 Repl. Vol.), the Board concludes that the public health, safety, and welfare imperatively require this emergency action of summary suspension. In addition, pursuant to COMAR 10.44.07.22, the Board concludes that there is a substantial likelihood that the Respondent poses a risk of harm to the public health, safety, or welfare.

ORDER

Based on the foregoing, it is by the Board hereby:

ORDERED that the Respondent's license to practice dentistry in the State of Maryland, under License Number 15785, 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, not to exceed thirty (30) days from the Board's receipt, at which the Respondent will be given an opportunity to be heard as to why the Order the Summary Suspension should not continue; and it is further

ORDERED that if the Respondent files a written request for a Show Cause Hearing and fails to appear, the Board shall uphold and continue the Summary Suspension; 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., General Provisions §§ 4-101 through 4-601 (Repl. Vol. 2014).

NOTICE OF HEARING

Following the Board's receipt of a written request for hearing filed by the Respondent, a Show Cause Hearing will be held at the offices of the Maryland 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, not to exceed thirty (30) days.

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 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 §§ 10-210 *et seq*.

November 9, 2018
Date

Arthur C. Lee, D.M.D., President
Maryland State Board of Dental Examiners