IN THE MATTER OF	*	**BEFORE THE**
DEEP MUKO, D.D.S.	*	**STATE BOARD OF**
RESPONDENT	*	**DENTAL EXAMINERS**
License Number: 12862	*	**Case Number: 2014-142**

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE DENTISTRY

The State Board of Dental Examiners (the "Board") hereby **SUMMARILY SUSPENDS** the license of **DEEP MUKO, D.D.S.**[1] (the "Respondent"), License Number 12862, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under Md. St. Gov't Code Ann. § 10-226(c)(2009 Repl. Vol.), concluding that the public health, safety and welfare imperatively require 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:[2]

1. At all times relevant to this Order for Summary Suspension (the "Order"), the Respondent was and is licensed to practice dentistry in the State of Maryland. The Respondent was initially licensed to practice dentistry in Maryland on or about June 24,

[1] The Respondent was originally licensed to practice dentistry in the State of Maryland under the name of Dipanjan Mukhopadhyay. On or about April 14, 2004, the Respondent legally changed his name to Deep Muko.

[2] The statements respecting 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.

2002, under License Number 12862. The Respondent's license is current through June 30, 2014.

2. At all times relevant to this Order, the Respondent operated a general dental practice located at 198 Thomas Johnson Drive, Suite 18, Frederick, Maryland 21702 (hereinafter the Respondent's "office").

3. The Board initiated an investigation of the Respondent after reviewing a complaint, dated January 10, 2014, from a representative of the Frederick County Health Department, who reported that the Department received an anonymous complaint that the Respondent's office was being operated "without hot or cold running water available."

4. Board investigation determined that on January 8, 2014, a major water leak occurred in the Respondent's office, which required assistance from the Frederick County Fire and Police Departments. Board investigation determined that a water pipe burst in the Respondent's office, leading the Fire Department to break down the door of the office because the leak was flooding the office spaces below.

5. As part of its investigation, the Board ordered an unannounced inspection of the Respondent's office.

6. On January 24, 2014, an independent Board infection control consultant ("Board expert") conducted an inspection of the Respondent's office to determine whether the office was in compliance with the Maryland Dentistry Act (the "Act") and the Centers for Disease Control ("CDC")[3] guidelines on universal precautions. A Board investigator accompanied the Board's expert to the inspection.

[3] 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

7. Upon arrival to the office on that date, the Board's expert encountered another dentist, Riku Mukherjee, DDS, and an office staff person. The Respondent arrived shortly thereafter. The Board's expert learned that the Respondent and Dr. Mukherjee practice at the office, which consists of two dental operatories, a sterilization room and a radiology/dark room.

8. The Board expert questioned the Respondent about the lack of cold or hot running water in the office. The Respondent stated that a pipe burst in the office sometime around January 9 or 10, 2014, and that because staff were not present when this occurred, the Fire Department broke down the office door and manually shut off the water leak in the office. The Respondent stated that a plumber was scheduled to arrive at 4:00 p.m. on January 24, 2014, to restore water to the office.

9. While no patients were present in the office during the inspection, the office appointment book stated that there were several patients scheduled for treatment during the morning and afternoon hours on January 24, 2014. The Respondent stated that he canceled all of his appointments for that day, but that his employee, Dr. Mukherjee, was treating all of the patients.

10. During the inspection, the Board expert reviewed a chart involving a patient who was scheduled for treatment on January 10, 2014. The patient's chart was devoid of much of the essential information needed to treat a patient. While the chart contained a medical history form, the rest of the record contained only financial information. There was no charting of the dental or periodontal tissues or any dental diagnosis or treatment plan. In addition, there was no information in the chart indicating that the procedure was canceled.

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.

11. Board investigation determined that the Respondent's office was providing dental services to patients despite the lack of cold and hot running water in the office. There was no evidence that there was any bottles of distilled water in the office.

12. The Board expert found CDC violations during the inspection, which included the following:

(a) The dental equipment, while serviceable, appeared dirty and not well-maintained;

(b) The office had no hot or cold running water;

(c) The Exposure Control Plan was incomplete and outdated;

(d) The office manual that details the proper infection prevention procedures was missing;

(e) While barriers were in place, it could not be determined how often they were replaced;

(f) Multiple working surfaces were unclean and were littered with particles, dust, debris and unidentifiable spots that may have been blood or other splatter from previous patients;

(g) There were considerable particles, dust, debris and unidentifiable spots throughout the working operatories, which indicated that no effective surface disinfection was being performed;

(h) Debris, dirt and dried blood were present on multiple patient contact surfaces;

(i) Upholstery on both dental chairs had dirt on them, especially in the area where the patient's feet would rest;

(j) Floors were stained and unclean;

(k) The instruments were bagged but there were no dates on the instrument packs; and

(l) There was a self-contained water delivery system but there was no water in the container. There was no chemical disinfectant found in the office to treat the dental unit waterlines ("DUWLs"), leading to questions about coolant water delivery that meets CDC recommendations.

13. The Board's expert issued a report, dated January 24, 2014, in which he stated,

> There were multiple and significant breaches in infection control identified in this inspection and in the current condition; it is not safe to treat patients in this office.
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> * * *
>
> There was no running water in this office and dental care was being performed. However, we were unable to determine exactly what procedures are being done and how often the office is in operation. Nor could we get a date when the water would be repaired. The cleaning and surface disinfection practices of this office are unacceptable. Based on the inspection of January 24, 2014, it is my opinion that it is unsafe for patients to undergo dental treatment in the office of Deep Muko, DDS, which is located at 198 Thomas Johnson Drive, Suite 18, Frederick, Maryland 21702.

14. Based on the above investigative facts, the Board has a basis to charge the Respondent with committing prohibited acts as set forth in the Act under H.O. § 4-315. Specifically, the Board finds that the Respondent violated one or more of the following subsections of H.O. § 4-315(a):

> (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; [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 guidelines on universal precautions[.]

15. Based on the above investigative facts, the Board concludes that the Respondent constitutes an imminent threat to the public, which imperatively requires the suspension of his license.

CONCLUSIONS OF LAW

Based on the foregoing investigative facts, the Board concludes that the Respondent constitutes a danger to the public and that the public health, safety or welfare imperatively require emergency action in this case, pursuant to Md. State Gov't Code Ann. § 10-226(c)(2)(2009 Repl. Vol.).

ORDER

Based on the foregoing findings, it is this 10th day of February, 2014, by a majority vote of a quorum of the State Board of Dental Examiners, by authority granted to the Board by Md. St. Govt. Code Ann. § 10-226(c)(2) (2009 Repl. Vol.), it is hereby:

ORDERED that the Respondent's license to practice dentistry in the State of Maryland, under License Number 12862, 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, 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 fails to request a Show Cause Hearing or makes a request for a Show Cause Hearing and fails to appear for it, the Board shall continue the Summary Suspension; and it is further

ORDERED that the Respondent shall immediately turn over to the Board all licenses to practice dentistry issued by the Board that are in his possession; and it is further

ORDERED that this document constitutes a Final Order of the Board and is therefore a public document for purposes of public disclosure, as required by Md. State Govt. Code Ann. § 10-617(h) (2009 Repl. Vol.).

Ngoc Quang Chu, D.D.S., President
Maryland State Board of Dental Examiners

NOTICE OF HEARING

A Show Cause Hearing to determine why the Order for Summary Suspension should not continue will be held before the Board at Spring Grove Hospital Center, Benjamin Rush Building, 55 Wade Avenue, Catonsville, Maryland 21228, at the Board's next regularly scheduled meeting, following a written request 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, request an evidentiary hearing. Unless otherwise agreed by the parties, the Board shall provide a hearing within forty-five (45) days after the Respondent's request. The Board

shall conduct an evidentiary hearing under the contested case provisions of Md. State Gov't Code Ann. §§ 10-210 *et seq.*