IN THE MATTER OF	*	**BEFORE THE MARYLAND**
BRYAN K. GOVER, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 11500	*	**Case Number: 2018-046**

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

CONSENT ORDER

On October 4, 2017, the Maryland State Board of Dental Examiners (the "Board") summarily suspended the license of **BRYAN K. GOVER, D.D.S.,** (the "Respondent"), License Number 9636, and charged her with violating the Maryland Dentistry Act (the "Act"), Md. Code Ann., Health Occ. I ("Health Occ. I") §§ 4-101 *et seq.* (2014 Repl. Vol.).

Specifically, the Board charged the Respondent with violating the following provisions of the Act under Health Occ. I § 4-315:

> (a) *License to practice dentistry* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may… 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 guidelines on universal precautions[.]

On November 1, 2017, a Case Resolution Conference was held before a committee of the Board. As a resolution of this matter, the Respondent agreed to enter into this public Consent Order consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Board makes the following Findings of Fact:

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 dentistry in Maryland on August 19, 1994, under License Number 11500. The Respondent's license is current through June 30, 2018.

2. At all times relevant, the Respondent practiced dentistry at a dental practice ("Practice A")[1] located in Riverdale, Maryland, alongside another Maryland licensed dentist ("Dentist A"), who owned Practice A.

II. COMPLAINT

3. 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.

[1] 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.

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

III. CDC INSPECTION

5. 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 the Respondent, two dental radiation technologists and a receptionist. The Board Inspector observed one patient in treatment operatory and other patients in the reception area. Dentist A was not present during the inspection.

6. 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.

7. 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.

8. 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.

9. 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.

10. The Board Inspector was able to observe patient treatment by the Respondent and an assistant. The Board Inspector observed that the Respondent failed to adhere to safe injection practices. The Board Inspector observed the Respondent handing an uncapped syringe to his assistant, who transported it to the sharps container. The Board Inspector also observed the Respondent 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 the Respondent treating a patient wearing prescription eyewear without side shields. Finally, the Board Inspector noted the Respondent and the assistant failed to use hand sanitizer after removing their gloves.

11. 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 and weekly spore testing.

12. 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.

13. 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.

9. As a result of the Board Inspector's findings, the Respondent proactively retained an infection control consultant to assist her with CDC policies and procedures. The Respondent's consultant conducted two, six-hour, consultation and training sessions on August 30 and September 17, 2017, to assist the Respondent in correcting the deficiencies the Board Inspector found. The Respondent's consultant has provided the Board with a favorable report of the Respondent's compliance with CDC Guidelines.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's failure to comply with CDC Guidelines in his practice of dentistry at Practice A constitutes: behaving dishonorably or unprofessionally, or violating a professional code of ethics pertaining to the dentistry profession, in violation of Health Occ. I § 4-315(a)(16); and except in an emergency life-threatening situation where it is not feasible or practicable, failing to comply with the Centers for Disease Control's guidelines on universal precautions, in violation of Health Occ. I § 4-315(a)(28).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, by a majority of the Board considering this case:

ORDERED that the Board's *Order for Summary Suspension* of the Respondent's license to practice dentistry in the State of Maryland, issued on October 4, 2017, is hereby **TERMINATED**; and it is further

ORDERED that the Respondent is hereby **REPRIMANDED,** and it is further

ORDERED that the Respondent is placed on **PROBATION** for a period of **TWO (2) YEARS**, subject to the following terms and conditions:

1. A Board-assigned inspector who is a licensed dentist shall conduct an unannounced inspection within ten (10) business days of the date of this Consent Order in order to evaluate the Respondent and his staff regarding compliance with the Act and infection control guidelines. The Board-assigned inspector shall be provided with copies of the Board's file, the Consent Order, and any other documentation deemed relevant by the Board.

2. The Respondent shall provide to the Board-assigned inspector a schedule of his office's regular weekly hours of practice and promptly apprise the inspector of any changes.

3. During the probationary period, the Respondent shall be subject to quarterly unannounced onsite inspections by a Board-assigned inspector.

4. The Board-assigned inspector shall provide inspection reports to the Board within ten (10) business days of the date of each inspection and may consult the Board regarding the findings of the inspections.

5. The Respondent shall, at all times, practice dentistry in accordance with the Act, related regulations, and shall comply with CDC and Occupational Safety and Health Administration's ("OSHA") guidelines on infection control for dental healthcare settings.

6. Any non-compliance with the Maryland Dentistry Act, all related statutes and regulations, and CDC and OSHA guidelines shall constitute a violation of probation and of this Consent Order.

7. On or before the fifth day of each month, the Respondent shall provide to the Board a copy of his current patient appointment book for that month.

8. Within six (6) months of the date of this Consent Order, the Respondent shall successfully complete a Board-approved four (4) credit hour course(s) in infection control protocols, which may not be applied toward his license renewal.

9. The Respondent may file a petition for early termination of his probation after one (1) year from the date of this Consent Order. After consideration of the petition, the Board, or a designated committee of the Board, may grant or deny such petition at its sole discretion.

AND IT IS FURTHER ORDERED that after the conclusion of the **TWO (2) YEAR** probationary period, 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, or a designated Board committee. The Board, or designated Board committee, may grant the termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints of similar nature; and it is further

ORDERED that if the Board has reason to believe that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be an evidentiary hearing before the Board. If there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before the Board; and it is further

ORDERED that after the appropriate hearing, if the Board determines that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice dentistry in Maryland. The Board may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent; and it is further

ORDERED that the Respondent shall at all times cooperate with the Board, any of its agents or employees, and with the Board-assigned inspector, in the monitoring, supervision and investigation of the Respondent's compliance with the terms and conditions of this Consent Order

ORDERED that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Provisions §§ 4-101 *et seq.* (2014).

11/1/17
Date

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

CONSENT

I, Bryan K. Gover, D.D.S., acknowledge that I am represented by counsel and have consulted with counsel 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 the 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 might have followed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

11-1-2017
Date

Bryan K. Gover D.D.S
Bryan K. Gover, D.D.S.
Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 1 day of November, 2017, before me, a Notary Public of the foregoing State and City/County personally appear Bryan K. Gover, D.D.S., and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed.

AS WITNESSETH my hand and notary seal.

Sandra A. Gage
Notary Public

My commission expires: 10/10/19