IN THE MATTER OF	*	**BEFORE THE MARYLAND**
JOHN F. SAVUKINAS, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 10866	*	**Case Number: 2018-197**

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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 **JOHN F. SAVUKINAS, D.D.S.** (the "Respondent"), License Number 10866, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under Md. Code Ann., State Gov't ("State Gov't") § 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 28, 1992, under License Number 10866. The Respondent's license is current through June 30, 2018.

2. At all times relevant, the Respondent practiced general dentistry at a dental office he owned in Rockville, Maryland (the "Office"). [2]

3. On or about April 11, 2018, the Board received a complaint from an individual (the "Complainant") stating that she had frequently witnessed the Respondent failing to comply with infection control protocols in his dental practice. The Complainant alleged that the Respondent used his bare hands to pull out dirty dental instruments from the ultrasonic cleaner and never bagged and sterilized certain dental instruments.

4. Based on the complaint, the Board initiated an investigation of the Respondent and his dental Office.

II. INFECTION CONTROL INSPECTION

5. Due to the Complainant's allegation concerning infection control, on or about April 24, 2018, a Board-contracted infection control expert (the "Board Inspector") visited the Respondent's Office and conducted an infection control inspection.

6. On arrival the Board Inspector noted the physical layout of the Respondent's Office, which consisted of a reception/waiting room that opened to the right followed by a restroom, three treatment operatories, an instrument/imaging processing room and a private office.

7. After speaking with the Respondent, the Board inspector determined that the Respondent was a sole-practitioner of general dentistry, who employed a

[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.

receptionist, a dental assistant and a dental hygienist. At the time of the inspection, the Respondent and the receptionist were present. A dental hygienist (the "Hygienist") arrived about thirty minutes later.

8. As part of the inspection, the Board Inspector utilized the Centers for Disease Control and Prevention ("CDC")[3] Infection Prevention Checklist for Dental Settings.

9. During the inspection, the Board Inspector was able to directly observe patient treatment by the Respondent and the Hygienist.

10. Based on the inspection, the Board Inspector found the following CDC violations:

Section I: Policies and Practices

a. **Administrative Measures** – Failure to maintain written infection prevention policies and procedures specific to the Respondent's Office.

b. **Infection Prevention Education and Training** – Failure to maintain training log of personnel training (upon hire and annually) on infection prevention and bloodborne pathogens standard.

c. **Dental Health Care Personnel Safety** – Failure to maintain exposure control plan specific to the Respondent's Office.

[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 (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 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 life-threatening and where it is not feasible or practicable to comply with the guidelines.

d. **Program Evaluation** – Failure to maintain policies and procedures for routine monitoring and evaluation for infection prevention.

e. **Hand Hygiene** – Failure to maintain personnel training log and posted protocol for hand hygiene.

f. **Personal Protective Equipment (PPE)** – Disposable gowns were available but not used. The Hygienist wore prescription glasses that were not equipped with side shields.

g. **Respiratory Hygiene/Cough Etiquette** – Failure to maintain and post respiratory hygiene policies and procedures for personnel and patients; and failure to maintain personnel training log.

h. **Sharps Safety** – Failure to maintain written policies, procedures and guidelines specific to his Office regarding exposure prevention and post-exposure management.

i. **Safe Injection Practices** – Failure to maintain written policies, procedures and guidelines specific to his Office regarding safe injection practices.

j. **Sterilization and Disinfection of Patient-Care Items and Devices** – Failure to maintain written policies and procedures regarding cleaning and processing of reusable items and devices; failure to maintain training log of personnel assigned to process reusable instruments and devices; and failure to maintain sterilization equipment maintenance log.

k. **Environmental Infection Prevention and Control** – Failure to maintain written policies and procedures on routine cleaning and disinfection of environmental surfaces.

l. **Dental Unit Water Quality** – Failure to maintain policies and procedures for proper maintenance of dental unit water quality; and failure to maintain testing logs. The dental unit water lines were connected to the municipal water supply.

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

m. **Performance of Hand Hygiene** – Failure to perform hand hygiene. The Board Inspector observed the Respondent, while treating a patient in operatory #2, removed his gloves and left them on the counter inside. Without washing his hands, the Respondent then left operatory #2 to check on a hygiene patient in operatory #3. When the Respondent returned to operatory #2, he used the same pair of gloves without washing his hands first and resumed treating the patient in operatory #2.

n. **Use of Personal Protective Equipment (PPE)** – Failure to use PPE correctly. During patient treatment by the Hygienist, the Board Inspector observed her wearing a short sleeve scrub and a pair of prescription glasses without side shields. The Hygienist also failed to wear the ear loop mask correctly. During patient treatment by the Respondent, the Board Inspector observed the Respondent wearing a cotton long sleeve open collar coat that required

laundering. The Respondent also used the same ear loop mask to treat multiple patients instead of discarding it after each patient.

o. **Sharps Safety** – Failure to use engineering controls and work practice controls to prevent injuries.

p. **Sterilization and Disinfection of Patient-Care Items and Devices** – Failure to properly sterilize and disinfect patient-care items and devices. During the inspection, the Board Inspector requested that the Respondent demonstrate post-operative instrument processing and disinfection. Using utility gloves, the Respondent brought the instruments to the processing room and hand scrubbed them. He then placed the instruments in an ultrasonic unit, which used domestic dishwasher powder solution. The Respondent then removed the utility gloves, washed his hands and wipe his hands with a reusable towel. After cleaning from the ultrasonic unit, the Respondent placed the instruments in sterilization pouches while the instruments were still wet. He then placed the instrument pouches in the Harvey Chemclave unit alongside unprocessed handpieces. The Board Inspector noted that the sterilization pouches were not dated. When the Board Inspector requested spore testing log, the Respondent provided reports showing that spore testing was done monthly rather than weekly.

q. **Environmental Infection Prevention and Control** – Failure to comply with environmental infection prevention and control. The Respondent wiped down the chair barrier with disinfectant wipe without removing the barrier itself. The Respondent next wiped down the A/W syringe with disinfectant wipe without removing it for sterilization. The Board Inspector checked a small refrigerator in the sterilization processing area and found that it contained both food and dental materials.

r. **Dental Unit Water Quality** - Failure to maintain policies and procedures for proper maintenance of dental unit water quality; and failure to maintain testing logs. The dental unit water lines were connected to the municipal water supply.

9. Based on her observations and inspection, the Board Inspector determined that the Respondent's dental practice at his Office posed a risk to patient and staff safety.

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 his license, pursuant to State Gov't § 10-226(c)(2) (2014 Repl. Vol.).

ORDER

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

ORDERED that the Respondent's license to practice dentistry in the State of Maryland, License Number 10866, is hereby **SUMMARILY SUSPENDED**; and it is further

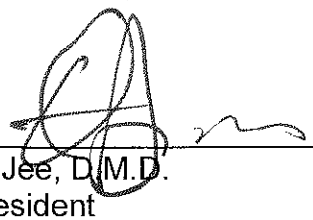
ORDERED that upon the Board's receipt of a written request from the Respondent, a Show Cause Hearing shall be scheduled at the Board's next regularly scheduled meeting but not to exceed thirty (30) days from the date of the Respondent's request, at which the Respondent will be given an opportunity to 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 his 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 his possession, including but not limited to his 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).

06/06/2018
Date



Arthur C. Jee, D.M.D.
Board President
Maryland 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 State Gov't §§ 10-201 *et seq.* (2014 Repl. Vol.).