IN THE MATTER OF	*	**BEFORE THE MARYLAND**
GREGORY C. FELTHOUSEN, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 10511	*	**Case Number: 2020-136**

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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 **GREGORY C. FELTHOUSEN, D.D.S.** (the "Respondent"), License Number 10511, 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

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

I. LICENSING 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 16, 1989, under License Number 10511. The Respondent's license is current through June 30, 2021.

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[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.

2. At all times relevant, the Respondent was employed as a staff dentist by another licensed dentist ("Dentist A") who owned and operated a dental practice with locations in Easton and Salisbury (the "Salisbury Office"), Maryland. The Respondent practiced dentistry at the Salisbury Office, which he previously owned and sold to Dentist A in December 2019.

II. COMPLAINT

3. On or about February 13, 2020, the Board received a complaint from a former employee (the "Complainant") at the Salisbury Office alleging, among other complaints, that Dentist A performed grafting procedures on multiple patients at different times using the same sterile bone and membrane grafting packet that was meant to be discarded after one-time use. The Complainant further alleged that Dentist A at times reused contaminated gloves during patient treatment.

4. Based on the complaint, the Board initiated an investigation of the Salisbury Office and its dental health care providers ("DHCP").

III. INFECTION CONTROL INSPECTION

5. Due to allegations of potential infection control issues at the Salisbury Office, on or about March 2, 2020, a Board-contracted infection control inspector (the "Board Inspector"), along with a Board investigator, visited the Salisbury Office and conducted an infection control inspection.

6. Present during the inspection were the following individuals: the Respondent, the office director (the "Office Director"), two dental hygienists, a dental radiation

technologist/dental assistant, a dental assistant and a patient care coordinator. Dentist A was not present during the inspection.

7. As part of the inspection, the Board Inspector utilized the Centers for Disease Control and Prevention ("CDC")[2] Infection Prevention Checklist for Dental Settings.

8. During the inspection, the Board Inspector was able to directly observe patient treatment by the DHCPs.

9. Based on the inspection, the Board Inspector made the following findings:

Section I: Policies and Practices

a. **Administrative Measures** – As a practicing dentist at the Salisbury Office, the Respondent failed to maintain on site any documented: written infection control policies and procedures specific to the Salisbury Office; annual reassessments of those policies and procedures; training on Infection Prevention/OSHA Bloodborne Pathogen; or utility gloves in the sterilization area. The Respondent maintained a partial system for early detection and management of potentially infectious persons at initial points of patient encounter.

[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.

The Respondent posted precautions poster for patients and offered face masks for patients but failed to designate a separate area for patients with respiratory symptoms and train staff on the importance of containing respiratory infection.

b. **Infection Prevention Education and Training** – As a practicing dentist at the Salisbury Office, the Respondent failed to maintain a log of personnel training (upon hire, annually and new tasks or procedure) on infection prevention and bloodborne pathogens standards. Subsequent to the inspection, Dentist A provided the Board a sign-in sheet for a bloodborne pathogens training that occurred on December 16, 2019, four months after Dentist A acquired the Salisbury Office. At least three employees presently working at the Salisbury Office failed to attend this training, including the Respondent.

c. **Dental Health Care Personnel Safety** – As a practicing dentist at the Salisbury Office, the Respondent failed to maintain on site any documented: exposure control plan specific to the Salisbury Office; employee training on OSHA Bloodborne Pathogens Standard (upon hire and at least annually); current CDC recommendations and office-specific policies on immunization, evaluation and follow-up; availability of Hepatitis B vaccination; post-vaccination screening of Hepatitis B surface antibody; availability of annual influenza vaccination; baseline tuberculosis screening for all dental health care

personnel; a log of needlesticks, sharps injuries and other exposure events; referral arrangements to qualified health care professionals; post-exposure evaluation and follow-up; or well-defined policies concerning contact of personnel with potentially transmittable conditions with patients.

d. **Program Evaluation** – As a practicing dentist at the Salisbury Office, the Respondent failed to maintain on site any documented policies and procedures on routine monitoring and evaluation of infection prevention and control program, and adherence to certain practices such as immunization, hand hygiene, sterilization monitoring and proper use of Personal Protective Equipment.

e. **Hand Hygiene** – As a practicing dentist at the Salisbury Office, the Respondent failed to maintain on site any documented dental personnel training regarding appropriate indications for hand hygiene including handwashing, hand antisepsis and surgical hand antisepsis.

f. **Personal Protective Equipment (PPE)** – As a practicing dentist at the Salisbury Office, the Respondent failed to maintain documentation that dental personnel received training on proper selection and use of PPE.

g. **Respiratory Hygiene/Cough Etiquette** – As a practicing dentist at the Salisbury Office, the Respondent failed to maintain on site any documented policies/procedures and personnel training logs on

containing respiratory secretion in people with signs and symptoms of respiratory infection. The Respondent also failed make available hand sanitizer in the waiting area or provide separate space for persons with respiratory symptoms.

h. **Sharps Safety** – As a practicing dentist at the Salisbury Office, the Respondent failed to maintain on site any documented policies, procedures and guidelines for exposure prevention and post-exposure management. The Respondent failed to maintain documentation on identifying, evaluating and selecting devices with engineered safety features at least annually or as they become available in the market.

i. **Safe Injection Practices** – As a practicing dentist at the Salisbury Office, the Respondent failed to maintain on site any documented policies, procedures and guidelines for safe-injection preparation and practices.

j. **Sterilization and Disinfection of Patient-Care Items and Devices** – As a practicing dentist at the Salisbury Office, the Respondent failed to maintain on site documentation, policies or procedures regarding: appropriate cleaning and processing of reusable instruments and devices; manufacturer's reprocessing instructions; upon hire and annual personnel training log on reprocessing of reusable instruments and devices; personnel training logs on appropriate use of PPE; maintenance logs on sterilization equipment; and responses in the

event of a reprocessing error/failure. The Respondent had inconsistent information on spore testing.

k. **Environmental Infection Prevention and Control** – As a practicing dentist at the Salisbury Office, the Respondent failed to maintain on site any documented policies and procedures on: routine cleaning and disinfection of environmental surfaces; upon hire and annual personnel training about infection prevention and control management of clinical contact and housekeeping surfaces; personnel training logs on appropriate use of PPE; periodic monitoring and evaluations of use of surface barriers; and decontamination of spills or blood or other body fluid.

l. **Dental Unit Water Quality** – As a practicing dentist at the Salisbury Office, the Respondent failed to maintain on site any policies and procedures for: maintaining dental unit water quality; using sterile water as a coolant/irrigant when performing surgical procedures; and responding to a community boil-water advisory.

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

m. **Performance of Hand Hygiene** – As a practicing dentist at the Salisbury Office, the Respondent failed to ensure that DHCPs at the Salisbury Office consistently perform handwashing before putting on gloves and after removing gloves between treating patients.

n. **Use of Personal Protective Equipment (PPE)** – As a practicing dentist at the Salisbury Office, the Respondent failed to ensure that DHCPs at the Salisbury Office consistently perform handwashing before removing PPE. DHCPs also failed to remove PPE before leaving the sterilization/instrument processing area. The Respondent failed to have available utility gloves in the sterilization area.

o. **Respiratory Hygiene/Cough Etiquette** – As a practicing dentist at the Salisbury Office, the Respondent failed to make available face masks and separate waiting area for patients who may have respiratory symptoms.

p. **Sharps Safety** – As a practicing dentist at the Salisbury Office, the Respondent failed to place sharps containers in readily accessible areas of the operatories.

q. **Sterilization and Disinfection of Patient-Care Items and Devices** – As a practicing dentist at the Salisbury Office, the Respondent failed to: have available puncture and chemical resistant utility gloves for manual cleaning; use a chemical indicator inside each sterilization package; label sterilization packages with sterilizer used, the cycle or load number, and the date of sterilization; and maintain logs for each sterilization cycle. The Respondent also failed to maintain consistent documentation on spore testing on site.

r. **Environmental Infection Prevention and Control** – As a practicing dentist at the Salisbury Office, the Respondent failed to consistently barrier-protect clinical contact surfaces such as radiologic exposure button, A/W syringes, HVE and SVE. Unopened sterile packs were placed on the same tray as used instruments. The Board Inspector also did not see an emergency medical kit, and the eye-wash station was not working properly. The medical waste box was placed at a poorly accessible area, and waste disposal manifest was poorly documented.

s. **Dental Unit Water Quality** – As a practicing dentist at the Salisbury Office, the Respondent failed to perform waterline testing and treatment to monitor dental water unit quality.

12. During the inspection, several staff members, including the Respondent, reported to the Board's investigator of having observed Dentist A transporting previously opened packages of membrane and grafting materials from his Easton Office to the Salisbury Office. They reported observing Dentist A using the membrane and grafting materials from the already opened packages on multiple patients at the Salisbury Office. Packages of membrane and grafting materials were meant for one-time use once the package is opened with the unused material discarded.

13. Based on the results of the inspection, the Board Inspector determined that the Respondent, as a practicing dentist at the Salisbury Office, failed to comply with CDC Guidelines as set forth above, which posed a direct risk to patient 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's failure to comply with CDC Guidelines poses a risk of harm to the public health, safety and welfare, which imperatively requires the immediate suspension of her license, pursuant to State Gov't § 10-226(c)(2) (2014 Repl. Vol. and 2019 Supp.).

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. and 2019 Supp.):

ORDERED that the Respondent's license to practice dentistry in the State of Maryland, License Number 10511, 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).

May 21, 2020
Date

Francis X. McLaughlin, Jr.
Executive Director
Maryland State Board of Dental Examiners

NOTICE OF HEARING[3]

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

[3] Due to the recent pandemic, Board hearing may be held remotely by video or telephone conferencing.

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. and 2019 Supp.).