IN THE MATTER OF	*	BEFORE THE MARYLAND
IVY JOHNSON	*	STATE BOARD OF
Applicant	*	DENTAL EXAMINERS
	*	

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FINAL ORDER

On the 17th day of January, 2024, the Maryland State Board of Dental Examiners (the "Board") notified **IVY JOHNSON** (the "Applicant") of the Board's intent to deny her *Application for Dental Hygiene Licensure* (the "Application"), filed on September 5, 2023, pursuant to the Maryland Dentistry Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 4-101 *et seq.* (2023 Repl. Vol.) and COMAR 10.44 *et al.*

The Board based its action on the Applicant's violation of the following provisions of the Act and COMAR:

Health Occ. § 4-315. Denials, reprimands, probations, suspensions, and revocations – Grounds.

(c) *License to practice dental hygiene.* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may deny a general license to practice dental hygiene, a teacher's license to practice dental hygiene, or a temporary license to practice dental hygiene to any applicant, reprimand any licensed dental hygienist, place any licensed dental hygienist on probation, or suspend or revoke the license of any licensed dental hygienist, if the applicant or licensee:

(3) Behaves unprofessionally or in a grossly immoral way, or violates a professional code of ethics pertaining to the dental hygiene profession;

(4) Practices dental hygiene in an unauthorized place;

(5) Practices dental hygiene in a professionally incompetent manner or in a grossly incompetent manner;

(7) Performs intraoral functions not authorized by statute or the rules and regulations of the Board;

(18) Except in an emergency life-threatening situation where it is not feasible or practicable, fails to comply with the Centers for Disease Control ["CDC"] and Prevention's guidelines on universal precautions[.]

Health Occ. § 4-601. License required to practice dentistry or dental hygiene

(a) *Practicing without license.* -- Except as otherwise provided in this title, a person may not practice, attempt to practice, or offer to practice dentistry or dental hygiene on a human being in this State unless licensed by the Board[.]

In its Notice, the Board informed the Applicant that she had the opportunity to request a hearing before the Board by submitting a request in writing to the Board's Compliance Manager within thirty days of service of the Notice. More than thirty days have elapsed since the service of the Notice on the Applicant, and the Applicant has not requested a hearing.

FINDINGS OF FACT

The Board makes the following findings of fact:

I. Application

1. On or about September 5, 2023, the Board received the Applicant's Application.

2. In her Application, the Applicant answered "yes" to question 1, which asked: "Has any licensing or disciplinary board of any jurisdiction, including Maryland, or any

federal entity denied your application for licensure, reinstatement or renewal, or take any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or non judicial punishment? If you are under a Board Order or were ever under a Board Order in a state other than Maryland you must enclose a certified legible copy of the entire Order with this application."

3. Based on the Applicant's acknowledgment on the Application that she had a disciplinary history, the Board began an investigation.

II. Background

4. The Applicant was initially licensed to practice dental hygiene in the State of Maryland on November 8, 1991, under license number 4023.

III. Disciplinary History/Board's Prior Findings

5. On October 18, 2000, following a Show Cause Hearing, the Board summarily suspended the Applicant's license to practice dental hygiene based on, among other things: the Applicant owning and operating a dental office without being licensed to practice dentistry in Maryland; practicing dentistry on patients without a dental license; violating numerous Centers for Disease Control Guidelines; fraudulently prescribing medications using the Drug Enforcement Agency ("DEA") number of licensed dentists; and otherwise putting patients at risk of harm.

6. The Applicant contested the Board's Order for Summary Suspension and a hearing concerning the matter was held at the Maryland Office of Administrative Hearings on December 19, 20 and 21, 2000, before Thomas G. Welshko, Administrative Law Judge. On January 19, 2001, the Administrative Law Judge issued a Proposed Decision in which

he made proposed Findings of Fact, and proposed to uphold the Board's Summary Suspension Order.

7. On January 28, 2004, the Board issued an Order of Revocation of Dental Hygiene license. In the Order, the Board adopted, *inter alia,* the following Findings of Fact from the January 19, 2001, Proposed decision by Judge Welshko:

a. At all times relevant to this proceeding, the Respondent was licensed as a Registered Dental Hygienist (R.D.H.). The Respondent's license number is 4023.

b. The Respondent owned and operated Quality Dental Care, Inc. ("Quality Dental Care"), a dental office located in Capital Heights, Maryland, from 1995 until October 2000. From 1995, the Respondent's dental office was located at 9244 East Hampton Drive in Capital H eights; the Respondent moved the office to 9146 Edgeworth Drive in Capital Heights on or about July 1, 1999.

c. The Respondent controlled the hiring and firing of employees and the financial affairs of Quality Dental Care, including the purchasing of supplies and equipment. Quality Dental Care maintained a business account at Chevy Chase Bank; the Respondent had sole control of this account and was the only individual with signature authority for it. The county occupancy permit for Quality Dental Care is in the Respondent's name alone.

d. To facilitate operations at Quality Dental Care, the Respondent hired temporary dentists to provide dental care services to patients. These dentists were subject to the control of the Respondent and, in the Respondent's view, had to obey all orders that she gave to them, including orders regarding patient treatment.

e. In 1998, the Respondent hired Dr. Fairborz Aghajani-Baik to serve as a dentist for Quality Dental Care. Dr. Baik usually worked on Tuesdays, Thursdays, and Saturdays. Dr. Baik worked at Quality Dental Care until March 2000.

f. The Respondent informed Dr. Baik that she owned Quality Dental Care.

g. During his time at Quality Dental Care, the Respondent ordered Dr. Baik to perform certain kinds of treatment. On one occasion, the ordered Dr. Baik to remove a patient's front teeth, which Dr. Baik refused to do. At times, during Dr. Baik's tenure, the Respondent rendered treatment to patients without allowing Dr. Baik to see them.

h. Sometime in 1999, the Respondent had contacted Dental Power, an agency that places licensed dentists in temporary positions, to have a temporary dentist assigned to Quality Dental Care. Dental Power sent Dr. Kia Kiani to work at Quality Dental Care. While working at Quality Dental Care, the Respondent attempted to give orders to Dr. Kiani related to patient care. On one occasion, the Respondent ordered Dr. Kiani to

place a partial denture in a patient's mouth in a certain way. Dr. Kiani was expected to perform the procedure as ordered.

i. On or about March 24, 2000, the Respondent called Hygiene Associates, another agency that places licensed dentists in temporary positions, to request a temporary dentist for Quality Dental Care. That agency is owned and operated by Pamela Quinones, a licensed dental hygienist.

j. Hygiene Associates sent Shokoufeh Khozein, D.D.S., a licensed dentist, to perform dental services at Quality Dental Care.

k. On or about March 30, 2000, Dr. Khozein was the only dentist working at Quality Dental Care. A patient came into the office that day for dental treatment. The Respondent directed Dr. Khozein to place a temporary crown on one of the patient's teeth. After examining the patient and evaluating the patient's chart, the Respondent determined that the patient needed a root canal. When Dr. Khozein explained this diagnosis to the Respondent, she became angry and directed him to place the temporary crown on the patient's tooth. Dr. Khozein refused. The patient left Quality Dental Care without being treated.

l. Placing a temporary crown on a tooth where a root canal procedure is needed could harm a patient's overall health. A root canal is needed when a patient's tooth becomes infected. This, in turn, can cause the infection to travel into the patient's bloodstream, which would allow the infection to spread throughout the patient's body. Furthermore, if the root canal is

not successful, the tooth may have to be extracted, which would make the having the crown superfluous.

m. Later on March 30, 2000, the Respondent called Ms. Quinones of Hygiene Associates to complain about Dr. Khozein. The Respondent was extremely upset; she yelled at Ms. Quinones, asserting that the dentist that she had sent refused to perform the procedure she had told him to perform. Ms. Quinones asked to speak with the dentist. The Respondent replied, "there's no dentist here. I decide what goes on here!" Ms. Quinones then asked if she could speak with the owner. The Respondent replied that she was the owner. Ms. Quinones asked the Respondent if she was a dentist. She respondent she was a hygienist, but also noted that she did not own the practice.

n. In April 2000, the Respondent called Dental Power to request another temporary dentist. Dental Power sent Dr. Afolabi Martins. During his tenure with Quality Dental Care, the Respondent instructed Dr. Martins to perform a pulpotomy as a final treatment o n a 16-year-old patient. A pulpotomy is a procedure where the pulp chamber of a tooth is removed as a temporary measure to relieve pain. A pulpotomy leaves the tooth's root intact. Dr. Martins refused to perform the pulpotomy.

o. A pulpotomy is never supposed to be used as a final treatment in a patient older than 12. It is usually performed on children with deciduous teeth (i.e., baby teeth). The danger of performing a pulpotomy on a patient

older than 12 is that the procedure could leave the root infected. This could cause the patient to lose the tooth and allow the infection to spread throughout the patient's body.

Patient A

p. On march 25, 2000, Patient A came to Quality Dental Care, for an examination and cleaning. Patient A had complained of tooth pain. The Respondent saw Patient A first; she performed an examination and scaling and dispensed Perio medication. Patient A then saw Dr. Khozein. Dr. Khozein did a composite build-up on tooth #30. He noted that this patient had several cavities (caries), needed her wisdom teeth extracted and required a root canal procedure on tooth #12. Dr. Khozein also determined that Patient A needed to have her braces removed to facilitate the treatment that he determined that the patient needed. He prescribed penicillin (Pen VK) for the infection he found in tooth#12 and 800 mg of Motrin for pain. Dr. Khozein did not authorize any refills for these prescriptions.

q. On or about March 29, 2000, Patient A returned to Quality Dental Care because of continued pain. No dentist was working there that day. The Respondent saw Patient A and prescribed 800 mg of Ibuprofen for her. She called the prescription into CVS Pharmacy, using Dr. Fairborz Aghajani-Baik's name. Dr. Baik was no longer working for Quality

Dental Care; he had not given the Respondent permission to use his name when ordering prescriptions.

r. On April 1, 2000, Patient A returned to Quality Dental Care. Dr. Martins was on duty, examined her, noted distal decay in tooth #18, and recommended that the tooth be extracted. He repeated Dr. Khozein's advice that she needed to have her braces removed to have further treatment.

s. On April 22, 2000, Patient A was still experiencing pain, so she returned to Quality Dental Care for additional treatment. The Respondent saw her. After examining Patient A, the Respondent prescribed Ibuprofen (800 mg.) and Pen VK (500 mg.) for her. She called the prescription into CVS pharmacy, using Dr. Martin's name. Dr. Martins never authorized the Respondent to order this or any other prescription.

t. On July 8, 2000, Patient A returned to Quality Dental Care for additional treatment. The Patient's jaw was swollen, because an infection had developed in tooth # 5. No dentist was present that day. The Respondent undertook treating Patient A. She placed a temporary filling in tooth #5, using a preparation called "Cavit." She also prescribed Amoxicillan [*sic*] (500 mg.) and Ibuprofen (800 mg.) using the name "Dr. Fairborz Aghajani" without Dr. Aghajani-Baik's permission to call the prescription into Giant Pharmacy.

u. The use of Cavit to fill an infected tooth is an inappropriate treatment technique. Proper procedure requires the infection to be drained and treated before any filling is placed in the tooth. The use of Cavit to fill an infected tooth seals in the infection, which allows the infection to seep into the bloodstream and travel throughout the patient's body.

Patient B

v. On April 8, 2000, Patient B came to Quality Dental Care for a routine examination and cleaning. Before receiving treatment, Patient B filled out a medical history form. On that form, she indicated that she had asthma and was taking Flovent for that condition. She also noted that she was allergic to Alupent. The Respondent then treated Patient B in the absence of a licensed dentist. She conducted a routine examination, performed prophylaxis (teeth cleaning) and took bitewings. She did not detect decay on Patient B's tooth #30 and discharged Patient B. The Respondent did not consult Patient B's physician concerning her asthmatic condition before treating her.

w. The Respondent's treatment of Patient B without consulting her physician concerning her asthma created a dangerous situation. The stress associated with a dental examination or dental treatment can trigger an asthma attack. If a patient has an acute asthma attack, a customary treatment to receive the asthmatic symptoms is the administration of the drug Alupent. Patient B is allergic to Alupent. Had Patient B suffered an

asthma attack while the Respondent was treating her and had Alupent been given to her, she could have suffered a life-threatening allergic reaction.

x. As of April 8, 2000, the Respondent did not know what Alupent was and had no idea how to treat a patient suffering from an acute asthma attack. This created a dangerous situation. The stress of dental treatment could trigger an asthma attack, which, in turn, can seriously impede or arrest a patient's ability to breathe.

Patient C

y. On October 2, 1999, Patient C came to Quality Dental Care to receive dental care services. The Respondent saw Patient C and performed a routine examination and teeth cleaning (prophylaxis), without being supervised by a licensed dentist. The Respondent also have the patient Perio-medication. She then scheduled Patient C for routine six-month check-up.

z. On October 12, 1999, Patient C returned to Quality Dental Care because tooth #7 had become sensitive. Dr. Hossein Mohoubi saw this patient. He evaluated an x-ray of the tooth #7 area and determined that teeth #s 6 and 7 needed root canal therapy. Dr. Mohoubi placed a sedative filling on tooth #7. The Respondent had not noticed problems with these teeth when she examined Patient C on October 2, 1999 and, consequently, did not make any notations on the patient's chart about them.

Patient D

aa. On August 28, 1999, Patient D visited Quality Dental Care for a routine dental check-up. The Respondent saw Patient D. She examined her teeth, took x-rays, and cleaned the Patient's teeth. In her medical history, Patient D also stated that she had felt pain in her teeth, clocking and pain in her jaw and had experience difficulty [*sic*] opening and closing her jaw. She also indicated that she had problems with chewing and that she clenched and grinded her teeth. In response to these complaints, the Respondent made the diagnosis that the patient had suffered from Temporo Mandibular Joint syndrome ("TMJ") and performed a therapeutic treatment for this condition on this patient. A dentist did not see Patient D. She placed this patient on a routine six-month recall.

bb. Patient D's x-rays indicated that recurrent decay was present on tooth #4, which required treatment. The Respondent did not diagnosis [*sic*] this problem. She attributed the problems with Patient D's tooth #4 to bone loss, rather than decay.

Patient E

cc. On or about January 5, 1999, Patient E came to Quality Dental Care for a routine dental examination and teeth cleaning (prophylaxis). Dr. Hossein Mahbouri saw Patient E. He noted that the patient's chart indicated that the patient had received a knee replacement and had diabetes and that because of these conditions, the patient's physician had

noted that Patient E must be pre-medication before he could receive dental treatment. Dr. Mahbouri examined the patient, cleaned his teeth and made a notation on the patient's chart that tooth #18 needed to be extracted.

dd. On February 16, 1999, Patient E returned to Quality Dental Care. He had been pre-medicated, so Dr. Mahbouri extracted tooth #18. Dr. Mahbouri also noted that Patient E needed crowns on teeth #s 2, 30 and 31.

ee. On September 9, 1999, Patient E returned to Quality Dental Care. On these occasions, the Respondent examined and cleaned Patient E's teeth without noting the need for pre-medication. On these occasions, the Respondent also noted that Patient E should return in six months for a regular check up. She did not refer to the treatment recommendations made by Dr. Mahbouri.

ff. The danger created by providing dental treatment to a patient who has diabetes and had a knee replacement without having that patient pre-medication is that of infection. If a prosthetic device becomes infected, treatment is difficult because this device is not organic and is not receptive to antibiotics. Diabetes makes infection more likely because peripheral blood flow to the extremities is often interrupted.

Patient F

gg. On December 28, 1999, Patient F came to Quality Dental Care for a routine examination and teeth cleaning. Upon arrival, she completed a

medical history form and indicated on that form that she had asthma and took Albuterol to treat that condition. The Respondent, without a dentist being present, examined Patient F's teeth and performed a routine cleaning. The Respondent performed these procedures without consulting the Patient's physician about her asthmatic condition.

hh. The danger created by not consulting an asthmatic patient's physician before performing dental treatment is that the stress of dental treatment could trigger an asthma attack, which, in turn, can seriously impede or arrest a patient's ability to breath [*sic*]. The Respondent did not know how to treat a patient with asthma.

Findings Related to Centers for Disease Control Guidelines

ii. On August 31, 2000, Lisa Schafer and Richard Hill, Board Investigators, conducted a Centers for Disease Control ("CDC") investigation at the offices of Quality Dental Care.

jj. The following conditions existed at Quality Dental Care on August 31, 2000 with regard to cleanliness and adherence to CDC guidelines:

1. There was no autoclave present for the sterilization of dental instruments. The autoclave was broken and had been sent out for repairs.
2. There was no separate contained for the disposal of bio-hazardous waste. The Respondent had disposed of bio-hazardous waste in normal trash containers.

3. No patients were being treated on August 31, 2000.

kk. On September 7, 2000, Lisa Schafer and Guy Shampaine, D.D.S., Board Compliance Officer, conducted a follow-up investigation at Quality Dental Care with regard to cleanliness and adherence to CDC guidelines.

ll. The following conditions existed at Quality Dental Care on August 31, 2000 with regard to cleanliness and adherence to CDC guidelines:

1. There was still no autoclave present for the sterilization of dental instruments. The autoclave was broken and had been sent out for repairs.
2. The Respondent had disposed of medical waste using a sharps container. The Respondent only placed bloody material in a bio-hazardous waste container. She placed all other medical waste, including non-bloody sharps, gloves, and all other bio-hazardous waste in normal trash containers.
3. The Respondent's contract with BFI (later known as Stericycle), a hazardous materials disposal company, had expired in 1999 and had not been renewed. Bio-hazardous waste had accumulated in the office.
4. When the autoclave was working, the Respondent used steam indicator strips to determine its effectiveness. This was an improper method of making that determination.

mm. The conditions present at the Respondent's dental office on August 31, 2000 and September 7, 2000 presented a danger to the public health.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact set forth in the January 28, 2004, Order of Revocation constitute grounds for denial of the Applicant's Application, *i.e.* a violation of Health Occ. § 4-601(a) Except as otherwise provided in this title, a person may not practice, attempt to practice, or offer to practice dentistry or dental hygiene on a human being in this State unless licensed by the Board; Health Occ. § 4-315(c)(3) Behaves unprofessionally or in a grossly immoral way, or violates a professional code of ethics pertaining to the dental hygiene profession; Health Occ. § 4-315(c)(4) Practices dental hygiene in an unauthorized place; Health Occ. § 4-315(c)(5) Practices dental hygiene in a professionally incompetent manner or in a grossly incompetent manner; Health Occ. § 4-315(c)(7) Performs intraoral functions not authorized by statute or the rules and regulations of the Board; Health Occ. § 4-315(c)(18) Except in an emergency life-threatening situation where it is not feasible or practicable, fails to comply with the Centers for Disease Control ["CDC"] and Prevention's guidelines on universal precautions.

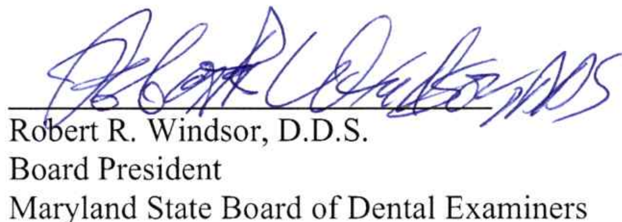
ORDER

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

ORDERED that the Applicant, Ivy Johnson's *Application for Dental Hygiene Licensure*, filed on September 5, 2023, be and hereby is **DENIED**; and it is further

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

3/6/24
Date



Robert R. Windsor, D.D.S.
Board President
Maryland State Board of Dental Examiners

NOTICE OF RIGHT TO APPEAL

Pursuant to Md. Code Ann., Health Occ. § 4-315(b) (2021 Repl. Vol.), you have a right to take a direct judicial appeal. A Petition for Judicial Review must be filed within thirty (30) days of service of this Order and shall be made as provided for judicial review of a final decision in the Md. Code Ann., State Gov't §§ 10-201 *et seq.* (2014 Repl. Vol.) and Title 7, Chapter 200 of the Maryland Rules.