IN THE MATTER OF	*	**BEFORE THE MARYLAND**
MOHAMMED S. WARSHANNA, D.M.D.	*	**STATE BOARD OF**
RESPONDENT	*	**DENTAL EXAMINERS**
License Number: 11884	*	**Case Number: 2019-148**

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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 **MOHAMMED S. WARSHANNA, D.M.D.** (the "Respondent"), License Number 11884, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under: Md. Code Regs. ("COMAR") 10.44.07.22, determining that there is a substantial likelihood that the Respondent poses a risk of harm to the public health, safety, or welfare; and Md. Code Ann., State Gov't § 10-226(c)(2) (2014 Repl. Vol. & 2018 Supp.), concluding that the public health, safety and welfare imperatively require emergency action.

INVESTIGATIVE FINDINGS

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

Background

1. The Respondent was initially licensed to practice dentistry in Maryland on or about September 5, 1996, under license number 11884. The Respondent's license is current through June 30, 2020.

[1] The statements regarding the Respondent's conduct identified herein are intended to provide the Respondent with reasonable notice of the asserted facts. 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.

2. At all times relevant, the Respondent practiced dentistry at a private dental practice in Catonsville, Maryland.

Disciplinary History

3. On or about June 3, 2015, the Board summarily suspended the Respondent's Class II Sedation Permit after determining that the Respondent: routinely provided anesthesia to a level beyond moderate sedation; routinely administered IV morphine after patients were already maximally sedated; inappropriately administered oxycodone to one patient; and failed to obtain informed consent for the type sedation he administered.

4. On or about May 18, 2016, the Board charged the Respondent with the violations of the Act to include professional incompetence and failing to meet generally accepted standards.

5. On or about March 1, 2017, the Respondent resolved the summary suspension of his sedation permit and the Board's charges by entering into a public Consent Order (the "2017 Consent Order") in which the Board found as a matter of fact that he: placed direct pulp cap on primary teeth that had carious pulp exposure; performed pulpotomies on teeth with irreversible pulpitis; consistent incised and drained abscessed teeth prior to pulpotomies; treated primary teeth that were close to exfoliating; failed to document dosage and frequency of antibiotics prescribed; failed to document the type of isolation used during endodontic procedures; failed to document the type of amount of anesthetic used; failed to document treatment rationale; and billed for limited examination without documented support.

6. Based on the findings of fact contained in the 2017 Consent Order, the Board concluded as a matter of law that:

> the Respondent's conduct constitutes the practice of dentistry in a professionally incompetent manner or in a grossly incompetent manner; demonstrates a course of conduct of providing dental care that is inconsistent with generally accepted professional standards of care in the practice of dentistry, regardless of whether actual injury to the patient occurs; and providing a dental service in a manner that is significantly inconsistent with generally accepted professional standards of care in the practice of dentistry, regardless of whether actual injury to the patient occurs, in violation of [Health Occ.] § 4-315(a)(6), (18) and/or (19), respectively.

7. Pursuant to the 2017 Consent Order, the Board reprimanded the Respondent and placed him on probation for minimum period of one-year and various conditions, including, but not limited to, that he "permanently cease treating patients who are 17 years old or younger, with the exception of orthodontia for patients ages 13 – 17 years old."

8. On or about October 17, 2018, the Board charged the Respondent with violating his 2017 Consent Order. Specifically, the Board alleged that the Respondent had violated the following provision of the 2017 Consent Order:

> **ORDERED** that that the Respondent permanently cease treating patients who are 17 years old or younger, with the exception of orthodontia for patients ages 13 – 17 years old [.]

9. On or about March 6, 2019, the Respondent entered into the 2019 Consent Order in order to resolve the charges that he violated the 2017 Consent Order.

10. The 2019 Consent Order found that the Respondent had provided dental services other than orthodontia to three minor patients, despite the 2017 Consent Order's prohibition on doing so, cited above, including: evaluation, radiographs, prophylaxis, and fluoride application.

11. The 2019 Consent Order reprimanded the Respondent extended the probationary imposed under the 2017 Consent Order for another nine (9) months.

12. Under the terms of the 2019 Consent Order, the Respondent was also subject to "records reviews of the Respondent's practice to determine the Respondent's compliance with the Consent Order and/or the Maryland Dentistry Act."

Complaint

13. During the course of one of the required record reviews pursuant to the 2019 Consent Order, the Board-approved reviewer was present at the Respondent's office. In the course of the review, the reviewer became concerned about the Respondent's compliance with infection control protocols.

14. Subsequently, on or about June 17, 2019, the reviewer submitted a written complaint to the Board (the "Complaint").

15. Based on the Complaint, the Board initiated an investigation regarding the Office's compliance with CDC guidelines. [2]

16. In furtherance of the investigation, the Board assigned an expert in infection control protocols (the "CDC Expert") to conduct an inspection of the Office.

Office Inspection

[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.

17. On or about June 21, 2019, the CDC Expert, accompanied by a Board investigator, conducted an inspection to determine whether the Office was complying with the CDC guidelines. The Respondent and an assistant were present and treating patients at the Office during the inspection.

Expert Report

18. Following the inspection, the CDC Expert completed a report (the "Expert Report") regarding compliance with CDC Guidelines at the Office.

19. In the Expert Report, the CDC Expert noted violations of the CDC Guidelines in a range of areas, specifically as outlined below.[3]

Section I: Policies and Practices

- **I.1 Administrative Measures**
  - Infection Control Manual contained generic guidelines in regard to administrative requirements. Practice-specific guidelines were not contained in the manual.
- **I.2 Infection Prevention Education and Training**
  - No Documentation of "Time of Hire" training
  - The only viable documented annual training for the Respondent and staff occurred on November 24, 2015
  - Blank OSHA Training Certificates were contained in the Practice Manual dated May 23, 2018 and October 30, 2017.
- **I.3 Dental Health Care Personnel Safety**
  - Manual did not contain specific requirements for the practice
  - No documentation of compliance with hepatitis B vaccination requirements for dental healthcare personnel (DHCP)

[3] The headings and numbering system used to outline the CDC-related issues herein are derived from the CDC's published "Infection Prevention Checklist," which the CDC Expert employed as a tool in completing her inspection.

- No documentation of tuberculosis screening of DHCP upon hire

- **I.4 Program Evaluation**
  - Manual did not contain specific requirements for the practice.
- **I.5 Hand Hygiene**
  - Manual did not contain specific requirements for the practice.
- **I.6 Personal Protective Equipment (PPE)**
  - Manual did not contain specific requirements for the practice regarding PPE
- **I.7 Respiratory Hygiene/Cough Etiquette**
  - Manual did not contain specific requirements for the practice.
- **I.8 Sharps Safety**
  - Manual did not contain specific requirements for the practice.
- **I.9 Safe Injection Practices**
  - Manual did not contain specific requirements for the practice.
- **I.10 Sterilization and Disinfection of Patient Care Items and Devices**
  - Manual did not contain specific requirements for the practice.
- **I.11 Environmental Infection Prevention and Control**
  - Manual did not contain specific requirements for the practice.
- **I.12 Dental Unity Water Quality**
  - Manual did not contain specific requirements for the practice.
  - Water Line Testing Program Certificate was contained in the Practice Manual - Expired December 19, 2002

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

- **II.1 Hand Hygiene is Performed Correctly**
  - Hand hygiene practices by DHCP were deficient

- Hand washing or the use of hand sanitizer was not performed before or after removing gloves.

- DHCP frequently would touch/adjust hair with gloved hands.

- **II.6 Sterilization and Disinfection of Patient Care Items and Devices**

  - Instrument processing location and layout of equipment and materials indicates the Office is not following a "Single Loop" sequence of sterilization

  - Sealed sterilization pouches containing instruments are not labeled with the date, load cycle, or which processor was used for sterilization

  - Spore tests have not been performed since September 19, 2018 according to the laboratory contracted to conduct them. The laboratory also confirmed that at the time of the inspection, the contract to perform spore testing for the Office was expired. The most recent documentation available for same-day submission to the CDC Expert at the Office was from 2013.

  - Items designated "Single Use" -- specifically nitrous masks -- were placed in Glutaraldehyde solutions in preparation to be re-used.

  - Glutaraldehyde was not marked as to date of activation.

  - Sterilization pouches were not consistently sealed properly.

- **II.7 Environmental Infection Prevention and Control**

  - Placement of a barrier on the A/W Syringe is compromised

  - Operatory biohazard waste receptacles do not have lids

  - Ceiling tile in the instrument processing area had a stain indicative of black mold

20. The Expert concluded that based on the violations of the CDC Guidelines found during the CDC Inspection, in particular those listed above, there exists a risk to patient and staff safety at the Office.

21. As a licensed dentist who practices at and owns the Office, the Respondent failed to ensure compliance with the CDC Guidelines at all times.

CONCLUSIONS OF LAW

Based on the foregoing Investigative Findings, and pursuant to its authority under Md. Code Ann., State Gov't § 10-226(c)(2) (2014 Repl. Vol. & 2018 Supp.), the Board concludes that the public health, safety, and welfare imperatively require this emergency action of summary suspension. In addition, pursuant to COMAR 10.44.07.22, the Board concludes that there is a substantial likelihood that the Respondent poses a risk of harm to the public health, safety, or welfare.

ORDER

Based on the foregoing, it is by the Board hereby:

ORDERED that the Respondent's license to practice dentistry in the State of Maryland, under License Number 11884, 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, not to exceed thirty (30) days from the Board's receipt, 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 files a written request for a Show Cause Hearing and fails to appear, the Board shall uphold and continue the Summary Suspension; 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., General Provisions §§ 4-101 through 4-601 (2014 Repl. Vol. & 2018 Supp.).

NOTICE OF HEARING

Following the Board's receipt of a written request for hearing filed by the Respondent, a Show Cause Hearing will be held at the offices of the Maryland 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, not to exceed thirty (30) days.

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 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 Md. Code Ann., State Gov't §§ 10-210 *et seq.* (2014 Repl. Vol. & 2018 Supp.).

July 19, 2019
Date

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