# STATE OF NEW HAMPSHIRE
## OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

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## BOARD OF DENTAL EXAMINERS

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| **In Re: Marina Becker, DMD License #03448**<br><br>Docket No.: 22-DEN-015 | **FINAL DECISION AND ORDER ON EMERGENCY LICENSE SUSPENSION - 10/28/22** |

## I. ATTENDEES:

Nikolas K. Frye, Presiding Officer
Puneet Kochhar, Board Chairperson
Linda Tatarczuch, Board Member
Lisa Scott, Board Member
Jay Patel, Board Member
Muhenad Samaan, Board Member
Jon J. Girald, Board Member
Virginia Kapetanakis Moore, Board Member
Dr. Marina Becker, Licensee
Attorney Mark V. Franko, Counsel for Licensee
Attorney Marissa Schuetz, Hearing Counsel
Jenna Wilson, Administrator
Jessica Whelehan, Administrator
Lauren Warner, Board Counsel
Elizabeth Eaton, Board Counsel (Observing)
Shane Goulet, Board Counsel (Zoom) (Observing)

## II. CASE SUMMARY/PROCEDURAL HISTORY:

On 10/03/22, the Board of Dental Examiners ("Board") reviewed a Complaint and Memo to the Board from Enforcement regarding Marina Eugene Becker ("Licensee"), alleging unsanitary conditions, tools not sterilized, and unclean office conditions. The Board voted to conduct an unannounced inspection of licensee's office, Queen City Dental, 60 Rogers Street Unit 1A Manchester, New Hampshire. On October 14, 2022, Investigators Myra Nikitas and Eric Goulet performed an unannounced inspection at

licensee's office. After receiving oral testimony from the Investigators regarding the lack of sanitary conditions including but not limited to lack of appropriate sterilization or metal implements, improper medication storage, expired medications, improper needle storage, improper disposal of biohazards, among other health and safety matters, the Board voted to suspend the Licensee's license on an emergency basis pursuant RSA 541-A:30(III), RSA 317-A:18-b, N.H. Code Admin. R., Title Den 207.04 ("Rule"), N.H. Code Admin. R., Title Plc 206.07 ("Plc"). This Final Decision and Order on Emergency License Suspension follows after a hearing on the merits held on 10/28/22.

## III. SUMMARY OF THE EVIDENCE:

The Board received the following evidence pursuant to RSA 541-A:33 and Rule 208.09:

a. Exhibits were submitted by Hearing Counsel, numbered as follows:

1. Complaint;
2. 10/04/22 Board Memorandum Requesting Unannounced Inspection;
3. Report of Inspection by Myra Nikitas;

b. Exhibits were submitted by Licensee, numbered and were re-labeled by the Board as follows:

A. Copies of Document Produced to the Board in Response to the Subpoena issued in this matter;
B. Resume of Karen Packard;
C. Report of Karen Packard dated 10/27/22; and
D. Webpage for Turbyne & Associates

c. Sworn testimony was received from:

1. Myra Nikitas (called by Hearing Counsel)
2. Karen Packard (called by Licensee)
3. Dr. Marina Becker, Licensee (called by Licensee)

## IV. CONDUCT OF THE HEARING AND EVIDENCE PRESENTED:

The Licensee has held a license as a dentist in New Hampshire since 2004. After receiving a complaint, ordering an unannounced inspection, learning of the inspector's findings, and emergently suspending the Licensee's license on a temporary basis, the Board conducted this adjudicative hearing on

10/28/22 where Licensee appeared with counsel. Pursuant to Rule 208.10, Hearing Counsel has the burden of proving her case by a preponderance of the evidence. The sole issue for the Board at this time is determining whether to affirm and continue the emergency suspension of the Licensee's license based upon the standard cited in RSA 317-A:18-b.[1] During an impromptu 10/28/22 Prehearing Conference held directly before the adjudicatory hearing, Hearing Counsel and Licensee's Counsel agreed to admit all evidentiary exhibits, which was allowed by the Board.[2] The credible evidence presented at the adjudicatory hearing allows the Board to find the following facts.

**HEARING COUNSEL'S CASE-IN-CHIEF:**

**Myra Nikitas:**

Hearing Counsel's sole witness was Myra Nikitas. According to her testimony, she is a dental hygienist and certified public health hygienist who the Board assigned to conduct an unannounced inspection of the Licensee's practice on 10/14/22. The Board had requested the inspection based upon an anonymous complaint received 06/17/22, alleging the Licensee had unsanitary conditions in her office. *See* Exhs. 1 and 2. Specifically the complaint had alleged the following conditions existed at the Licensee's office:

RUSTY INSTRUMENTS
DIRTY INSTRUMENTS/NOT STERILIZED
Dirty operatories/visual blood splatter
items not sterilized visual gunk caked on before put in mouth
dr doesn't always wear gloves to enter mouth
no quality control
no covid guidelines followed
dr doesn't always wear mask
sterilization area visually not clean
items/open possibly used before
bathroom dirty
drawers dirty can visually see unclean

[1] "In cases involving imminent danger to life or health, the board shall order a suspension of a license or privileged granted under this chapter pending a hearing for a period of no more than 60 days."

[2] This reference serves as the prehearing conference order from the prehearing conference held on 10/31/22.

dirty/dust blowing around while dr. working
insurance payment/out of pocket payment doesn't add up correctly
dirt falling from the overhead light visually dirty
can see barrier not changed frequently/blood splatter
… [sic]

Exh. 1.

Ms. Nikitas explained that she had used the 2016 checklist for Infectious Disease Control when inspecting the Licensee's office. Ms. Nikitas' testimony and report revealed the following concerns in the sterilization area of the Licensee's office: 1) the sterilization area of the office was not divided into four distinct areas (namely receiving/cleaning decontamination, preparation and packaging, sterilization, and storage); 2) sterile and non-sterile areas were not separated in the sterilization chamber; 3) unsterilized dental hand pieces were piled on a tray on top of the sterilizer; 4) bagged instruments in the sterilization area and in the operatories were not labeled with all of the information required by CDC guidelines; and 5) the sterilization chamber was overloaded with items and without shelves to separate them. With respect to the last item, Ms. Nikitas opined during her testimony that items in the chamber were likely not achieving sterilization because the chamber was overloaded, which creates an inability for proper steam flow and penetration to items. *See* Exh. 3 at page 2.

Ms. Nikitas' testimony and report also addressed concerns she had with the way the Licensee conducted biological spore testing. Both the report and her testimony indicated Ms. Nikitas found no documentation of weekly biological indicator results at the Licensee's office. Further, Ms. Nikitas' report explains that the Licensee had said during the inspection that she did not conduct this regular documentation, but instead noted on a piece of paper next to the sterilizer the date of when a cycle is started for sterilization. Ms. Nikitas explained in her report and during testimony that under CDC guidelines the Licensee's process was insufficient because "… [t]he ability of a sterilizer to achieve

sterilization should be monitored with a combination of parameters such as biological, mechanical, and chemical indicators." Exh. 3 at page 3. The testimony and report also noted with respect to the instrument washer that it was not being drained, wiped down, or had the fluid solution in it changed on daily basis, per CDC guidelines.

Ms. Nikitas' testimony and report covered a wide variety of other sanitation related concerns as well. For example, she said there was a red sharps container full of used sharps with a loose cover next to the sink in the sterilization area. Additionally, While Ms. Nikitas explained that the Licensee had a statim sterilizer, it was not in use because it needed to be repaired. Ms. Nikitas also stated in her report that "[t]he unit was full of water and cassette appeared wet with condensation." Exh. 3 at page 3. According to Ms. Nikitas, the Licensee also appeared to have no puncture and chemical resistant gloves for instrument cleaning and decontaminating or hospital grade disinfectants.

The Inspector's testimony also expressed concern for the general cleanliness of the Licensee's office. Ms. Nikitas described the Licensee's office as messy and having unorganized drawers with debris in them. She stated that the Licensee said she contracts with a house cleaning company for her office. Nonetheless, Ms. Nikitas testified that the Licensee was responsible for the sterilization and infection control issues noted in the report because a common house cleaner has no training and experience in biological hazard cleaning. Ms. Nikitas also stated that she learned during the visit that the Licensee had no biohazard waste storage area because she did not believe she needed it. Ms. Nikitas' report explains that the Licensee's position is contrary to the New Hampshire Department of Environmental Services definition of infectious waste. Exh. 3 at page 4.

Ms. Nikitas' report and testimony also addressed the state of the Licensee's operatory areas. She described the drawers as "cluttered, overflowing and unorganized." Exh. 3 at page 4. Additionally, she noted some of the instruments on a tray ready for a procedure had visible residue

on them and the cover to a sharps container was open and loose, in similar fashion to the one located in the sterilization area. Exh. 3 at page 4. Ms. Nikitas also testified that during her discussion with the Licensee about this issue, she learned the Licensee was storing sharps awaiting hazardous waste removal in the electrical closet of her office in a few large, approximately two-foot high, storage containers that were unlabeled. Her testimony revealed that the last pickup for hazardous waste material at the Licensee's office was approximately a year and a half ago. In relation to this testimony, Ms. Nikitas' report also noted that there were multiple large containers of x-ray processing chemicals in the mechanical closet that she told the Licensee could pose a fire hazard. Exh. 3 at page 4.

Although Ms. Nikitas' report raised other concerns, the only others her testimony placed significant emphasis on were that the Licensee appeared to be using a single refrigerator for both work and personal usage, did not have material safety datasheets, had bottles containing antibiotics which indicated they were expired, and had left certain patient data sheets unsecured.

Cross examination of Ms. Nikitas revealed that there were some things stated in the complaint that were supported by Ms. Nikitas' inspection and some things that were not. For example, the Licensee highlighted that there was no blood splatter found on the premises during the inspection and evidence presented that the Licensee normally wears gloves and masks during office visits with patients. Ms. Nikitas also described the Licensee as cooperative and willing to listen to the recommendations she made to her about rectifying the issues found during the inspection.

**LICENSEE'S CASE-IN-CHIEF:**

**Karen Packard:**

The Licensee first called Karen Packard, who started by testifying to her extensive training and experience in dental hygiene and community health, which is addressed in her resume. *See* Exh. B. Ms. Packard testified that she was hired by the Licensee to inspect the Licensee's office on

10/24/22 and create a report of what she thought needed to be addressed to ensure that the office followed appropriate sanitation and hygiene guidance. Ms. Packard's testimony summarized much of her report, which included the information she obtained from the Licensee about the Licensee's practice before conducting the inspection, what she found during her inspection, and the recommendations that she made to the Licensee based upon the inspection. Ms. Packard testified that she identified many of the same issues Ms. Nikitas had during her inspection, as well as a few others. For example, according to her testimony, she additionally recommended that the Licensee replace some of the lead aprons because they were wearing down and throw away the fake plants collecting dust and debris.

Ms. Packard testified that by the time she had conducted her inspection of the Licensee's office, the Licensee had already begun addressing many of the concerns in Ms. Nikitas' report. She stated that she had verified that the Licensee had re-sterilized and repacked instruments, cleaned the autoclave, installed a new shelf, obtained hospital grade cleaner, and addressed the antibiotic medication situation by ordering smaller bottles that did not have an expired label. Ms. Packard also explained that the Licensee had hired Turbyne & Associates to provide training in safety/risk management as well with implementing the recommended changes made by Ms. Packard and Ms. Nikitas. According to Ms. Packard, the woman running Turbyne & Associates has done OSHA training for approximately 30 years. Ms. Packard said that Turbyne & Associates was scheduled to conduct an inspection and appointment with the Licensee on 11/01/22. Ms. Packard also testified that it was her opinion that the Licensee had genuinely taken the information and recommendations provided to her "to heart" and could implement the proposed recommendations within one to two weeks. Ms. Packard lastly clarified that she had identified two refrigerators during her visit to the office and both appeared clean, although she acknowledged there being a few food items in the

freezer. She also noted the Licensee had told her that the antibiotics in the "expired" medication bottle were not expired but had been placed from a larger non-expired bottle into a smaller bottle. According to her testimony, the Licensee had told her she did not check the expiration date on the smaller bottle, which was labeled as being expired.

On cross examination, Ms. Packard acknowledged that it was her opinion that the Licensee's office was currently not ready to re-open. She also agreed that the Licensee had made an error in moving the antibiotics stored in the larger bottle to a smaller secondary container. She explained that she was confident the Licensee could successfully act on all recommendations made by herself and Ms. Nikitas within two weeks.

**Licensee:**

The Licensee was the last witness to testify. She generally acknowledged the issues with her office as outlined in Ms. Nikitas' and Ms. Packard's respective reports. She explained the affirmative steps she had taken to bring her office into compliance with the recommendations provided by Ms. Nikitas and Packard. Among those changes she has implemented are: hiring Ms. Packard and following her recommendations; hiring Turbyne & Associates and receiving training and guidance from them; purchasing new equipment, a new rack, and new shelving; re-sterilizing and removing discarded medical wastes and liquids; ordering updated antibiotic medications; ordering new n95 masks; ordering new oxygen masks; cleaning the electrical and wastes/sharps area; removing fake plants; and hiring a locksmith for 10/31/22 to fix the cabinets where patient files are stored. The Licensee also provided Exhibit A, which is a series of paperwork produced pursuant to the subpoena from Inspector Nikitas. It includes some of the documentation she was unable to provide to Ms. Nikitas during the inspection. The Licensee explained that the inspection had made her flustered to the point that she either had forgotten where certain paperwork was or that the inspector had made a

request of certain documentation during the inspection. Consequently, the paperwork was not provided during the inspection but existed.

Board questioning mainly focused on the fact that many of the issues noted by the Board inspector and Ms. Packard are basic things learned through continuing education coursework and available through the CDC website. The Licensee acknowledged this fact and stated she believed she was following proper protocol. She testified, and her attorney explained, that she acknowledged her deficiencies and has been extremely proactive in addressing the problems.

## V. DISCUSSION AND FINDINGS OF FACTS / CONCLUSIONS OF LAW:

After reviewing all the evidence and accounting for the presentation and demeanor of all the witnesses, the Board finds and concludes, by a preponderance of the evidence, that the Licensee still currently presents an "imminent danger to life or health", RSA 317-A:18-b, such that her license shall remain temporarily suspended. The facts are rather straightforward and largely uncontested— upon the filing of a complaint alleging sanitation and hygiene concerns in the Licensee's office, the Board ordered an unannounced inspection that generally confirmed the concerns in the complaint. The Licensee then hired an expert to inspect her office for cleanliness and hygiene-related issues as well and she also found issues in the office that confirm some of the allegations in the complaint. While the Licensee is working diligently to correct those issues, Ms. Packard opined that the Licensee's office is not ***currently*** ready to open from a sanitation and hygiene standpoint. The facts presented by Ms. Nikitas confirms this opinion. Based upon the foregoing, the Board affirms its emergency suspension and provides orders related thereto.

## VI. ORDERS:

Pursuant to RSA 317-A:18-b, the Board hereby AFFIRMS its temporary emergency suspension of Dr. Marina Becker's license to practice dentistry. Before the Board entertains terminating the emergency suspension, the following shall occur:

1) the Licensee shall file with the Board Administrator documentary proof of her receiving recent training for infection control in the practice of dentistry. The sufficiency of such proof shall be determined in the sole discretion of the Board;

2) the Licensee shall rectify all issues noted in the Board Inspector's Report of 10/20/22;

3) A Board inspector shall inspect the Licensee's office, confirm full compliance with the Board Inspector's Report of 10/20/22, and send a Memorandum to the Board summarizing same; and

4) The Board shall review the Memorandum and determine whether it agrees with the Board Inspector's recommendation as to the Licensee's compliance.

5) All above items shall be accomplished in a timely manner such that the Board may review the Board Inspector's recommendations and documentary proof of training for infection control no later than its December 2022 meeting and render a decision as to whether to lift the temporary emergency suspension.

DATED: 11/03/2022

___/s/ Nikolas K. Frye, Esq._____
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