BEFORE THE OKLAHOMA BOARD OF DENTISTRY
STATE OF OKLAHOMA

IN THE MATTER OF THE COMPLAINT AGAINST WAYNE SCOTT HARRINGTON, D.M.D. license # 3666, Specialty license – Oral Surgery #59

Case No: 13-005

Received and filed by the Oklahoma Board of Dentistry

Date

-SEAL-

STATEMENT OF COMPLAINT

YOU ARE HEREBY NOTIFIED on the following charges made against you.

GENERAL BACKGROUND

1. The Board of Dentistry ("Board") has jurisdiction over the practice of dentistry, individuals licensed to practice dentistry in the State of Oklahoma and this proceeding pursuant to the State Dental Act ("Act"), Title 59 O.S., § 328.1 et. seq., and its predecessor statutes.

2. **WAYNE SCOTT HARRINGTON, D.M.D. license # 3666, issued June 23, 1974 and Oral Surgery specialty license # 59, issued June 10, 1977,** is licensed to practice dentistry in the State of Oklahoma. Dr. Harrington's State Dental license, OBD distribution permit and anesthesia permit as well as his DEA and OBNDD drug registrations were voluntarily surrendered on March 20, 2013 pending an emergency hearing. A full hearing is scheduled for April 19, 2013 at the State Board of Dentistry, 201 NE 38th Terrace, Suite 2, Oklahoma City, Oklahoma. The actions relevant to this Statement of Complaint occurred in and around Tulsa, Oklahoma.

3. The acts and omissions, which constitute the allegations contained in this Statement of Complaint, occurred during the period from January 01, 2010 through March 19, 2013, but at all times relevant to the State Dental Act. The requirements of the State Dental Act and the Rules and Regulations of the Board to regulate the conduct herein were in effect for all times appropriate to the actions described in this Statement of Complaint.

SPECIFIC ALLEGATIONS

Each of the paragraphs, as stated above, are incorporated and adopted by reference herein for each specific allegation.

1. On March 15, Board investigators were notified by officials from the State Department of Health of an investigation they were conducting of a potential Hepatitis C contamination at a dental office and requested assistance pursuant to a complaint. Health department officials

advised that an unidentified person referred to as "the index patient" had recently tested positive for HIV and Hepatitis C, after defining a short window of time of contraction, with no other known risk factors other than receiving dental treatment. During the investigation the State and County Health Officials had inspected the office of Wayne Scott Harrington, D.M.D.. During this inspection, Dr. Jana Winfree, the Chief of the Dental Health Service at the Oklahoma Department of Health, Janet Wilson, RN, the Adult Viral Hepatitis Prevention Coordinator for the State Department of Health, and Kelly VanBuskirk the Division Chief of the Health Data and Evaluation Division at the Tulsa County Health Department were present.

2. Dr. Winfree advised Dental Board investigators that during the initial health department inspection, they had found that there were multiple sterilization issues, multiple cross-contamination issues, the drug cabinet was unlocked and unattended during the day and that during interviews with the dental assistants, they were routinely providing the IV sedation for the procedures.

3. On Monday March 18th, Board investigators, Susan Rogers, Executive Director and James Seely, Chief Investigator accompanied state and county health department officials to an unannounced office inspection of Dr. Harrington located at 2111 South Atlanta Place, Tulsa, Oklahoma. Dr. Harrington also has a satellite office at 12806 East 86th Place North, Owasso, Oklahoma. The dental assistants were interviewed separately by teams of Board investigators and Health Department officials regarding safety protocols, techniques and regular practices within the office including a walk-through of their daily procedures.

4. Board investigators requested to see where Dr. Harrington and staff's dental and drug licenses were on display. The office manager pulled out Dr. Harrington's licenses out of a folder in the cabinet. Staff was asked where the dental assistant's permits were and the office manager advised that she would have to check with Dr. Harrington. Upon her return she stated "we need you to educate us on that issue". No dental assistant permits were found except for an expanded duty permit for radiation safety for Lisa Young.

5. Board investigators requested to see Dr. Harrington's drug logs and drug cabinet. The drug logs as kept listed only the amounts of drugs administered to each patient during procedures. There were no logs of inventory in and out of the drug cabinet that would show where each scheduled drug went after receiving it from the distributor. No daily count of scheduled drugs was conducted. The drug cabinet was found to be unlocked and unsupervised. Scheduled drugs and legend drugs were mixed and not in any specific order within the cabinet. Multiple drug vials both scheduled and legend were expired. One drug vial found had expired in 1993. All of these are violations of Dental Board, Oklahoma Bureau of Narcotics and Drug Enforcement Agency's state and federal laws. Multiple bottles of hydrocodone syrup were found in the back of the cabinet and staff advised it was for "one-patient". According to the drug logs kept by the assistant's morphine had been used on patients intermittently throughout 2012. According to DEA records, Dr. Harrington has not received morphine from a distributor since 2009.

6. Dr. Harrington and staff advised health department officials that they had a high population of known infectious disease carrier patients in the practice. Two separate sets of instruments were kept, one set for patients known to have infectious diseases and another set for persons unknown or not believed to have an infectious disease. Each set had a different cleaning method. The set of instruments used for the known infectious disease carriers was dipped in bleach in addition to other cleaning methods. During the investigation an inspection of each set

of instruments in the lab area was conducted and the instruments used for the known infectious disease carriers had multiple tools that had no sheen and red-brown spots on the metal making the instruments appear to be rusted. The Centers for Disease Control (CDC) has determined that rusted instruments are porous and cannot be properly sterilized. A plastic box identified as the "dry socket box" had open vials of medication with dark brown contents and the box was light brown in color due to staining. The box also had gauze strips inside.

7. The autoclave used to sterilize all the instruments was not being properly used. According to the manufacturer's instructions, a monthly test is required to be performed and sent to a lab to determine that the autoclave is successfully sterilizing all instruments. No such test had ever been performed in the 6 years one dental assistant had been working at the office. No sterilization log was present or had been kept by staff. Bags are not used during the disinfecting process, instruments are wrapped in a cloth then by autoclave tape to determine that the instruments reach the recommended amount of heat to be disinfected. After instruments were cleaned they were placed in a tray under the cabinet with a bib covering the instruments.

8. Both dental assistants were performing IV sedation including determining amounts and types of medication to administer to patients in order to attain a sedative state before dentist entered the room. The dental assistants were individually recording the amount of drugs they administered on each patient "they treated". Admissions to this were made to health department officials on both inspections and Board investigators by Dr. Harrington and the assistants.

9. Each dental assistant had a "drug tray" that was kept in the top of the drug cabinet with multiple opened and unopened vials of scheduled and legend drugs and needles. The drug trays were kept in the operatory rooms during multiple procedures. Other opened and unopened vials of medication were found in drawers in the operatory areas with needles. Needles used for the drugs to be injected into the port were being filled in the operatory room and if additional amounts of medication were needed, the needles would be reinserted into the vials then into the ports. All of these practices cause a great risk of cross-contamination. Multi-dose vials of controlled and legend drugs were used on multiple patients, not dedicated to individual patients.

10. No written infection prevention policies and procedures were available or utilized by staff. Staff was asked what the procedure was when a barrier breach by cut or needle had occurred. The procedure was to soak the cut or punctured area in bleach until it turned white.

11. During the inspections, Dr. Harrington referred to his staff regarding all sterilization and drug procedures in the office. He advised, "they take care of that I don't."

12. On Thursdays, Staff would travel to Owasso and carry instruments and drugs to and from the Owasso location in addition to the patient files. Staff advised that the doctor did not want to leave the drugs there due to concern about theft. Dr. Harrington does not have a DEA permit for the Owasso location.

The above acts and omissions set forth above constitute violations of State and Federal laws and the State Dental Act.

Counts I and II – 59 O.S. § 328.32(A)(5) Authorizing or aiding an unlicensed person to practice dentistry by allowing dental assistants Terri (Waugh) Valega and Lisa Young to perform acts that only a licensed dentist may perform, specifically IV sedation on patients.

Count III - 59 O.S. § 328.32(A)(5) and 59 O.S. § 328.32(A)(7) Unauthorized personnel taking radiographs without an assistant expanded duty permit.

Count IV - 59 O.S. § 328.32(A)(13) Being a menace to the public health by reasons of practicing dentistry in an unsafe or unsanitary manner or place, specifically violations of Board Rule 195:35-1-3(c) sterilization equipment and its adequacy shall be tested and verified on a regular basis.

Count V-XI 59 O.S. § 328.32(A)(13) Being a menace to the public health by reasons of practicing dentistry in an unsafe or unsanitary manner or place, specifically violations of Board Rule 195:35-1-4(a)(1) failing to comply with universal precautions recommended for dentistry by the Centers for Disease Control and Prevention (CDC); by use of multi-dose medication vials used on multiple patients; use of multi-dose medication vials in the operatory area; use of multi-dose vials of medication without attaching the appropriate dates; having open vials of medication and absorbent materials in the "dry socket" box used on multiple patients; separation of instruments and different cleaning procedures for known infection carrier patients versus unknown or non-infection carrier patients; utilization of non-sterilized porous and rusty instruments;

Count XII - 59 O.S. § 328.32(A)(17) - Committing gross negligence in the practice of dentistry specifically by deferring all decisions and supervision of cleaning, infection control and turning over all inventory and maintenance of scheduled and legend drugs to dental assistants.

Count XIII – 59 O.S. § 328.32(A)(30) – Practicing dentistry without displaying, at the dentist's primary place of practice, the license issued to the dentist by the Board to practice dentistry and the current renewal certificate;

Count XVI – 59 O.S. § 328.32(A)(35) Violating or attempting to violate the provisions of the State Dental Act or the rules of the Board 195:30-1-5(a) by failure to keep a suitable record of dangerous drugs;

Count XVII - 59 O.S. § (B)(3)(b) unlawful practices; It shall be unlawful for any person to: (b) aid or abet another person in violation of the State Dental Act, specifically by allowing or authorizing dental assistants Terri (Waugh) Valega and Lisa Young to practice dentistry without a license in violation of 59 O.S. § 328.49(B)(a).

Additional counts may be added as the investigation continues upon notice to the defendant.

POTENTIAL SANCTION(S)

The Board is authorized, after notice or opportunity for a hearing pursuant to Article II of the Administrative Procedures Act, to issue an order to impose sanction(s) whenever the Board finds, by clear and convincing evidence, that a licensee has violated the State Laws or Rules in regards to their license. The minimum to maximum sanction in this matter ranges from no action to revocation of license. This matter is currently set for a hearing on April 19th, 2013 at the State Board of Dentistry located at 201 N.E. 38th Terrace, Suite 2, Oklahoma City, Oklahoma at 10:00 a.m., this hearing date may be rescheduled by agreement of the parties.

ATTORNEY'S FEES

The Board is authorized, after notice or opportunity for a hearing pursuant to Article II of the Administrative Procedures Act, to request the costs of prosecution and attorney's fees be recovered from the Respondent. The Board is requesting costs and attorney's fees.

Respectfully Submitted,

Susan Rogers, Esq.
Executive Director

Date March 26, 2013

Review Panel:
James A. Sparks D.D.S., District 1
Jeffrey Nelson, D.D.S., District 6