IN THE MATTER OF	*	BEFORE THE MARYLAND
EMIL SEDRAKYAN, D.D.S.	*	STATE BOARD OF DENTAL
Respondent	*	EXAMINERS
License Number: 15021	*	Case Number: 2021-054

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CONSENT ORDER

In or around September 2020, the Maryland State Board of Dental Examiners (the "Board") opened an investigation of **EMIL SEDRAKYAN, D.D.S.** (the "Respondent"), License Number 15021. Based on its investigation, the Board determined that it had grounds to charge the Respondent with violating the Maryland Dentistry Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 16-101 *et seq.* (2014 Repl. Vol. & 2020 Supp.).

The pertinent provisions of the Act provide:

Health Occ. § 4-315

(a) *License to practice dentistry.* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may … reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the … licensee:

(16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession [and]

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

Prior to the Board issuing disciplinary charges, the Respondent agreed to enter this public Consent Order consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Board makes the following Findings of Fact:

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 June 17, 2011, under License Number 15021. The Respondent's license is current through June 30, 2023.

2. At all times relevant, the Respondent owns and operates a dental practice with office locations in Dundalk (the "Dundalk Office") and Glen Burnie, Maryland

II. COMPLAINT

3. On or about September 5, 2020, the Board received a complaint alleging, among other things, that there were substandard infection control practices at the Dundalk Office. Based on the complaint, the Board initiated an investigation of the Dundalk Office's compliance with CDC guidelines. [1]

[1] 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.

III. INFECTION CONTROL INSPECTION

4. Due to allegations of potential infection control issues at the Dundalk Office, on or about December 11, 2020, a Board-assigned infection control inspector (the "Board Inspector"), along with a Board investigator, visited the Dundalk Office and conducted an infection control inspection (the "Inspection").

5. The Respondent was present during the Inspection, as was a dental assistant employed at the Dundalk Office (the "Dental Assistant"). Also present was an office staff member (the "Staff Member").

6. As part of the Inspection, the Board Inspector utilized the publicly available Centers for Disease Control and Prevention ("CDC") Infection Prevention Checklist for Dental Settings. Based on the Inspection, the Board Inspector made the following findings regarding the Dundalk Office's compliance with the CDC Guidelines:

Section I: Policies and Practices

I.1 Administrative Measures – The Respondent failed to maintain on site any documented infection control policies and procedures specific to the Dundalk Office. The Respondent also failed to maintain records of training on infection prevention policies and procedures upon hire, reassessed at least annually, and according to state and federal requirements. Subsequent to the Inspection, the Respondent produced a certificate of attendance at a continuing education course from May 14, 2020 and stated that he was in charge of the infection prevention program and yet there was no documentation of any program on site.

The Dundalk Office lacked infection control supplies including N95 respirators, KN 95 respirators, and face shields. The Dundalk Office only had surgical face masks and eight disposable gowns for the Respondent. Utility gloves were available but not used.

The Dundalk Office lacked a system for early detection and management of potentially infectious persons at initial points of patient encounter including signs at entrances to instruct patients on procedures necessary to prevent the spread of respiratory issues,

precaution posters posted for patients, and masks to offer patients. The reception area was too small to social distance more than two people, did not have trashcans, and had materials that could be handled by multiple people.

I.2 Infection Prevention Education and Training – 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. Neither the Dental Assistant nor the Staff Member could recollect receiving such training.

I.3 Dental Health Care Personnel Safety – The Respondent failed to maintain on site any documented: exposure control plan for the Dundalk Office; employee training on Occupational Safety and Health Administration ("OSHA") Bloodborne Pathogens Standard upon hire and at least annually; 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 ("DHCP"); a log of needlestick or sharp injuries or other employee 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 transmittible conditions with patients.

I.4 Program Evaluation – The Respondent failed to maintain on site any documented policies or procedures for routine monitoring and evaluation of the infection prevention and control program and adherence to practices such as immunization, hand hygiene, sterilization monitoring and proper use of Personal Protective Equipment ("PPE").

I.5 Hand Hygiene – The Respondent failed to maintain on site supplies for surgical hand scrub technique including antimicrobial soap, alcohol-based hand scrub with persistent activity. The Respondent also failed to maintain on site any documented dental personnel training regarding appropriate indications for hand hygiene including handwashing, hand antisepsis and surgical hand antisepsis.

I.6 Personal Protective Equipment (PPE) – The Respondent failed to maintain on site any N95 respirators, KN 95 respirators, face shields or hair bonnets. The Respondent also had an insufficient supply of disposable gowns or jackets. In addition, the Respondent failed to maintain documentation that dental personnel received training on proper selection and use of PPE.

I.7 Respiratory Hygiene/Cough Etiquette – The Respondent failed to maintain on site signs at the point of entry and personnel training logs on containing respiratory secretion in people with signs and symptoms of respiratory infection. The Respondent failed to make available: face masks at the front desk, a trash receptacle in the waiting room, and sufficient space for persons with respiratory symptoms to socially distance.

I.8 Sharps Safety – 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 and training logs on identifying, evaluating, and selecting devices with engineered safety features at least annually or as they become available in the market.

I.9 Safe Injection Practices – The Respondent failed to maintain on site any documented policies, procedures, and guidelines for safe injection practices.

I.10 Sterilization and Disinfection of Patient Care Items and Devices – 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; personnel training logs on reprocessing of reusable instruments and devices upon hire, annually, and whenever new equipment processes are introduced; personnel training logs on appropriate use of PPE; and maintenance logs on sterilization equipment.

I.11 Environmental Infection Prevention and Control – The Respondent failed to maintain on site any documented policies and procedures on: routine cleaning and disinfection of environmental surfaces; personnel training on infection prevention and control management of clinical contact and housekeeping surfaces upon hire, following procedure/policy changes, and annually; personnel training logs on appropriate use of PPE; periodic monitoring and evaluations of use of surface barriers; and decontamination of spills of blood or other body fluid.

I.12 Dental Unit Water Quality – The Respondent failed to maintain on site any documented 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.

<u>Section II: Direct Observation of Personnel and Patient Care Practices</u>

II.1 Performance of Hand Hygiene – The Respondent failed to ensure that DHCPs at the Dundalk Office consistently perform handwashing before putting on gloves.

II.2 Use of Personal Protective Equipment (PPE) – The Respondent and the Dental Assistant failed to remove PPE before leaving the work area, wear appropriately fitted surgical masks to protect from aerosol generating procedures, and change their masks. The Respondent further failed to ensure that DHCP wore puncture and chemical resistant gloves when cleaning instruments and performing housekeeping tasks involving contact with blood or other potentially infectious material ("OPIM"). The Respondent failed to ensure that DHCP were provided and wore sufficient protective clothing to protect personal clothing and skin from blood, saliva or OPIM. During the Inspection, the

Respondent donned the same protective jacket and failed to change it after the jacket was soiled during a procedure.

II.3 Respiratory Hygiene/Cough Etiquette – The Respondent failed to post signs at entrances regarding respiratory infection precautions, provide a "no touch" trash receptacle, offer face masks to coughing or other symptomatic people upon entry, and provide a separate waiting area for patients with respiratory symptoms.

11.4 Sharps Safety – The Respondent failed to provide mechanical devices for holding the needle cap when recapping needles, designed for sharps safety. The Respondent also failed to provide biohazardous waste disposal bags and maintain biohazardous waste disposal logs.

II.5 Safe Injection Practices – The administration of local anesthetic to a patient was not observed.

II.6 Sterilization and Disinfection of Patient Care Items and Devices – The Respondent failed to practice controls that minimize contact with sharp instruments during manual cleaning. Specifically, the Dental Assistant did not utilize available puncture-resistant gloves and no long-handed brush was noted by the Inspector. In addition, sterile packs were not labeled with information including, but not limited to, sterilizer used, the cycle/load number, and the date of sterilization. The Respondent further failed to: maintain a log regarding the use of biologic indicators or sterilizer cycles, inspect autoclave bags for integrity and reprocess compromised bags before use, and provide in the instrument processing area a workflow pattern designed to ensure that devices and instruments clearly flow from high contamination areas to clean/sterile areas. The work flow pattern maintained by the Respondent at the Dundalk Office included a dangerous situation where paper towels were behind a sink and susceptible to contamination from the initial instrument scrubbing process.

11.7 Environmental Infection Prevention and Control – The Respondent failed to ensure that surface barriers were consistently used to protect clinical contact surfaces that are difficult to clean; spray bottles used for cleaning and disinfecting were labeled, and DHCP consistently wore PPE during environmental cleanup. The Respondent also failed to appropriately handle and dispose of regulated medical waste and maintain logs /current invoices for a medical waste contractor for the Dundalk Office.

11.8 Dental Unit Water Quality – The Respondent failed to provide and monitor dental unit waterline treatment devices or products to ensure compliance with EPA standards.

Section III: Direct Observation of COVID-specific infection prevention

1. Filing of a Governors Certificate – The Respondent failed to file and post a Governors Certificate at the Dundalk Office.

2. Patient Pre-Screening for Symptoms and Temperature Check – The Respondent failed to perform a pre-screening for temperature and symptom check on patients.

3. Staff Pre-Screening temperature check and symptom check performed – The Respondent failed to perform a pre-screening for temperature and symptom check on staff.

4. One Week Supply of Adequate PPE – The Respondent failed to provide any N95 respirators, KN 95 respirators, face shields, or bonnets. The Respondent also failed to provide an adequate supply of fresh gowns for the Dental Assistant. In addition, the Respondent repeatedly trimmed patient dentures without first disinfecting them and performed this procedure without extra-oral suction.

5. Use of an N95 or KN 95 Respirator for Aerosol Generating Procedures – The Respondent failed to use extra-oral suction or don a N95 or KN 95 respirator during aerosol generating denture trimming procedures.

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7. Appropriate PPE is Used, Donned, Doffed, and Changed Between Patients and Disposed of Properly – The Respondent failed to change his disposable jacket between patents, even after it was soiled. The Respondent never wore a bonnet or face shield when necessary. The Respondent failed to provide N95 and KN 95 respirators and ensure that the Dental Assistant wore a disposable gound when necessary.

8. Telephone Screening and Triage of Patients Prior to Appointment – The Respondent failed to ensure that a telephone screening and triage of patients was conducted prior to scheduling appointments.

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10. Social Distancing (6 feet separation) at All Areas of Practice – The Respondent failed to provide a reception area with sufficient room to social distance. In addition, the Respondent and the Dental Assistant wore their PPE in the front desk area.

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12. Barriers at Front Desk and Between Treatment Rooms Practice – The Respondent failed to provide barriers at the front desk to protect front desk staff.

13. Respiratory Precaution Signs and Respiratory and Cough Etiquette – The Respondent failed to prominently post respiratory precaution signs and practice respiratory hygiene and cough etiquette.

. . .

16. All Operatories are Set Up Efficiently, Supplies and Patient Treatment Items are Not Exposed to Aerosol and as Few Individuals in the Treatment Room as Possible – The Respondent filed to set up the operatories efficiently; the operatories were cluttered.

17. Post-Operative Instructions to Patients should Include Follow-Up if they Test Positive During Dental Visit. No such post-operative instructions were observed.

7. Based on the observations made by the Board Inspector, the Respondent, as the owner of and practicing dentist, failed to ensure compliance with CDC Guidelines at the Dundalk Office.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent, as the owner and practicing dentist at the Dundalk Office, and the Respondent's conduct, as described above, constitutes violations of the Act as cited above, including but not limited to, failing to ensure compliance with the CDC Guidelines at the Dundalk Office which constitutes: behaving dishonorably or unprofessionally, in violation of Health Occ. § 4-315(a)(16); and failing to comply with Centers for Disease Control's guidelines on universal precautions, in violation of Health Occ. § 4-315(a)(28).

ORDER

It is, on the affirmative vote of a majority of the Board, hereby:

ORDERED that the Respondent shall ensure that the Dundalk Office immediately ceases all dental treatment until the Board issues a separate Order terminating this provision (the "**Order Lifting Voluntary Cessation**"); and it is further

ORDERED that upon the Board's receipt of verified documentation that the Respondent has formally retained the services of a qualified Board-approved infection control consultant and that the consultant has issued a favorable report substantiating that the Respondent and her office staff are in substantial compliance with CDC Infection Control Guidelines, the Board shall issue an **Order Lifting Voluntary Cessation**, which shall allow the practice cited above to resume dental treatment; and it is further

ORDERED that the Respondent is **REPRIMANDED**; and it is further

ORDERED that from the date of the Board's the **Order Lifting Voluntary Cessation**, the Respondent shall be placed on **PROBATION** for a period of **TWO (2) YEARS** under the following terms and conditions:

1. A Board-assigned inspector shall conduct an unannounced inspection within ten (10) business days (or as soon as practicable) in order to evaluate the Respondent and staff regarding compliance with the Act and infection control guidelines. The Board-assigned inspector shall be provided with copies of the Board file, the Consent Order, and any other documentation deemed relevant by the Board;

2. On a continuing basis, the Respondent shall provide to the Board-assigned inspector a schedule of the Office's regular weekly hours of practice and promptly apprise the consultant of any changes;

3. During the probationary period, the Respondent shall be subject to quarterly unannounced onsite inspections by a Board-assigned inspector;

4. The Board-assigned inspector shall provide inspection reports to the Board within ten (10) business days of the date of each inspection and may consult with the Board regarding the findings of the inspections;

5. The Respondent shall, at all times, practice dentistry in accordance with the Act, related regulations, and shall comply with CDC and Occupational Safety and Health Administration's ("OSHA") guidelines on infection control for dental healthcare settings, including enhanced COVID-19 related precautions; and

6. At any time during the period of probation, if the Board makes a finding that the Respondent is not in compliance with CDC and/or OSHA guidelines, the Respondent shall have the opportunity to correct the infractions within seven (7) days and shall be subject to a repeat inspection within seven (7) days to confirm that the violation has been remedied.

7. The Respondent is fined in the amount of **TWO THOUSAND FIVE HUNDRED DOLLARS ($2500)**, due within sixty (60) days to the board;

8. Within three (3) months of the Order Lifting Voluntary Cessation, the Respondent shall successfully complete a Board-approved in-person (or, if in-person courses are not available due to the current State of Emergency, then by video-conference) four (4) credit hour course(s) in infection control protocols, presented by a board-approved instructor, which may not be applied toward his license renewal.

9. Within three (3) months of the Order Lifting Voluntary Cessation, the Respondent shall successfully complete a Board-approved in-person (or, if in-person courses are not available due to the current State of Emergency, then by video-conference) two (2) credit hour course(s) in ethics, presented by a board-approved instructor, which may not be applied toward his license renewal.

10. If the above-mentioned courses are not completed within three (3)

months of the date of the Consent Order, the Board may allow an extension of three (3) additional months if the Respondent demonstrates to the Board's satisfaction that he was unable to complete the courses despite a good-faith effort.

11. The Respondent may file a petition for early termination of his probation after one (1) year from the date of this Consent Order. After consideration of the petition, the Board, or a designated committee of the Board, shall grant the petition if the Respondent has satisfactorily complied with the terms and conditions of this Consent Order.

AND IT IS FURTHER ORDERED that no part of the training or education that the Respondent receives in order to comply with this Consent Order may be applied to his required continuing education credits, and it is further

ORDERED that the Respondent shall at all times cooperate with the Board, any of its agents or employees, and with the Board-assigned inspector, in the monitoring, supervision and investigation of the Respondent's compliance with the terms and conditions of this Consent Order, and it is further

ORDERED that the Respondent shall be responsible for all costs incurred under this Consent Order; and it is further

ORDERED that after a minimum of two (2) years from the effective date of the Order for Reinstatement, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board. The Board shall grant termination if the Respondent has fully and satisfactorily complied with all of the probationary terms

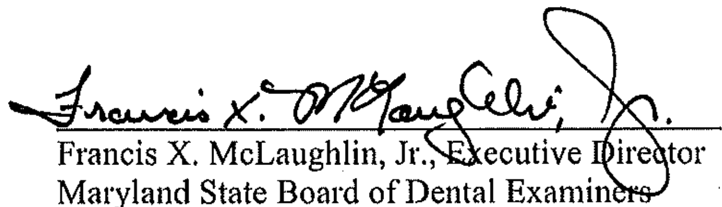
and conditions and there are no pending investigations or outstanding complaints related to the findings of fact in this Consent Order; and it is further

ORDERED that if the Respondent allegedly fails to comply with any term or condition of probation or this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be an evidentiary hearing before the Board. If there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before the Board; and it is further

ORDERED that after the appropriate hearing, if the Board determines that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice dentistry in Maryland. The Board may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent; and it is further

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

9/23/2021
Date



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

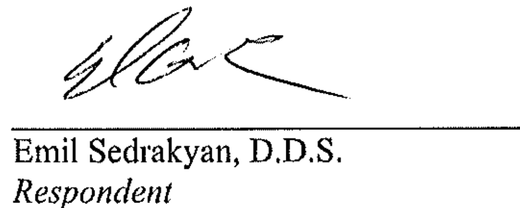
CONSENT

By this Consent, I, Emil Sedrakyan, D.D.S., agree and accept to be bound by this Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact and Conclusions of Law.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I acknowledge the legal authority and the jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I also affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing.

I sign this Consent Order after having had the opportunity to consult with counsel, and I fully understand and comprehend the language, meaning and terms of this Consent Order. I voluntarily sign this Order, and understand its effect.

9/15/21
Date



Emil Sedrakyan, D.D.S.
Respondent