IN THE MATTER OF	*	**BEFORE THE MARYLAND**
GERALD AWADZI, D.M.D.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 15143	*	**Case Numbers: 2018-257 & 2019-015**

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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 **GERALD AWADZI, D.M.D.** (the "Respondent"), **License Number 15143**, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under: 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. & 2017 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]

1. At all times relevant hereto, the Respondent was and is licensed to practice dentistry in Maryland. The Respondent was initially licensed on or about September 8, 2011, under license number 15143. The Respondent's license is current through June 30, 2019.

2. At all times relevant hereto, the Respondent practiced dentistry through his ownership and directorship in a professional corporation called Dental Professionals of Maryland,

[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.

Gerald Awadzi, P.C., which, among other practice locations, owned and operated a dental practice called Family Dental Care of Maple Lawn, located at 7570 Montpelier Road, Laurel, MD 20723 (the "Maple Lawn Practice"), and of a second dental practice called Loch Ridge Dental Care, located at 1708 Joan Avenue, Parkville, Maryland 21234 (the "Loch Ridge Practice").

The Maple Lawn Practice

3. On or about May 3, 2018, the Board received a complaint against the Maple Lawn Practice from the Howard County Health Department reporting that on or about April 23, 2018, it received information that several trash bags of biohazardous waste and patient dental charts from the Maple Lawn Practice were found inside a dumpster at a gas station close to the Maple Lawn Practice.

4. Based on the complaint, the Board initiated an investigation of the Maple Lawn Practice and its dental practitioners.

5. Due to allegations of improper disposal of biohazardous waste from the Maple Lawn Practice in the complaint, on or about May 15, 2018, a Board-contracted infection control expert (the "Board Inspector") and a Board investigator visited the Maple Lawn Practice for the purpose of conducting an infection control inspection to evaluate compliance with CDC Guidelines. [2]

[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.

6. The Board Inspector and the Board investigator arrived at the Maple Lawn Practice at approximate 9:00 a.m. and met with the practice manager of operation ("Employee A"). The Board Inspector and the Board investigator introduced themselves and explained the purpose of their visit. They confirmed that two Maryland licensed staff dentists ("Dentist A and Dentist B") were the only two dentists practicing at this location.

7. At the start of the inspection at approximately 9:30 a.m., the Board Inspector noted the following individuals on the premises: Employee A, Dentist A, two registered dental hygienists, two dental assistants and three patients.

8. Prior to the start of the inspection, Employee A made several telephone calls to individuals affiliated with the Maple Lawn Location. By 10:30 a.m., the following additional individuals arrived at Maple Lawn: two corporate representatives one of whom was the Occupational and Health Administration ("OSHA") coordinator from Heart Source, L.L.C. (a dental service organization that manages administrative functions for the Maple Lawn Practice) ("the DSO"), another dental assistant and Dentist B.

9. As part of the inspection, the Board Inspector utilized the Centers for Disease Control and Prevention Infection Prevention Checklist for Dental Settings.

10. During the inspection, the Board Inspector was able to directly observe patient treatment by Dentist A and other dental staff members.

11. Based on the inspection, the Board Inspector found the following CDC violations:

Section I: Policies and Practices

a. **Administrative Measures** – The Respondent, as the owner and director, and other Maple Lawn Practice personnel failed to: make available written infection prevention policies and procedures specific

for the dental setting; reassess and update the policies and procedures at least annually; assign an individual trained in infection prevention the responsibility of coordinating the program; make available supplies necessary for adherence to Standard Precaution; and have a system for early detection and management of potentially infectious persons.

i. At approximately 9:30 a.m., upon request by the Board Inspector, none of the Maple Lawn Practice personnel were able to produce any manuals that listed infection prevention procedures specific for the Maple Lawn Practice. The same request was made at approximately 10:30 a.m. to the DSO corporate representatives and Dentist B, but none was able to produce any written policies and procedures specific to the Maple Lawn Practice.

ii. None of the staff members or DSO corporate representatives were able to confirm or provide documents to demonstrate that infection prevention policies and procedures were reassessed at least annually.

iii. No staff member who was trained in infection prevention was assigned the responsibility for coordinating the program.

iv. The Maple Lawn Practice did not have supplies, such as disposable laboratory jackets, proper protective eyewear, or hi-quality utility gloves, necessary to adhere to Standard Precautions.

v. The Board Inspector did not observe any precaution posters at the Maple Lawn Practice. There were no signs at the entrance instructing patients on how to prevent spread of respiratory secretions. There were no masks available to patients with potential respiratory issues.

b. **Infection Prevention Education and Training** – The Respondent and other Maple Lawn personnel failed to maintain training logs of personnel training (upon hire and annually) on infection prevention and bloodborne pathogens standard.

c. **Dental Health Care Personnel Safety** – No one, including the Respondent or other Maple Lawn Practice personnel, was able to provide documents to demonstrate: having an exposure control plan tailored to the specific requirements of the Maple Lawn Practice; training relevant staff members on the OSHA Blood Pathogen Standards; having available current CDC recommendations for immunization, evaluation and follow-up; having available Hepatitis B vaccinations for relevant staff members; having available post-vaccination screening for Hepatitis B; having offered annual influenza vaccination to staff members; staff members receiving baseline tuberculosis screening; maintaining a log of needle-sticks and sharps injuries; having in place referral arrangements to qualified health care professionals for provision of preventive, medical and post-exposure management services; having post-exposure evaluation and follow-up

subsequent to occupational exposure event; and maintain policies on contact between personnel having potentially transmissible conditions with patients.

d. **Program Evaluation** – No one, including the Respondent or other Maple Lawn Practice personnel, was able to provide documents to demonstrate: having available written policies and procedures for routine monitoring and evaluation of infection prevention and control program; and adhering with certain practices such as immunizations, hand hygiene, sterilization monitoring, and proper use of personal protective equipment.

e. **Hand Hygiene** – No one, including the Respondent or other Maple Lawn Practice personnel, was able to provide documents to demonstrate that staff members were trained regarding appropriate indications for hand hygiene.

f. **Personal Protective Equipment (PPE)** – No one, including the Respondent or other Maple Lawn Practice personnel, was able to provide documents to demonstrate that staff members were trained on proper selection and use of PPE.

g. **Respiratory Hygiene/Cough Etiquette** – No one, including the Respondent and other Maple Lawn Practice personnel, was able to provide documents to demonstrate: having policies and procedures to contain respiratory secretions in people who have signs and symptoms

of a respiratory infection; and staff members having received training on the importance of containing respiratory secretions.

i. The Board Inspector did not observe any precaution posters at the Maple Lawn Practice. There were no signs at the entrance instructing patients on how to prevent spread of respiratory secretions. There were no masks available to patients with potential respiratory issues

h. **Sharps Safety** – No one, including the Respondent or other Maple Lawn Practice personnel, was able to provide documents to demonstrate: having available written policies, procedures and guidelines for exposure prevention and post-exposure management; having staff member(s) identify, evaluate and select devices with engineered safety features at least annually.

i. **Safe Injection Practices** – No one, including the Respondent or other Maple Lawn Practice personnel, was able to provide documents to demonstrate having available written policies, procedures, and guidelines for safe injection practices.

j. **Sterilization and Disinfection of Patient-Care Items and Devices** – No one, including the Respondent or other Maple Lawn Practice personnel, was able to provide documents to demonstrate: having available written policies and procedures to ensure reusable instruments were cleaned and reprocessed appropriately; having available policies, procedures and manufacturer reprocessing instructions for reusable

instruments; having appropriately trained staff member(s) responsible for reprocessing reusable instruments upon hire and at least annually; having available training and equipment to ensure proper use of PPE; performing and documenting routine maintenance for sterilization equipment; and having in place policies and procedures outlining dental setting response in the event of a reprocessing error or failure.

i. For the autoclave, the Maple Lawn Practice personnel maintained a rudimentary log sheet that was incomplete and prefilled. According to the log, spore testing was not done at least weekly.

ii. The Board Inspector observed processed sterilization pouches that were not dated, and were not labeled as to which autoclave was used for the sterilization.

iii. The Board Inspector observed that the eyewash station was located at the sink where dirty instruments were washed.

k. **Environmental Infection Prevention and Control** – No one, including the Respondent or other Maple Lawn Practice personnel, was able to provide documents to demonstrate: having available written policies and procedures for routine cleaning and disinfection of environmental surfaces; staff members who perform environmental infection prevention procedures received job-specific training about infection prevention and control management upon hire and at least annually; having available training and equipment to staff members to

ensure proper use of PPE; periodic monitoring and evaluation of cleaning, disinfection and use of surface barriers; and having in place procedures for decontamination of spills of blood or other body fluids.

l. **Dental Unit Water Quality** – No one, including the Respondent or other Maple Lawn Practice personnel, was able to provide documents to demonstrate: having in place policies and procedures for maintaining dental unit water quality that met Environmental Protection Agency standards; having policies and procedures in place for using sterile water as coolant/irrigant when performing surgical procedures; and having available written policies and procedures outlining response to a community boil-water advisory.

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

m. **Performance of Hand Hygiene** – The Board inspector observed Dentist A and/or other staff members failing to consistently perform hand hygiene before and after treating patients, before putting on gloves and after removing gloves. The Board Inspector further noted that he did not see a posting of hand hygiene protocol poster at the Maple Lawn Practice.

n. **Use of Personal Protective Equipment (PPE)** – The Board Inspector observed the Maple Lawn Practice personnel: not removing PPE before leaving work area; failing to perform hand hygiene after removing PPE; failing to change masks between patients; failing to wear masks during processing and sterilization of instruments; not having eye-

shields on PPE; failing to wear puncture and chemical resistant utility gloves during cleaning; and failing to change visibly soiled protective clothing in between patients and after processing instruments.

o. **Respiratory Hygiene/Cough Etiquette** – The Board Inspector found the Maple Lawn Practice personnel failed to: post "Cover Your Cough" poster at the entrance; have available masks for symptomatic persons; and have available segregated area for symptomatic persons.

p. **Sharps Safety** – The Board Inspector observed the Maple Lawn Practice personnel failing to consistently use engineering controls and work place controls for sharps to prevent injuries. The Board Inspector observed two sharps containers, one in the operatory and one in the processing area, that were difficult to access. The Board Inspector requested Dentist A, Dentist B and other staff members for documents demonstrating that sharps containers were properly disposed, but they were unable to provide such documents.

q. **Safe Injection Practices** – Based on the Board Inspector's observations, the Maple Lawn Practice personnel complied with CDC Guidelines on Safe Injection Practices.

r. **Sterilization and Disinfection of Patient-Care Items and Devices** – The Respondent, as the owner/director, failed to ensure that the Maple Lawn Practice personnel properly sterilize and disinfect patient-care items and devices for reasons including:

i. The Board Inspector observed multiple patient-care items and devices, such as burs, bur blocks, XCP equipment and other instruments, that could not be verified as being properly sterilized.

ii. Staff members retrieved sterile packs for patient use despite the external indicators not having changed to the proper dark shade.

iii. The Board Inspector noticed that regular water was used for sterilization instead of distilled water.

iv. The instrument processing workflow pattern did not follow high contamination area to clean/sterile area.

v. The Board Inspector could not verify the type of solution used in the ultrasonic cleaner and how often the solution was changed.

vi. The Board Inspector further noticed that the sterile packs failed to contain labels indicating the sterilizer used, the cycle or load number, the date of sterilization, and when applicable, the expiration date.

vii. The Board Inspector noted that a folder labeled Spore Test Result was empty. A log near the autoclaves was prefilled and contained varying dates ranging from a week apart to a month apart. The Respondent, other staff members and the DSO corporate representatives were unable to provide documents to support that spore testing was performed at least weekly.

viii. The Board Inspector observed dental hand-pieces attached to lines in operatories that were not in use. These hand-pieces should be in sterile pouches if not in use.

s. **Environmental Infection Prevention and Control** – The Respondent, as the owner/director, failed to ensure that the Maple Lawn Practice personnel comply with CDC Guidelines on Environmental Infection Prevention and Control for reasons including:

i. The Board Inspector observed multiple examples of missing barrier protection on dental units, water lines, A/W syringes, HVE, SVE, connectors, computer keyboards/mouse and radiological exposure buttons. Non-sterile bib clips were on a bracket table along with sterile bags.

ii. The Board Inspector observed biohazardous waste cans placed next to regular waste cans. The Board Inspector found used examination gloves placed in the regular waste can.

iii. The Board Inspector was unable to verify that cleaners and disinfectants were used according manufacturer instructions.

iv. The Board Inspector was unable to find any large biohazardous waste boxes at Maple Lawn. The Respondent, other staff members and the DSO corporate representatives were unable to provide documents that demonstrated proper pickup and disposal of biohazardous waste.

v. The Board Inspector observed clutter around every sink with patient education materials and instruments.

vi. The Board Inspector observed an uncovered portable oxygen/nitrous oxide cart covered in dust placed at a corner of the sterilization area.

t. **Dental Unit Water Quality** – No one, including the Respondent, other staff members and the DSO corporate representatives, was able to produce documents to demonstrate that waterline testing was ever performed. When asked, Dentist A, Dentist B, other staff members and the DSO corporate representatives were unable to confirm whether daily or weekly flushing of dental unit waterline was being performed.

12. Based on his observations and inspection, the Board Inspector determined that the practice of dentistry at the Maple Lawn Practice under the current operating conditions posed a direct risk to the health of patients, employees and community at large.

13. On or about June 4, 2018, the Board received a letter from the Respondent with attached documents that purported to address some of the deficiencies noted at the inspection.

The Loch Ridge Practice

14. On or about June 21, 2018, the Board received a complaint (the "Loch Ridge Complaint") against the Loch Ridge Practice forwarded by the State Department of Labor, Licensing, and Regulation (DLLR). DLLR stated it had received the Loch Ridge Complaint on June 14, 2018, but determined the Board had jurisdiction to investigate.

15. The Loch Ridge Complaint alleged that the Loch Ridge Practice was failing to practice proper infection control protocols, including: using burs and instruments that were not in sterile bags; failing to autoclave the bur blocks; wiping composite instruments instead of sterilizing; failing to use barriers; and failing to use techniques to prevent cross contamination.

16. In general, the Loch Ridge Complaint stated that the Loch Ridge Practice was "very dirty, unorganized, and just about everything is cross contaminated!" and added that the employees at the Loch Ridge Practice "desperately need help with following OSHA standards and regulations ASAP!"

17. Based on the Loch Ridge Complaint, the Board initiated an investigation regarding the Respondent's compliance with CDC guidelines.

18. In furtherance of the investigation, the Board assigned an expert in infection control protocols (the "CDC Expert") to conduct an inspection of the Loch Ridge Practice.

19. On or about July 9, 2018, the CDC Expert, accompanied by a Board staff member, conducted an inspection of the Loch Ridge Practice to determine whether the Loch Ridge Practice was complying with the CDC guidelines. During the inspection, the CDC Expert was able to observe patient treatment by dentists employed by the Respondent and the state of the facility. In addition, during the inspection, a representative arrived from the DSO, which also manages many administrative services at the Loch Ridge Practice.

20. Following the inspection, the CDC Expert completed a report (the "Expert Report") regarding the Loch Ridge Practice's compliance with CDC Guidelines. Based on the inspection, the CDC Expert opined that the Loch Ridge Practice posed a risk to patient and staff safety and noted numerous violations of the CDC Guidelines.

21. Specific deficiencies noted include the following:

a. Instrument processing and sterilization area does not follow "single loop" concept, creating the risk of cross contamination;

b. Inconsistent use of personal protective equipment (PPE), including a lack of sterile gloves and improper mask usage.

c. Weekly spore testing log indicated that some dates had been missed, and in at least one case, an expired test strip was used. Nevertheless, there was no documentation of any remedial action taken to correct or retest.

d. Unverifiable sterilization of dental instruments, with an inconsistent or compromised seal on putatively sterilized pouches;

e. Disinfectant containers were not labeled to indicate their contents or their activation/expiration dates;

f. No documentation of dental unit waterline testing. No documentation of protocols used for equipment maintenance for autoclave, emergency eyewash station, dental equipment, or dental unit waterlines;

g. No emergency eyewash station;

h. Sterile gloves not used and not available for surgical procedures (nitrile gloves were available);

i. Inconsistent barrier protection as evident in dental treatment and devices;

j. Hepatitis B Vaccination documentation proof not available. Baseline tuberculosis testing not available;

k. No staff training log at time of hire or annual training is maintained at practice site;

l. No posting of "Hand Hygiene" protocol, and hand hygiene was inconsistent; and

m. No posting of "Cover your Cough" or "We take precautions for You" posters.

22. As the owner/director of the Loch Ridge Practice and the Maple Lawn Practice, 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.), 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 15143, 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 (Repl. Vol. 2014).

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.*

August 28, 2018
Date

Arthur C. Jee, D.M.D., President
Maryland State Board of Dental Examiners