IN THE MATTER OF	*	**BEFORE THE MARYLAND**
PRITA GHOSH, D.M.D.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 1332	*	**Case Number: 2019-049**

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ORDER

On or about October 17, 2018, the Maryland State Board of Dental Examiners (the "Board") charged **PRITA GHOSH, D.M.D.** (the "Respondent"), License Number 13332, under the Maryland Dentistry Act, codified at Md. Code Ann., Health Occ. ("Health Occ.") §§ 4-101 *et seq.* (2014 Repl. Vol. & 2017 Supp.) (the "Act") and the regulations adopted by the Board at Md. Code Regs. ("COMAR") 10.44.01 *et seq.*

Specifically, the Board charged the Respondent with violating the following provisions of law:

Health Occ. § 4-315. Denials, reprimands, probations, suspensions, and revocations -- Grounds.

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

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

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

On December 19, 2018 and January 16, 2019, the Board held evidentiary hearings on this matter. The Respondent was present and represented by counsel throughout both days of the

hearing. There were two different quorums of the Board for each day of the hearing. However, the entire Board reviewed the entire record and all submissions prior to issuing this order.

FACTS

On May 3, 2018, the Maryland Board of Dental Examiners (the Board") received a complaint concerning Family Dental Care of Maple Lawn, a Dental Professionals of Maryland-Gerald Awadzi, P.C. owned practice (hereinafter "Maple Lawn"). Based on the complaint, the Board conducted an unannounced inspection of Maple Lawn on May 15, 2018 where it observed treatment rendered by Dr. Vikaskumar Patel, D.D.S. As a result of this inspection, on August 27, 2018, the Board summarily suspended the licenses of Dr. Patel as well as Dr. Manpreet Dhillon, the other dentist that worked and treated patients at Maple Lawn. On June 21, 2018, the Board received a complaint concerning Loch Ridge Dental Care, a Dental Professionals of Maryland-Gerald Awadzi. P.C. owned practice (hereinafter "Loch Ridge'"). Based on the complaint, the Board conducted an unannounced inspection of Loch Ridge on July 9, 2018 where it observed treatment rendered by Dr. Hirsch Seidman, D.D.S. As a result of this inspection, on August 15, 2018, the Board summarily suspended the licenses of Dr. Seidman as well as Dr. Charles Michelson, the other dentist that worked and treated patients at the Loch Ridge office.

On August 28, 2018, the Board summarily suspended the license of Dr. Awadzi based on that fact he owned both practices through a professional corporation. After learning of their ownership interest through documents produced to the Board on September 19, 2018, the Board charged Dr. Joyce Thomas and Dr. Prita Ghosh with violations of the Dental Practice Act on October 17, 2018. Like Dr. Awadzi, the basis for these charges was the ownership interest of Dr. Thomas and Dr. Gosh in the Maple Lawn and Loch Ridge practices.

On September 19, 2018, the Board held case review conferences for Drs. Patel, Dhillon, Seidman and Michelson wherein consent orders were agreed upon by all parties that lifted the

summary suspensions of Drs. Patel, Dhillon, Seidman and Michelson and placed them on probation with conditions. On October 3, 2018, a show cause hearing was held for Dr. Awadzi. The Board found that "the public health, safety or welfare" imperatively required it to summarily suspend Dr. Awadzi's license and did not lift Dr. Awadzi's summary suspension. The Board learned that Dr. Awadzi was not the sole owner of the practices at issue in this case on September 19, 2018 through document discovery. As a result of that knowledge, the Board charged Dr. Thomas and Dr. Ghosh with violations of the Dental Practice Act on October 17, 2018. Dr. Thomas and Dr. Ghosh's cases were consolidated with Dr. Awadzi's and on December 19, 2018, the Board conducted the first day of a two-day evidentiary hearing into the suspension of Dr. Awadzi and charges against Drs. Thomas, Ghosh and Awadzi. The hearing was completed on January 16, 2019.

SUMMARY OF THE EVIDENCE

The following exhibits were admitted into evidence during the hearing:

STATE'S EXHIBITS

No. 1 -19 Admitted into evidence

RESPONDENT'S EXHIBITS

No. 1, 2, 3,4, 5, 6, 9-17, 19, 20

SUMMARY OF WITNESS TESTIMONY

The State called David Hanauer, Howard Freundlich, D.D.S. and Roseanna Morgan, R.D.H. as its witnesses. The Respondent called Christine Wisnom, R.N., Ronald F. Moser, D.D.S., Gerald Awadzi, D.M.D., Prita Ghosh, D.D.S. and Joyce Thomas, D.D.S. Dr. Freundlich, Ms. Morgan and Ms. Wisnom each testified as an expert in CDC guidelines and compliance. No other witnesses testified in this matter.

David Hanauer was the first witness called by the State. He investigated the matter for the Board. He testified that the Board investigated Loch Ridge and Maple Lawn for CDC violations. During the investigation, he discovered that, according to their websites both practices were owned and operated by Dental Professionals of Maryland, Gerald Awadzi, P.C.

Dr. Freundlich testified next. On May 3, 2018, the Board received the first complaint against Maple Lawn from the Howard County Health Department, reporting that several bags of biohazardous waste and patient dental charts from the Maple Lawn practice were found inside a dumpster at a nearby gas station. Based on the complaint, the Board initiated an investigation of Maple Lawn's CDC guideline compliance. The Board contracted with Dr. Freundlich, to be an independent expert in CDC infection control practices. On May 15th, Dr. Freundlich visited Maple Lawn and conducted his inspection, using the CDC's published Infection Control Checklist. Dr. Freundlich observed serious and wide-ranging violations at Maple Lawn. After the inspection, he drafted a report for the Board. His report of this inspection was admitted into evidence. Further, Dr. Patel and Dr. Dhillon, the dentists who worked and treated patients at Maple Lawn, entered into a settlement of their part of the case with the Board. In their Consent Orders, Drs. Patel and Dhillon admitted to the violations alleged in Dr. Freundlich's report.

The State's final witness was Roseanna Morgan, R.D.H. On June 21, 2018, the Board received a complaint about Loch Ridge. The complaint alleged that Loch Ridge was dirty, unorganized and cross-contaminated. Based on the complaint, the Board initiated an investigation of Loch Ridge's CDC guideline compliance. Ms. Morgan was retained as the Board's independent CDC inspector. On July 9, 2019 she conducted an inspection of Loch Ridge. Ms. Morgan found a variety of serious CDC violations at Loch Ridge on that day. After the inspection, she drafted a report for the Board. Her report of this inspection was admitted into

evidence. Further, Dr. Seidman and Dr. Michelson, the dentists that worked and treated patients at Loch Ridge, entered into a settlement of their part of the case with the Board. In their Consent Orders, Drs. Seidman and Michelson admitted to the violations alleged in Ms. Morgan's report.

The first witness for the Respondents was Dr. Ronald F. Moser. Dr. Moser was the acting Executive Director of the Board at the time these cases were investigated and charged. Dr. Moser testified about his recollection of the case.

The next witness for the Respondents was Christine Wisnom. Ms. Wisnom was hired by the Respondents to remediate the violations Maple Lawn and Loch Ridge. She did not dispute the violations reported by the Board's experts. Further, she attributed the violations to the volume of business done by each practice and failure to appropriately staff the practices.

Drs. Awadzi, Ghosh and Thomas all testified on their own behalf. Each admitted to owning Maple Lawn and Loch Ridge. None of them would admit to being a proprietor, manager or conductor of Maple Lawn or Loch Ridge. Dr. Awadzi admitted to owning fifty-one percent of Dental Professionals of Maryland, Gerald Awadzi. P.C. Drs. Ghosh and Thomas each own twenty-four and one half percent of Dental Professionals of Maryland, Gerald Awadzi. P.C. None of the doctors testified to having any knowledge of the twenty-one different practices they own through their professional corporation. Only Dr. Awadzi would even admit to having set foot in Maple Lawn and Loch Ridge, the practices that were summarily suspended. The Board did not find their testimony to be credible. All were evasive in their answers. As an example, none of three dentists could define the word "proprietor."

Drs. Awadzi, Ghosh and Thomas produced a redacted contract to attempt to prove that they have contracted with the dentists who treated the patients at each location to take responsibility for CDC compliance at each location. They offered no testimony to show how

CDC compliance was actually accomplished and monitored under the contract. In spite of this contract, it was undisputed that both Loch Ridge and Maple Lawn had major deficiencies.

FINDINGS OF FACT

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 July 1, 2004, under license number 13332. The Respondent's license is current through June 30, 2019.
2. At all times relevant hereto, the Respondent has practiced dentistry at Neibauer Dental Care located at 117 St. Patrick's Dr., Waldorf, Maryland 20720, and through her ownership, along with two other dentists, in a professional corporation called Dental Professionals of Maryland, 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 a second dental practice called Loch Ridge Dental Care, located at 1708 Joan Avenue, Parkville, Maryland 21234 (the "Loch Ridge Practice").[1]

Maple Lawn

3. On or about May 3, 2018, the Board received a complaint against Maple Lawn 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 Maple Lawn were found inside a dumpster at a gas station close to Maple Lawn.
4. Based on the complaint, the Board initiated an investigation of Maple Lawn and its dental practitioners.

[1]Dental Professionals of Maryland, Gerald Awadzi, P.C. currently owns approximately twenty-one (21) dental practices in Maryland.

5. Due to allegations of improper disposal of biohazardous waste from Maple Lawn in the complaint, on or about May 15, 2018, a Board-contracted infection control expert (the "Board Inspector") and a Board investigator visited Maple Lawn for the purpose of conducting an infection control inspection to evaluate compliance with CDC Guidelines.[2]
6. The Board Inspector and the Board investigator arrived at Maple Lawn 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 (Drs. Patel and Dhillon) 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, Dr. Patel, 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 Maple Lawn. 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 Maple Lawn) ("the DSO"), another dental assistant and Dr. Dhillon.
9. As part of the inspection, the Board Inspector utilized the Centers for Disease Control and Prevention Infection Prevention Checklist for Dental Settings.

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[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.

10. During the inspection, the Board Inspector was able to directly observe patient treatment by Dr. Patel 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 an owner, 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 personnel were able to produce any manuals that listed infection prevention procedures specific to Maple Lawn. The same request was made at approximately 10:30 a.m. to the DSO corporate representatives and Dr. Dhilllon, but none was able to produce any written policies and procedures specific to Maple Lawn.

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. Maple Lawn 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 Maple Lawn. 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 log of personnel training (upon hire and annually) on infection prevention and bloodborne pathogens standard.

c. **Dental Health Care Personnel Safety** – No Maple Lawn personnel were able to provide documents to demonstrate: having an exposure control plan tailored to the specific requirements of Maple Lawn; training relevant staff members on the OSHA Bloodborne Pathogen Standards; having available current CDC recommendations for immunization, evaluation and follow-up; having available Hepatitis B vaccination to 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 at Maple Lawn 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 at Maple Lawn 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 at Maple Lawn 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 at Maple Lawn 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 Maple Lawn. 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 at Maple Lawn, 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 at Maple Lawn 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 at Maple Lawn 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, Maple Lawn 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 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 at Maple Lawn 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 at Maple Lawn 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

a. **Performance of Hand Hygiene** – The Board inspector observed Dr. Patel 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 Maple Lawn.

b. **Use of Personal Protective Equipment (PPE)** – The Board Inspector observed Maple Lawn 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 mask 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.

c. **Respiratory Hygiene/Cough Etiquette** – The Board Inspector found Maple Lawn 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.

d. **Sharps Safety** – The Board Inspector observed Maple Lawn 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 Dr. Patel, Dr. Dhillon and other staff members for documents demonstrating that sharps containers were properly disposed, but they were unable to provide such documents.

e. **Safe Injection Practices** – Based on the Board Inspector's observations, Maple Lawn personnel failed to comply with CDC Guidelines on Safe Injection Practices.

f. **Sterilization and Disinfection of Patient-Care Items and Devices** – The Respondent, as an owner of Maple Lawn, failed to ensure that Maple Lawn 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 pre-filled and contained varying dates ranging from a week apart to a month apart. No one at Maple Lawn was able 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.

g. **Environmental Infection Prevention and Control** – The Respondent, as an owner of Maple Lawn, failed to ensure that Maple Lawn 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. No one at Maple Lawn was able 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.

h. **Dental Unit Water Quality** – No one at Maple Lawn was able to produce documents to demonstrate that waterline testing was ever performed. When asked, Dr. Patel, Dr. Dhillon, 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 Maple Lawn 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 a representative of the professional corporation with attached documents that purported to address some of the deficiencies noted at the inspection.

Loch Ridge

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 Loch Ridge 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 Loch Ridge was "very dirty, unorganized, and just about everything is cross contaminated!" and added that the employees at Loch Ridge "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 Roseanna Morgan, R.D.H., an expert in infection control protocols (the "CDC Expert") to conduct an inspection of Loch Ridge.

19. On or about July 9, 2018, Roseanna Morgan, R.D.H., the CDC Expert, accompanied by a Board staff member, conducted an inspection of Loch Ridge to determine whether Loch Ridge 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 Loch Ridge.

20. Following the inspection, Ms. Morgan completed a report (the "Expert Report") regarding Loch Ridge's compliance with CDC Guidelines. Based on the inspection, Ms. Morgan opined that Loch Ridge 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 an owner of Loch Ridge and Maple Lawn, the Respondent failed to ensure compliance with the CDC Guidelines at all times.

23. As a result of the Board Inspectors' findings, the Respondent's professional corporation retained an infection control consultant to assist with CDC policies and procedures. The consultant conducted thorough consultations and training sessions at Loch Ridge and Maple Lawn to assist the Practices and the Respondent in correcting the deficiencies the Board Inspectors found. The consultant has provided the Board with a favorable report of the Respondent's compliance with CDC Guidelines at Maple Lawn and Loch Ridge.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent has violated Health Occ. § 4-315(a)(30) and § 4-315(a)(16).

Under Health Occ. § 4-101(L)(1), the Board considers any person who is "a manager, a proprietor, or a conductor of or an operator in any place in which a dental service or dental operation is performed intraorally" to be practicing dentistry. As an owner and operator of Maple Lawn and Loch Ridge, the Respondent falls squarely within this definition. Under the act, majority and minority owners are responsible for CDC compliance their practices. As such, the Respondent's numerous violations of CDC Guidelines, as detailed within the Findings of Fact, and disregard for those guidelines' detailed procedures to minimize infection transmission constitute a violation of Health Occ. § 4-315(a)(30). The only exception to adherence of these guidelines occurs in an emergency and life-threatening situation. No such emergency situation prevented the Respondent from following the CDC's standards for infection control at Maple Lawn and Loch Ridge.

Furthermore, as an owner and operator of Maple Lawn and Loch Ridge, the Respondent's failure to comply with CDC Guidelines at her practices represents unprofessional conduct in the practice of dentistry, thereby violating Health Occ. § 4-315(a)(16).

The Respondent's failure to comply with CDC Guidelines in her practice of dentistry based on her minority ownership/directorship of Maple Lawn and Loch Ridge constitutes: failure to comply with the CDC Guidelines on universal precautions, in violation of § 4-315(a)(30); and unprofessional behavior, in violation of Health Occ. § 4-315(a)(16).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, by a majority of the Board considering this case:

ORDERED that the Respondent is hereby **REPRIMANDED,** and it is further

ORDERED that the Respondent is placed on **PROBATION** for a period of **TWO (2) YEARS**, subject to the following terms and conditions:

1. A Board-assigned inspector shall conduct an unannounced inspection at both Maple Lawn and Loch Ridge within ten (10) business days of the date of this Consent Order to evaluate the Respondent and her staff regarding compliance with the Act and infection control guidelines. The Board-assigned inspector shall be provided with copies of the Board's file, the Consent Order, and any other documentation deemed relevant by the Board.

2. The Respondent shall provide to the Board-assigned inspector a schedule of the regular weekly office hours of both Maple Lawn and Loch Ridge and promptly apprise the inspector of any changes.

3. During the probationary period, both Maple Lawn and Loch Ridge shall be subject to quarterly unannounced onsite inspections by a Board-assigned inspector.

4. Any dental practice owned by Dental Professionals of Maryland, Gerald Awadzi, P.C., including but not limited to the twenty-one (21) practices listed in Exhibit 1 to this Consent Order, may at the Board's sole discretion be subject to an unannounced onsite inspection by a Board-assigned inspector.

5. 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 the Board regarding the findings of the inspections.

6. The Respondent shall, at all times, practice dentistry in accordance with the Act, related regulations, and shall comply with CDC and OSHA guidelines on infection control for dental healthcare settings.

7. On or before the fifth day of each month, the Respondent shall provide to the Board a copy of the current patient appointment book for that month for both Maple Lawn and Loch Ridge.

8. Within ninety (90) days of the date of this Consent Order, the Respondent shall pay a fine in the amount of **FIVE THOUSAND DOLLARS** ($5000) by bank certified check or money order made payable to the Maryland Board of Dental Examiners.

9. Within three (3) months of the date of this Consent Order, the Respondent shall successfully complete a Board-approved in-person four (4) credit

hour course(s) in infection control protocols, which may not be applied toward her license renewal.

10. Within three (3) months of the date of this Consent Order, the Respondent shall successfully complete a Board-approved in-person two (2) credit hour course(s) in professional ethics, which may not be applied toward her license renewal.

11. If the above-mentioned courses are not completed within three (3) months of the date of the Consent Order, there shall be an automatic extension of three (3) additional months if the Respondent demonstrates to the Board's satisfaction that she was unable to complete the courses despite a good-faith effort.

12. The Respondent may file a petition for early termination of her 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, may grant or deny such petition at its sole discretion.

AND IT IS FURTHER ORDERED that the Respondent, through Dental Professionals of Maryland, Gerald Awadzi, PC, shall coordinate with practice administrators to implement practice-wide policies and training to ensure that all dentists practicing at locations owned by Dental Professionals of Maryland, Gerald Awadzi, PC, shall be able to comply with CDC Guidelines, including but not limited to their ability to access and update, when applicable, policies, procedures, manuals, training logs, manifests and maintenance logs relating to CDC compliance. The Respondent shall provide verification of the implementation of such policies and training to the Board via semiannual reports during probation.

ORDERED that if, at any time during the period of probation, the Respondent or the Respondent's professional corporation relinquishes ownership of either Maple Lawn or Loch Ridge, the Respondent shall make all necessary agreements with the subsequent owner(s) to guarantee that the Board is permitted to continue the inspection terms outlined above until at least one year from the effective date of this Consent Order; and it is further

ORDERED that after the conclusion of the **TWO (2) YEAR** probationary period, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the Board may terminate probation, through an order of the Board, or a designated Board committee. The Board, or designated Board committee, shall grant the termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints of similar nature; and it is further

ORDERED that if the Board has reason to believe that the Respondent has failed 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 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

ORDERED that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Provisions §§ 4-101 *et seq.* (2014).

November 22, 2019
Date

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