IN THE MATTER OF	*	**BEFORE THE MARYLAND**
HIRSCH SEIDMAN, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 6725	*	**Case Number: 2019-016**

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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 **HIRSCH SEIDMAN, D.D.S.** (the "Respondent"), License Number 6725, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under: Md. Code Regs. ("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 has been licensed to practice dentistry in Maryland. The Respondent was initially licensed on or about June 22, 1978, under license number 6725. The Respondent's license is current through June 30, 2019.

2. At all times relevant hereto, the Respondent, practiced dentistry at a practice called Loch Ridge Dental Care, located at 1708 Joan Avenue, Parkville, Maryland 21234 (the

[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.

"Practice"). The Practice is owned by a Professional Corporation called Dental Professionals of Maryland, Gerald Awadzi, P.C.

Complaint

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

4. The Complaint alleged that the 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.

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

6. Based on the Complaint, the Board initiated an investigation regarding the Respondent's compliance with CDC guidelines. [2]

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

Investigation

[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.

8. On or about July 9, 2018, the CDC Expert, accompanied by a Board staff member, conducted an inspection of the Practice to determine whether the Respondent was complying with the CDC guidelines. During the inspection, the CDC Expert was able to observe the Respondent's patient treatment and the state of the Practice. In addition, during the inspection, the Respondent contacted Heart Source, L.L.C., a dental service organization (DSO) that manages many administrative services at the Practice. A representative from Heart Source arrived shortly thereafter to observe the inspection.

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

10. 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.

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 6725, 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 her possession, including but not limited to her 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 15, 2018

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