IN THE MATTER OF	*	**BEFORE THE MARYLAND**
AKASH AGRAWAL, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 15281	*	**Case Number: 2020-138**

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CONSENT ORDER

On or about May 15, 2020, the Maryland State Board of Dental Examiners (the "Board") issued and served on **AKASH AGRAWAL, D.D.S.** (the "Respondent"), License Number 15281: **CHARGES** under the Maryland Dentistry Act, codified at Md. Code Ann., Health Occ. ("Health Occ.") §§ 4-101 *et seq.* (2014 Repl. Vol. & 2019 Supp.) (the "Act"); and an **ORDER FOR SUMMARY SUSPENSION,** by which it summarily suspended the Respondent's license to practice dentistry in the State of Maryland, pursuant to its authority under Md. Code Ann., State Gov't § 10-226(c) (2014 Repl. Vol.), concluding that the public health, safety and welfare imperatively required emergency action.

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

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;

(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…;

On June 3, 2020, a Case Resolution Conference ("CRC") was held at the Board's office. As a resolution of this case, the Respondent agreed to enter into this Consent Order consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Board finds the following facts.

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 March 14, 2013, under License Number 15281. The Respondent's license is current through June 30, 2021.

2. At all times relevant, the Respondent practiced dentistry at a dental practice in Waldorf, Maryland (the "Office"), which he owns.

II. COMPLAINT

3. On or about January 22, 2020, the Board received a complaint from a former temporary employee (the "Complainant") at the Office alleging, among other things, that there were substandard infection control practices at the Office.

4. Based on the complaint, the Board initiated an investigation of the Office's compliance with CDC guidelines. [1]

III. INFECTION CONTROL INSPECTION

5. Due to allegations of potential infection control issues at the Office, on or about February 24, 2020, a Board-contracted infection control inspector (the "Board Inspector"), along with a Board investigator, visited the Office and conducted an infection control inspection.

6. The Respondent was not present during the inspection. However, another dentist whom the Respondent employs ("Dentist A") was present. Also present were at least the following individuals: an office manager/receptionist, a financial coordinator, an office staff member, and four clinical staff members.

7. 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.

8. During the inspection, the Board Inspector was able to directly observe patient treatment by dental practitioners employed at the Office, including Dentist A.

[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.

9. Based on the inspection, the Board Inspector made the following findings:

Section I: Policies and Practices

1.1 ADMINISTRATIVE MEASURES

A. There were no employee (records/assessments) folders of any kind. There was no office manual of any kind and no records whatsoever of training on infection prevention policies and procedures upon hire, reassessed at least annually, or according to state and federal requirements. There was no record of Infection Prevention/OSHA Bloodborne Pathogens Training according to federal and state requirements or based on evidenced based guidelines. There was no annual training, on-boarding, or updates of any kind that could be provided at this site visit.

B. There are no infection prevention policies and procedures that are reassessed at least annually or according to state or federal requirements and updated if appropriate. One employee said she took a one-hour online course on Bloodborne Pathogens Training. This was the extent of any training anyone in the entire practice has ever taken to the best of their recollection.

C. There was no individual officially responsible for coordinating the infection control program according to anyone present, even according to the Respondent. The Respondent could not provide any data or documentation that supports that he has ever had training in infection prevention.

D. There was a great lack in the necessary supplies for adherence to Standard Precautions. There were no utility gloves available in the sterilization area.

E. The facility has no system in place for early detection and management of potentially infectious persons at initial points of encounter. There was no precautions poster posted for patients. The policies and procedures to contain respiratory secretions in people who have signs and symptoms of respiratory infection, beginning at the entry to the dental setting could not be provided. There are no signs at entrances to instruct patients on procedures necessary to prevent the spread of their respiratory issues. There are no signs offering face masks to coughing patients and other symptomatic persons when they are entering the setting. There is no documentation that Dental Health Care Practitioners ("DHCP") receive training on protocols for containing respiratory infections.

1.2 INFECTION PREVENTION EDUCATION AND TRAINING

A. There was no documentation that DHCP received any job or task specific training on infection prevention policies and procedures and the OSHA Bloodborne Pathogens Standard at all, whether upon hire, annually, or when new tasks or procedures affect the employee's occupational exposure.

B. Training records are not maintained in accordance with state and federal requirements.

1.3 DENTAL HEALTH CARE PERSONNEL SAFETY

A. The Office has no exposure control plan that is tailored to the specific requirements of the facility.

B. There is no documentation stating that the DHCP for whom contact with blood or other potentially infectious material ("OPIM") is anticipated are trained on the OSHA Bloodborne Pathogens Standard at all, whether upon hire or at least annually.

C. There was no documentation of current CDC recommendations for immunizations, evaluation, and follow-up available. There is no written policy regarding immunizing DHCP, including a list of all required and recommended immunizations for DHCP.

D. There was no documentation at the Office that Hepatitis B vaccination is available to all employees who are at risk of occupational exposure to blood or OPIM.

E. There is no documentation that post-vaccination screening for protective levels of Hepatitis B surface antibody is conducted.

F. There was no documentation that all DHCP are offered annual influenza vaccination.

G. There was no documentation that all DHCP receive baseline TB screening upon hire regardless of the risk classification of the setting at the time of inspection.

H. There was no log of needle-sticks, sharps injuries, and other employee exposure events that is maintained according to state and federal requirements at the time of the inspection.

I. There was no documentation that referral arrangements are in place to qualified healthcare professionals to ensure prompt and appropriate provision of preventative services, occupationally-related medical services, and post-exposure management with medical follow-up.

J. There was no documentation that following an occupational exposure event, that there is a post-exposure evaluation and follow-up, including prophylaxis as appropriate, are available at no cost to the employee, and are supervised by a qualified healthcare professional.

K. There is no documentation that the facility has well-defined policies concerning contact of personnel with patients when personnel have potentially transmissible conditions, including: work-exclusion policies that encourage reporting of illnesses and do not penalize staff with loss of wages, benefits, or job status; and education of personnel on the importance of prompt reporting of illnesses to supervisors.

1.4 PROGRAM EVALUATION

A. There was no documentation that written policies and procedures for routine monitoring and evaluation of the infection prevention and control program are available.

B. There was no documentation of adherence with practices such as: immunizations, hand hygiene, sterilization monitoring, and proper use of Personal Protective Equipment ("PPE") with feedback provided to DHCP.

1.5 HAND HYGIENE

A. There are inconsistent supplies necessary for adherence to hand hygiene for routine dental procedures.

B. There is no documentation that DHCP are trained regarding appropriate indications for hand hygiene including: handwashing, hand-antisepsis, and surgical antisepsis.

1.6 PERSONAL PROTECTIVE EQUIPMENT

A. There is insufficient and inappropriate PPE available.

B. There is no documentation that DHCP receive training on proper selection and use of PPE.

1.7 RESPIRATORY HYGIENE/COUGH ETIQUETTE

A. There was no documentation of policies and procedures to contain respiratory secretions in people who have signs and symptoms of a respiratory infection, beginning at the point of entry to the dental setting. There were no signs posted at the entrances stating the protocol to cover their mouth and nose when coughing or sneezing, use and disposal of used tissues, and hand hygiene after respiratory secretion contact. There were tissues provided and there was a trash can in the waiting room but it had no lid. There

was no hand sanitizer in the waiting room. Face masks are not offered to coughing/symptomatic patients.

B. There is no documentation that DHCP receive training on the importance of containing respiratory secretions in people who have signs and symptoms of respiratory infection.

1.8 SHARPS SAFETY

A. There was no documentation of written policies, procedure, and guidelines for exposure prevention and post-exposure management that are available.

B. There was no evidence of policy that DHCP identify, evaluate, and select devices with engineered safety features, either annually or as they become available in the market.

1.9 SAFE INJECTION PRACTICES

A. There was no documentation of written policies, procedures, and guidelines for safe-injection practices that are available.

B. There was no documentation or policy that clearly states that injections are required to be prepared using aseptic technique in a clean area free from contamination or contact with blood, body fluids, or contaminated equipment.

1.10 STERILIZATION AND DISINFECTION OF PATIENT-CARE ITEMS AND DEVICES

A. There was no documentation of written policies and procedures that are available to ensure reusable patient care instruments and devices are cleaned and reprocessed appropriately before use on another patient.

B. There was no documentation of policies, procedures, and manufacturer reprocessing instructions for reusable instruments and dental devices that are available.

C. There was no documentation that DHCP responsible for reprocessing reusable dental instruments and devices are appropriately trained upon hire, at least annually, or whenever new equipment or processes are introduced.

D. There was no documentation that there is the training and all essential equipment available to ensure that DHCP wear appropriate PPE.

E. There was no proper documentation that routine maintenance for sterilization equipment is performed to manufacturer instructions and documented by written and complete maintenance logs.

F. There was no documentation of policies and procedures that were in place outlining the dental setting response in the event of a reprocessing error/failure. There was no information on site about spore tests.

1.11 ENVIRONMENTAL INFECTION PREVENTION and CONTROL

A. There was no documentation of written policies and procedures that are available for routine cleaning and disinfection of environmental surfaces.

B. There was no documentation that DHCP performing environmental prevention procedures receive job-specific training about infection prevention and control management of clinical contact and housekeeping surfaces upon hire, at least annually, or when procedures/policies change.

C. There was no documentation to confirm that cleaning, disinfection, and use of surface barriers are periodically monitored and evaluated to ensure that they are consistently and correctly performed.

D. There was no documentation that cleaning, disinfection, and use of surface barriers are periodically monitored and evaluated to ensure that they are consistently and correctly performed.

E. There was no documentation that procedures are in place for decontamination of spills of blood or other body fluids.

1.12 DENTAL UNITY WATER QUALITY

A. There is no documentation that policies and procedures are in place for maintaining dental unit water quality that meets EPA regulatory standards for drinking water.

B. There was no documentation that policies and procedures are in place for using sterile water as a coolant/irrigant when performing surgical procedures.

C. There is no documentation that written policies and procedures are available outlining the response to a community boil-water advisory.

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

II.1 HAND HYGIENE IS PERFORMED CORRECTLY

A. Hands were washed when visibly soiled.

B. Barehanded touching of instruments was not observed.

C. There was inconsistency of washing hands between patients. The gloves would be removed and fresh ones put on for a new patient, but compliance of the hand-washing for every patient was inconsistent.

D. There was an inconsistency with hand-washing before putting on gloves.

E. There was inconsistency with hand-washing immediately after removing gloves.

F. There were no surgical procedures being performed, so surgical hand scrubbing couldn't be observed.

II.2 PERSONAL PROTECTIVE EQUIPMENT (PPE) IS USED CORRECTLY

A. PPE was not removed before leaving the work area. All assistants, hygienists, and Dentist A never changed their PPE jacket while going from patient to the sterilization area, to the front desk, and back. Only Dentist A took off his PPE jacket (cloth) during lunch.

B. There was inconsistent observation of hand hygiene being performed immediately after removal of PPE.

C. Masks were worn for every patient encounter but in some cases, not properly. Dentist A never had the mask cover his nose. Not a single employee used eye protection with solid side shields. One employee did not wear eye protection at all.

D. The providers consistently wear gloves when there is potential contact with blood, bodily fluids, mucous membranes, non-intact skin, or contaminated equipment. Gloves were never reused. There were no puncture- and chemical-resistant utility gloves at the Office for use when cleaning instruments in the sterilization area or when housekeeping tasks involving contact with blood or OPIM occurred.

E. DHCP do not wear PPE/protective clothing properly. There are no disposable gowns at all. Quite often the staff did not remove their PPE/protective clothing when leaving the sterilization/instrument processing area, or going to lunch, or even when they go home. They are expected to clean their own PPE at home. The gloves very rarely covered the wrists of the DHCP. Even when the PPE (jackets) was visibly dirty, the DHCP never changed it.

II.3 RESPIRATORY HYGIENE/COUGH ETIQUETTE

A. Signs (Cover Your Cough) were not posted at entrances with instructions to patients with symptoms of respiratory infection and all other associated notifications.

B. There were tissues in the reception area, but there was only a trash can without a lid for dirty tissues.

C. There was a bathroom for patients to perform hand hygiene near the reception area.

D. There are no face masks in the waiting area and there is no documentation that they would be offered to any patient with a respiratory condition.

E. There is no documentation demonstrating a policy or any training to ask patients with respiratory symptoms being encouraged to move away from other patients in the reception area. However, no one with visible respiratory symptoms appeared during the inspection so this practice could not be directly observed during the inspection.

II.4 SHARPS SAFETY

A. Engineering controls are not used to prevent injuries.

B. Work practice controls are not used to prevent injuries.

C. DHCP recap used needles by using both hands or other inappropriate ways.

D. DHCP occasionally used a one-handed scoop technique, but never a safe mechanical device to recap needles.

E. All sharps are disposed of in a puncture resistant container. They were located in the operatories but in extremely poor locations. A puncture resistant container was in the sterilization area, but also in a poor location. Staff stated that the containers, when full, are eventually disposed of with the rest of the biohazard waste. There was a biohazard box, but there was nothing in there. The biohazard box in the lab was in such a difficult place to access that it would take several minutes to remove what was interfering with its access. There was no documentation that the biohazard box was picked up in

at least two months. There were no biohazard containers in the operatories -- only regular trashcans were in the operatories.

F. The inspector was informed that sharps containers are disposed of in accordance with federal, state, and local regulated medical waste rules and regulations, but it couldn't be verified in any fashion.

II.5 SAFE INJECTION PRACTICES

A. Injections are not prepared using an aseptic technique in a clean area. Many syringes were set up before the patient was seated. Additionally, those prepared syringes were left directly on a dirty countertop.

B. Needles and syringes are used for only one patient.

[C. D. E. F. G. H. I. - There were no surgical procedures performed during our inspection, so these sections could not be evaluated.]

II.6 STERILIZATION AND DISINFECTION OF PATIENT-CARE ITEMS AND DEVICES

A. Single use devices are discarded after one use.

B. Reusable critical dental items are ostensibly cleaned and heat sterilized according to the manufacturer instructions between use. However, spore test logs did not exist. Autoclave logs were non-existent. Therefore, it is impossible to verify sterilization.

C. Items are thoroughly cleaned and visually inspected before sterilization.

D. FDA cleared ultrasonic cleaners are properly used.

E. There were no long-handled brushes available and no puncture resistant gloves being used.

F. After cleaning and drying, the instruments were packed appropriately.

G. Chemical indicators are not used inside sterile packages. Sterile packs had external chemical indicators only.

H. All sterile packs were not labeled with the sterilizer used, the cycle or load number, or the date of sterilization.

I. FDA-cleared medical devices for sterilization are used according to manufacturer instructions.

J. Because there were no logs for the sterilizers, it is impossible to tell if the spore test is used at least weekly and with every load containing implantable items.

K. Logs for each sterilizer cycle are non-existent.

L. It appears that after sterilization the packets are stored so sterility is not compromised. However, since the packets are not labeled at all with the required information, there is no way to determine their integrity or when they are out of date.

M. It did not appear that any compromised packages had been used.

N. It did not appear that any defectively autoclaved packages were utilized.

O. The instrument processing area has less than an ideal workflow, and there is completely inadequate space to do a proper job. Because all the working

areas are so close together, there is a chance that the dirty to clean procedure flow can easily be broken. The initial trays with dirty instruments should be to the right of the sink. Now dirty instruments are sitting next to the autoclave, which should be a cleaner area. The counter surface material is breaking down, impossible to clean, and just plain filthy. In this area, biohazardous waste appears to be put in regular waste cans. The biohazard box was inaccessible. A model trimmer was sitting in such close proximity to this area, that it is almost certainly covered with OPIM.

P. & Q. High level disinfection products are used and contained according to manufacture instructions.

R. Dental high-speed handpieces are cleaned and heat-sterilized according to manufacturer instructions. The low-speed handpieces remain attached even though they are not permanently attached to the air and water lines, and are only wiped down.

S. FDA cleared barriers are used on the digital radiology sensors and are changed between uses. After the barrier is used the sensor was cleaned and sterilized.

II.7 ENVIRONMENTAL INFECTION PREVENTION AND CONTROL

A. Clinical contact surfaces are inconsistently barrier-protected. Radiologic exposure control buttons were not barrier-protected. Other surfaces are cleaned with appropriate disinfectants. Barriers were not used on A/W syringes, HVE, and SVE.

B. Surface barriers are inconsistently used on equipment, but those that were used were changed between patients. The computer keyboard and mouse were never protected.

C. Cleaners and disinfectants appeared to be used in accordance with manufacturer instructions.

D. There is no record of regulated medical waste being disposed of according to local, state, and federal regulations. If it occurs, there were no records/manifests of the dates of the pick-ups. The main medical waste box was poorly placed in a very difficult-to-access area in the sterilization area. This could potentially cause accidental contact with OPIM. In each operatory there were only puncture resistant sharps containers and a regular trash can. In the regular trash can quite often OPIM was found.

E. DHCP engaged in environmental cleaning failed to wear appropriate PPE to prevent exposure to infectious agents and chemicals.

In addition, the Board Inspector made the following additional observations regarding environmental infection prevention and control:

1. The portable oxygen/nitrous oxide cart was dirty and was located in a filthy area next to an open furnace.

2. Unopened sterile packets were placed on a tray occasionally where the instruments were eventually dropped onto when the packets were opened. The outside of the packets was not sterile and should not touch an area where working instruments are placed.

3. The parts that held the saliva ejectors, HVE tips, and A & W syringes never had protective barriers.

4. The eye-wash station in the office was positioned in a manner where the user would have to put his head under a cabinet to utilize it, which would make proper usage very difficult. Additionally, it was attached to the faucet of the sink where the dirty instruments are initially placed. That means the eye-wash device could get contaminated with OPIM.

5. There was no emergency medical kit available.

6. Radiograph rings and sensors were placed on (potentially infectious) trays where the outside of unopened sterile packets was lying. This made the rings potentially unsterile because the outside of the packets could have been compromised.

7. Not a single provider wore a radiation badge during the inspection.

II.8 DENTAL UNIT WATER QUALITY

A. There was no evidence that waterline testing was ever performed. No employee was aware of any maintenance logs or waterline treatment products.

B. No one could verify that daily or weekly flushing of the dental unit water lines was being performed.

C. No surgical procedures were performed during the inspection. Therefore, the Inspector could not verify that sterile saline or sterile water is used when performing surgical procedures.

10. Based on the observations made buy the Board Inspector, the Respondent as the owner of the Office failed to ensure compliance with CDC Guidelines at the Office as set forth above, which posed a direct risk to patient safety.

CONCLUSIONS OF LAW

The Board concludes as a matter of law that the Respondent's conduct as described above, including but not limited to failing to ensure compliance with the CDC Guidelines at the Office as described above, constitutes: behaving dishonorably or unprofessionally, or violating a professional code of ethics pertaining to the dentistry profession, 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

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 **REPRIMANDED**; and further it is

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 his office staff are in substantial compliance with CDC Infection Control Guidelines, the Board shall issue an **Order for Reinstatement** lifting the summary suspension issued on May 15, 2020; and it is further

ORDERED that from the date of the Board's the Order for Reinstatement, 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 who is a licensed dentist shall conduct an unannounced inspection within ten (10) business days (or as soon as practicable) after the Respondent's license is reinstated in order to evaluate the Respondent and his 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. The Respondent shall provide to the Board-assigned inspector a schedule of his 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; 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 OSHA guidelines or the Act, 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 60 (sixty) calendar days of the reinstatement of the Respondent's license;

8. Within three (3) months of the date of the reinstatement of the

Respondent's license, 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 date of the reinstatement of the Respondent's license, 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.

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;

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

6/4/2020
Date

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

CONSENT

By this Consent, I, Akash Agrawal, 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 have consulted 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.

6/3/2020
Date

Akash Agrawal
Akash Agrawal, D.D.S.
Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF: Charles

I HEREBY CERTIFY that on this 3rd day of June 2020, before me, a Notary Public of the State and County aforesaid, personally appeared[2] Akash Agrawal, D.D.S., and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Notary Public

My commission expires: October 2, 2021

[2] During the current State of Emergency, and in compliance with the Governor's emergency orders, notarization may be accomplished remotely.