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8 -	BEFORE THE				
9	BOARD OF PHARMACY DEPARTMENT OF CONSUMER AFFAIRS				
10	STATE OF CALIFORNIA				
11	In the Matter of the Accusation Against:  Case No. 4410				
12	LINDSEY NICOLE CARLSON 8889 Caminito Plaza Centro 7213				
13	San Diego, CA 92122  A C C U S A T I O N				
14	Pharmacy Technician License No. TCH 94160				
15					
16	Respondent.				
17	Complainant alleges:				
18	<u>PARTIES</u>				
19	1. Virginia Herold (Complainant) brings this Accusation solely in her official capacity				
20	as the Executive Officer of the Board of Pharmacy, Department of Consumer Affairs.				
21	2. On or about November 16, 2009, the Board of Pharmacy issued Pharmacy Technician				
22	License Number TCH 94160 to Lindsey Nicole Carlson (Respondent). The Pharmacy Technician				
23	License was in full force and effect at all times relevant to the charges brought herein. Pharmacy				
24	Technician License Number TCH 94160 expired on April 30, 2013 and has not been renewed.				
25	JURISDICTION				
26	3. This Accusation is brought before the Board of Pharmacy (Board), Department of				
27	Consumer Affairs, under the authority of the following laws. All section references are to the				
28	Business and Professions Code unless otherwise indicated.				
	1				

### 7. Section 4060 of the Code states:

No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, or a physician assistant pursuant to Section 3502.1, or naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052. This section shall not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse practitioner, or physician assistant, when in stock in containers correctly labeled with the name and address of the supplier or producer.

Nothing in this section authorizes a certified nurse-midwife, a nurse practitioner, a physician assistant, or a naturopathic doctor, to order his or her own stock of dangerous drugs and devices.

#### 8. Section 4301 of the Code states:

The board shall take action against any holder of a license who is guilty of unprofessional conduct or whose license has been procured by fraud or misrepresentation or issued by mistake. Unprofessional conduct shall include, but is not limited to, any of the following:

(f) The commission of any act involving moral turpitude, dishonesty, fraud, deceit, or corruption, whether the act is committed in the course of relations as a licensee or otherwise, and whether the act is a felony or misdemeanor or not.

(h) The administering to oneself, of any controlled substance, or the use of any dangerous drug or of alcoholic beverages to the extent or in a manner as to be dangerous or injurious to oneself, to a person holding a license under this chapter, or to any other person or to the public, or to the extent that the use impairs the ability of the person to conduct with safety to the public the practice authorized by the license.

(j) The violation of any of the statutes of this state, or any other state, or of the United States regulating controlled substances and dangerous drugs.

(o) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any provision or term of this chapter or of the applicable federal and state laws and regulations governing

### **FACTS**

- 15. Respondent was employed at UCSD Edith and William Perlman Ambulatory Care Pharmacy (hereinafter "Pharmacy") since May 4, 2010 as a pharmacy technician.
- 16. In or about June, 2011, L.S., the Acting Interim Pharmacist-In-Charge of the Pharmacy observed changes in Respondent's behavior at work. L.S. noticed that Respondent was having a hard time staying awake and that her eyes appeared heavy and glossed over and that she performed her duties as a technician more slowly. On or about June 23, 2011, L.S. discussed these changes with Respondent, who attributed them to hectic pre-wedding planning and lack of rest. L.S. gave Respondent a verbal warning about her behavior and performance at work.
- 17. On or about July 1, 2011, L.S. observed Respondent helping a patient at the drop-off window of the Pharmacy and overhead the patient ask Respondent if she was okay. When L.S. looked at Respondent, Respondent appeared to be slipping in and out of consciousness; her eyes were shut; her speech slurred; and her body swayed. L.S. removed Respondent from her duties at the window and sent her home.
- 18. Respondent's behavior at work did not improve. L.S. noticed that Respondent was constantly taking breaks and was having a hard time staying focused. L.S. found that Respondent was frequently in the break room and was often missing from her assigned position. Respondent slept during her lunch break, which often exceeded one hour. She was often late to work and, on September 2, 2011, Respondent failed to appear for work without having first advised her manager. L.S. observed Respondent's speech to often be slurred and delayed, her eyes droopy, her body swaying and her handwriting sloppy.
- 19. On or about October 22, 2011, J.B., the Supervising Pharmacist at the Pharmacy, had a meeting with Respondent because he too had observed her looking tired and fatigued on more than one occasion. Respondent explained that she was an insomniac and that she fell asleep on her lunch break and was having a tough time waking up from that nap.
- 20. On October 28, 2011, Respondent was assigned to the mail department where her responsibilities included processing and filling prescriptions that had been mailed or faxed to the Pharmacy. Respondent was not able to complete her assignment despite having once been a

 stellar pharmacy technician. Two other technicians were pulled from their regular duties to assist Respondent.

- 21. Two pharmacy technicians reported that a 5 mg bag of zolpidem (Ambien) had been missing since October 28, 2011 but later mysteriously re-appeared on November 3, 2011 in the back of the controlled substance drawer. One of the technicians observed Respondent lingering by the controlled substance drawer on October 28, 2011 even though there was no need for Respondent to remove any drugs from the controlled substance drawer because the other technician had pulled all of the controlled substances that were needed to fill prescriptions.
- 22. On October 28, 2011, J.B. observed that Respondent had slurred speech, appeared disoriented and stumbled around. J.B. reported this behavior to his supervisor. Respondent was sent to UCSD Center for Occupational Medicine and Environmental Health ("COEM") to be evaluated for fitness for duty and for performance of a drug screen. Respondent submitted to a drug screen on October 28, 2011.
- 23. November 2, 2011, Respondent was working as the pharmacy clerk or cashier. A radiology technician came to the Pharmacy window to pick up a prescription and later advised L.S. that Respondent was "obviously wasted."
- 24. On November 7, 2011, the Pharmacy was notified Respondent's drug screen was positive and Respondent was placed on investigatory leave. She was later terminated for abusing drugs and for reporting to work impaired.
- 25. Respondent's drug screen was positive for the following benzodiazepines: nordiazepam, oxazepam and temazepam, which are all metobolites of diazepam. Nordiazepam, oxazepam and temazepam may also be taken as individual drugs. However, according to the California State Board of Pharmacy Controlled Substance Utilization Review and Evaluation System (hereinafter "CURES") Report, the only benzodiazepine dispensed to Respondent by prescription between 2009 and 2011 was clonazepam.
- 26. According to Respondent's CURES Report, the last time Respondent filled a prescription for clonazepam was on September 28, 2010 for a 30-day supply of clonozapam, which was about one year before the drug screen on October 28, 2011.

- 27. The metabolites of clonazepam were not found in the drug screen. The presence of all three metabolites of benzodiazepine in Respondent's drug screen indicates diazepam use. Diazepam was not listed in Respondent's CURES Report.
- 28. On March 13, 2012, the Board investigator received a letter sent to Respondent at her address of record that was returned with the notation: "FORWARD TIME EXPRENTION SEND."

### FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Use Of Controlled Substance In Manner Dangerous to Self or Impairs Ability to Practice as Pharmacy Technician Safely)

29. Respondent is subject to disciplinary action under Code section 4301, subdivision (h) for unprofessional conduct by administering to herself, a controlled substance, to the extent or in a manner that is dangerous or injurious to herself or to the extent that the use impairs Respondent's ability to practice as a pharmacy technician safely in that during the period June through October, 2011, Respondent was observed to be under the influence of a controlled substance, later identified as benzodiazepine, while working as a pharmacy technician, as more fully set forth in paragraphs 15-27 above and incorporated by this reference as though set forth in full herein.

## SECOND CAUSE FOR DISCIPLINE

## (Unprofessional Conduct - Violation of Laws Regulating Controlled Substances)

30. Respondent is subject to disciplinary action under Code section 4301, subdivision (j), in conjunction with Code section 4060 and Health and Safety Code section 11170, for unprofessional conduct by violating statutes regulating controlled substances in this state or of the United States in that Respondent administered a controlled substance to herself, to wit, benzodiazepine, without a prescription, as more fully set forth in paragraphs 15-27 above and incorporated by this reference as though set forth in full herein.

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### THIRD CAUSE FOR DISCIPLINE

# (Unprofessional Conduct - Commission of Any Act Involving Moral Turpitude, Dishonesty, Fraud or Deceit)

31. Respondent is subject to disciplinary action under Code section 4301, subdivision (f), for unprofessional conduct by committing acts involving moral turpitude, dishonesty, fraud or deceit in that Respondent administered to herself, a controlled substance, without a prescription; appeared for work as a pharmacy technician while under the influence and while her ability to practice as a pharmacy technician was impaired; and, lied about the cause of her behavior when confronted, as more fully set forth in paragraphs 15-27 above and incorporated by this reference as though set forth in full herein.

## FOURTH CAUSE FOR DISCIPLINE

## (Unprofessional Conduct – Dispensing Drugs While Under the Influence of Controlled Substance)

32. Respondent is subject to disciplinary action under Code section 4301, subdivision (o), in conjunction with Code section 4327, for unprofessional conduct by violating or attempting to violate any provision of the applicable federal and state laws and regulations governing pharmacy, by selling and/or dispensing drugs while under the influence of a controlled substance, as more fully set forth in paragraphs 15-27 above and incorporated by this reference as though set forth in full herein.

### FIFTH CAUSE FOR DISCIPLINE

## (Failure to Advise Board of Change in Address of Record)

33. Respondent is subject to disciplinary action under Code section 4301, subdivision (o) in conjunction with title 16, California Code of Regulations, section 1704, for unprofessional conduct by violating or attempting to violate any provision of the applicable federal and state laws and regulations governing pharmacy, including regulations established by the Board, in that Respondent failed to advise the Board of a change in her address of record, as more fully set forth in paragraph 28 above and incorporated by this reference as though set forth in full herein.

### **PRAYER**

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Pharmacy issue a decision:

- 1. Revoking or suspending Pharmacy Technician License Number TCH 94160, issued to Lindsey Nicole Carlson;
- 2. Ordering Lindsey Nicole Carlson to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,
  - 3. Taking such other and further action as deemed necessary and proper.

DATED:	7	22	13

VIRGINIA HEROLD

Board of Pharmacy

Department of Consumer Affairs

State of California Complainant

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