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BEFORE THE
BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **HANFORD COMMUNITY HOSPITAL** **dba ADVENTIST MEDICAL CENTER** **115 Mall Drive** **Hanford, CA 93230** **Original Permit Number No. HSP 30446** **and** **DEBORAH ANN CAMACHO** **371 McCreary** **Hanford, CA 93230** **Original Pharmacist License No. RPH 41441** Respondents.	Case No. 5419 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Virginia Herold (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Pharmacy, Department of Consumer Affairs.

2. On or about November 1, 1984, the Board of Pharmacy issued Original Permit Number HSP 30446 to Hanford Community Hospital dba Adventist Medical Center (Respondent Hanford). Deborah Ann Camacho is and has been the Pharmacist-In-Charge at Respondent

Hanford since December 5, 1996. The Original Permit was in full force and effect at all times relevant to the charges brought herein and will expire on November 1, 2015, unless renewed.

3. On or about November 2, 1987, the Board of Pharmacy issued Original Pharmacist License Number RPH 41441 to Deborah Ann Camacho (Respondent Camacho). The Original Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2017, unless renewed.

JURISDICTION

4. This Accusation is brought before the Board of Pharmacy (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Code section 4300.1 states:

> The expiration, cancellation, forfeiture, or suspension of a board-issued license by operation of law or by order or decision of the board or a court of law, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee shall not deprive the board of jurisdiction to commence or proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license.

BUSINESS AND PROFESSIONS CODE

6. Code section 4029 states:

> (a) "Hospital pharmacy" means and includes a pharmacy, licensed by the board, located within any licensed hospital, institution, or establishment that maintains and operates organized facilities for the diagnosis, care, and treatment of human illnesses to which persons may be admitted for overnight stay and that meets all of the requirements of this chapter and the rules and regulations of the board.
>
> (b) A hospital pharmacy also includes a pharmacy that may be located outside of the hospital in another physical plant that is regulated under a hospital's consolidated license issued pursuant to Section 1250.8 of the Health and Safety Code. As a condition of licensure by the board, the pharmacy in another physical plant shall provide pharmaceutical services only to registered hospital patients who are on the premises of the same physical plant in which the pharmacy is located, except as provided in Article 7.6 (commencing with Section 4128). The pharmacy services provided shall be directly related to the services or treatment plan administered in the physical plant. Nothing in this subdivision shall be construed to restrict or expand the services that a hospital pharmacy may provide.

7. Code section 4059(a) states, "A person may not furnish any dangerous drug, except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7. A person may not furnish any dangerous device, except upon

the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7."

8. Code section 4059.5 states, in pertinent part:

> (a) Except as otherwise provided in this chapter, dangerous drugs or dangerous devices may only be ordered by an entity licensed by the board and shall be delivered to the licensed premises and signed for and received by a pharmacist. Where a licensee is permitted to operate through a designated representative, the designated representative shall sign for and receive the delivery.
>
> (b) A dangerous drug or dangerous device transferred, sold, or delivered to a person within this state shall be transferred, sold, or delivered only to an entity licensed by the board, to a manufacturer, or to an ultimate user or the ultimate user's agent. . . .

9. Code section 4060 states, in pertinent part:

> A person shall not 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, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to Section 4052.1, 4052.2, or 4052.6. This section does not apply to the possession of any controlled substance by a manufacturer, wholesaler, third-party logistics provider, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse practitioner, or physician assistant, if in stock in containers correctly labeled with the name and address of the supplier or producer. . . .

10. Code section 4068(a) states:

> (a) Notwithstanding any provision of this chapter, a prescriber may dispense a dangerous drug, including a controlled substance, to an emergency room patient if all of the following apply:
>
> (1) The hospital pharmacy is closed and there is no pharmacist available in the hospital.
>
> (2) The dangerous drug is acquired by the hospital pharmacy.
>
> (3) The dispensing information is recorded and provided to the pharmacy when the pharmacy reopens.
>
> (4) The hospital pharmacy retains the dispensing information and, if the drug is a schedule II, schedule III, or schedule IV controlled substance, reports the dispensing information to the Department of Justice pursuant to Section 11165 of the Health and Safety Code.
>
> (5) The prescriber determines that it is in the best interest of the patient that a particular drug regimen be immediately commenced or continued, and the prescriber reasonably believes that a pharmacy located outside the hospital is not available and accessible at the time of dispensing to the patient.

(6) The quantity of drugs dispensed to any patient pursuant to this section are limited to that amount necessary to maintain uninterrupted therapy during the period when pharmacy services outside the hospital are not readily available or accessible, but shall not exceed a 72-hour supply.

(7) The prescriber shall ensure that the label on the drug contains all the information required by Section 4076.

11. Code section 4081 states:

(a) All records of manufacture and of sale, acquisition, receipt, shipment, or disposition of dangerous drugs or dangerous devices shall be at all times during business hours open to inspection by authorized officers of the law, and shall be preserved for at least three years from the date of making. A current inventory shall be kept by every manufacturer, wholesaler, third-party logistics provider, pharmacy, veterinary food-animal drug retailer, physician, dentist, podiatrist, veterinarian, laboratory, clinic, hospital, institution, or establishment holding a currently valid and unrevoked certificate, license, permit, registration, or exemption under Division 2 (commencing with Section 1200) of the Health and Safety Code or under Part 4 (commencing with Section 16000) of Division 9 of the Welfare and Institutions Code who maintains a stock of dangerous drugs or dangerous devices.

(b) The owner, officer, and partner of a pharmacy, wholesaler, third-party logistics provider, or veterinary food-animal drug retailer shall be jointly responsible, with the pharmacist-in-charge, responsible manager, or designated representative-in-charge, for maintaining the records and inventory described in this section.

(c) The pharmacist-in-charge, responsible manager, or designated representative-in-charge shall not be criminally responsible for acts of the owner, officer, partner, or employee that violate this section and of which the pharmacist-in-charge, responsible manager, or designated representative-in-charge had no knowledge, or in which he or she did not knowingly participate.

12. Code section 4104(c) states:

Every pharmacy shall report and provide to the board, within 14 days of the receipt or development thereof, the following information with regard to any licensed individual employed by or with the pharmacy:

(1) Any admission by a licensed individual of chemical, mental, or physical impairment affecting his or her ability to practice.

(2) Any admission by a licensed individual of theft, diversion, or self-use of dangerous drugs.

(3) Any video or documentary evidence demonstrating chemical, mental, or physical impairment of a licensed individual to the extent it affects his or her ability to practice.

(4) Any video or documentary evidence demonstrating theft, diversion, or self-use of dangerous drugs by a licensed individual.

(5) Any termination based on chemical, mental, or physical impairment of a licensed individual to the extent it affects his or her ability to practice.

(6) Any termination of a licensed individual based on theft, diversion, or self-use of dangerous drugs.

13. Code section 4113 states, in pertinent part:

(a) Every pharmacy shall designate a pharmacist-in-charge and, within 30 days thereof, shall notify the board in writing of the identity and license number of that pharmacist and the date he or she was designated.

. . .

(c) The pharmacist-in-charge shall be responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy. . . .

14. Code section 4300 states, in pertinent part:

(a) Every license issued may be suspended or revoked.

(b) The board shall discipline the holder of any license issued by the board, whose default has been entered or whose case has been heard by the board and found guilty, by any of the following methods:

(1) Suspending judgment.

(2) Placing him or her upon probation.

(3) Suspending his or her right to practice for a period not exceeding one year.

(4) Revoking his or her license.

(5) Taking any other action in relation to disciplining him or her as the board in its discretion may deem proper . . . .

15. Code section 4301 states, in pertinent part:

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:

. . .

(c) Gross negligence

. . .

(q) Engaging in any conduct that subverts or attempts to subvert an investigation of the board. . . .

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16. Code section 4332 states, "Any person who fails, neglects, or refuses to maintain the records required by Section 4081 or who, when called upon by an authorized officer or a member of the board, fails, neglects, or refuses to produce or provide the records within a reasonable time, or who willfully produces or furnishes records that are false, is guilty of a misdemeanor."

HEALTH AND SAFETY CODE

17. Health and Safety Code section 11165(d) states:

> For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy, clinic, or other dispenser shall report the following information to the Department of Justice as soon as reasonably possible, but not more than seven days after the date a controlled substance is dispensed, in a format specified by the Department of Justice:
>
> (1) Full name, address, and, if available, telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.
>
> (2) The prescriber's category of licensure, license number, national provider identifier (NPI) number, if applicable, the federal controlled substance registration number, and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.
>
> (3) Pharmacy prescription number, license number, NPI number, and federal controlled substance registration number.
>
> (4) National Drug Code (NDC) number of the controlled substance dispensed.
>
> (5) Quantity of the controlled substance dispensed.
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> (6) International Statistical Classification of Diseases, 9th revision (ICD-9) or 10th revision (ICD-10) Code, if available.
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> (7) Number of refills ordered.
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> (8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.
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> (9) Date of origin of the prescription.
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> (10) Date of dispensing of the prescription.

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18. Health and Safety Code section 11207 states:

(a) No person other than a pharmacist as defined in Section 4036 of the Business and Professions Code or an intern pharmacist, as defined in Section 4030 of the Business and Professions Code, who is under the personal supervision of a pharmacist, shall compound, prepare, fill or dispense a prescription for a controlled substance.

(b) Notwithstanding subdivision (a), a pharmacy technician may perform those tasks permitted by Section 4115 of the Business and Professions Code when assisting a pharmacist dispensing a prescription for a controlled substance.

CALIFORNIA CODE OF REGULATIONS

19. California Code of Regulations, title 16, section 1714 states, in pertinent part:

. . .

(b) Each pharmacy licensed by the board shall maintain its facilities, space, fixtures, and equipment so that drugs are safely and properly prepared, maintained, secured and distributed. The pharmacy shall be of sufficient size and unobstructed area to accommodate the safe practice of pharmacy.

. . .

(d) Each pharmacist while on duty shall be responsible for the security of the prescription department, including provisions for effective control against theft or diversion of dangerous drugs and devices, and records for such drugs and devices. Possession of a key to the pharmacy where dangerous drugs and controlled substances are stored shall be restricted to a pharmacist. . . .

20. California Code of Regulations, title 16, section 1715.6 states, "The owner shall report to the Board within thirty (30) days of discovery of any loss of the controlled substances, including their amounts and strengths."

21. California Code of Regulations, title 16, section 1793.7(b) states, "Pharmacy technicians must work under the direct supervision of a pharmacist and in such a relationship that the supervising pharmacist is fully aware of all activities involved in the preparation and dispensing of medications, including the maintenance of appropriate records.

COST RECOVERY

22. Code section 125.3 provides, in pertinent part, that a Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES

23. "Codeine Phosphate/APAP," Codeine with acetaminophen, is a dangerous drug as defined in Code section 4022, and a schedule III controlled substance as defined in Health and Safety Code section 11056(e).

24. "Cocaine" is a dangerous drug as defined in section 4022 of the Code and a schedule II controlled substance and narcotic as defined by section 11055(b)(6) of the Health and Safety Code.

25. "Fentanyl Citrate," also known by the brand name Sublimaze, is a strong analgesic, pharmacodynamically similar to meperidine and morphine. Fentanyl and fentanyl citrate preparations are Schedule II controlled substances as designated by Health and Safety Code section 11055(c)(8), and a dangerous drug within the meaning of Code section 4022.

26. "Hydrocodone w/APAP" (hydrocodone with acetaminophen tablets) is a semisynthetic narcotic analgesic, a dangerous drug as defined in Code section 4022, a Schedule III controlled substance and narcotic as defined by section 11056(e) of the Health and Safety Code, and a Schedule III controlled substance as defined by section 1308.13(e) of Title 21 of the Code of Federal Regulations.

27. "Hydromorphone Hydrochloride," also known by the brand name Dilaudid, is a semi-synthetic opioid derivative and is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(J), and a dangerous drug within the meaning of Code section 4022. Hydromorphone hydrochloride is a strong analgesic used in the relief of moderate to severe pain.

28. "Ketamine" is a medication used mainly for starting and maintaining anesthesia. Other uses include sedation in intensive care, as a pain killer, as treatment of bronchospasm, as a treatment for complex regional pain syndrome, and as an antidepressant. It is a Schedule III controlled substance as defined by Health and Safety Code, section 11056(g).

29. "Meperidine Hydrochloride" is a strong synthetic opioid analgesic used in the relief of moderate to severe pain, as a pre-operative supplement to anesthesia, and to provide pain relief during labor. Also known by the brand name Demerol, meperidine hydrochloride preparations

are subject to control as Schedule II controlled substances as designated by Health and Safety Code section 11055(c)(17), and dangerous drugs within the meaning of Code section 4022.

30. "Midazolam" is a benzodiazepine, used for preoperative sedation, particularly useful when anxiety relief and diminished recall are desired. Midazalom is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(21), and a dangerous drug within the meaning of Code section 4022.

31. "Morphine Sulfate," aka as brand names Astramorph, Duramorph, MSIR, RMS Uniserts, and Roxanol, is for use in patients who require a potent opioid analgesic for relief of moderate to severe pain, and is a dangerous drug as defined in section 4022 of the Code and a Schedule II controlled substance as defined in section 11055(b)(1)(L) of the Health and Safety Code.

32. "Oxycodone" with acetaminophen and oxycodone with aspirin both contain oxycodone, a white odorless crystalline powder derived from the opium alkaloid, thebaine. Oxycodone is a semisynthetic narcotic analgesic with multiple actions qualitatively similar to those of morphine. It is a dangerous drug as defined in Code section 4022, a schedule II controlled substance and narcotic as defined by section 11055(b)(1)(M) of the Health and Safety Code, and a Schedule II controlled substance as defined by section 1308.12(b)(1) of Title 21 of the Code of Federal Regulations.

33. "Carisoprodol" is a muscle-relaxant and sedative. It is a dangerous drug as defined in Code section 4022.

34. "Methadone Hydrochloride," aka as brand names Dolophine, Methadose, and Physeptone, is a synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine, it is a dangerous drug as defined in section 4211 of the Code, and a schedule II controlled substance as defined in section 11055(c)(14) of the Health and Safety Code.

35. "Percocet" is the trade name for the combined generic substance Oxycodone Hydrochloride and Acetaminophen is a semisynthetic narcotic analgesic with multiple actions qualitatively similar to those of morphine, and is a controlled substance as defined in Schedule II,

section 11055(b)(1)(L) of the Health and Safety Code. Percocet is a dangerous drug as defined in Code section 4022.

BACKGROUND

36. Adventist Health Central Valley Network (Adventist) owns and operates four hospitals: Adventist Medical Center-Hanford (Respondent Hanford), Adventist Medical Center-Selma, Adventist Medical Center-Reedley; and Central Valley General Hospital. Each hospital has a pharmacy. All of Adventist's pharmacists work at each hospital. Respondent Camacho is and was the Director of Pharmacy for all four hospitals. As the Director of Pharmacy for Adventist, Camacho was responsible for the scheduling of pharmacy staff at all four of Adventist's hospitals.

37. After the Board received an arrest notification on Adventist's employee, E.C., a licensed pharmacist (indicating that E.C. was arrested at an airport with a large amount of controlled substances in her possession), Board Inspector D.P. conducted an investigative inspection at Respondent Hanford's pharmacy on or about March 4, 2014.

38. When Inspector D.P. arrived at Respondent Hanford's pharmacy, at approximately 10:30 a.m., D.P. was greeted by a pharmacy technician who informed D.P. that there was no pharmacist in the pharmacy. D.P. observed approximately five people in the pharmacy, some of whom were pulling medication from the shelf.

39. Approximately ten to fifteen minutes after Inspector D.P.'s arrival at Respondent Hanford's pharmacy, D.P. was greeted by pharmacist A.A-K. A.A-K. relayed the following information:

a. A pharmacist is not scheduled to be present in the pharmacy for a number of hours in the morning.

b. Prescription orders were checked by "remote" pharmacists who check the data entry information on prescriptions.

c. Most of the prescription medication was issued from Omnicell automated dispensing machines on the floor. The Omnicell machine provided documentation of medication removed. In general, the medication could not be removed unless a prescription order was in the system.

There are some instances where an override of that procedure could occur, such as when there is an immediate need for medication.

d. The technicians fill prescriptions for orders of medication not stocked in the Omnicell machine, and dispense medication to restock the Omnicell machines.

e. When a medication order is ready to be checked, a pharmacist was called from their workstation on the hospital floor, to return to the pharmacy and check the prescription dispensed.

f. The controlled substances were kept in the Omnicell narcotic locker which only the pharmacy technicians could access. Pharmacists did not verify the counts of the controlled substances in the narcotic locker. This process was established by Respondent Camacho.

g. The filling process for controlled substances consisted of a pharmacy technician accessing the controlled substance narcotic locker, and the medication order and pulled controlled substance were laid on the counter for the pharmacist to check. Pharmacists did not verify narcotic counts with the technicians.

h. When controlled substances were received from the supplier, a pharmacist would sign for the order, open the box and count the controlled substances, compare their count against the wholesaler's invoice to verify inventory ordered and received, the controlled substances were then laid on top of the invoice on a counter near the narcotic locker, and at some point during the day the pharmacy technicians would put the controlled substances into the narcotic locker (this process was not supervised by a pharmacist).

i. When Omnicell discrepancies occurred from other hospital locations, the head technician ran the reports and followed up on the discrepancies.

40. Head technician M.M. provided Inspector D.P. with the last DEA biennial inventory, dated December 21, 2013. Schedule II medication was not separate from Schedule III-V inventory. The inventory listed two columns, "Omni count" (representing the quantity of medication that the Omnicell listed as should be present) and "Current on hand" (representing the physical quantity of medication present). Of the 120 medications listed, only sixty-six had matching counts. Head technician M.M. informed D.P. that any discrepancies on this inventory were reported to Respondent Camacho.

41. On or about March 7, 2014, Inspector D.P. met with Respondent Camacho. Respondent Camacho relayed the following:

a. Pharmacists had access to the narcotic safe, however the pharmacists did not know how to use the Omnicell software to access it.

b. Respondent Camacho did not know about the discrepancies on the last DEA inventory, dated December 21, 2013.

42. After Respondent Camacho had technician M.M. open the narcotic safe, M.M. counted three medications in Inspector D.P. and Camacho's presence—morphine 30mg tablets; oxycodone 20 mg tablets; and carisoprodol 350 mg tablets. Following the count, it was discovered that the Omincell inventory for the morphine was 141, while actual inventory was 121, and that the Omnicell inventory for the carisoprodol was 57, while actual inventory was 38. Camacho said that if the inventory of the Omnicell was found to be inaccurate, a technician would verify the count, and that a pharmacist would verify with the technician; however, Camacho did not know if the initials of the verifying pharmacist were recorded.

43. During Inspector D.P.'s meeting with Respondent Camacho on March 7, 2014, D.P. requested that Camacho immediately provide audits on the following controlled substances that were found in E.C.'s possession at the time of her arrest: meperidine, morphine (all oral strengths), oxycodone (all oral strengths), methadone (all oral strengths), amphetamine (all brands and oral strengths which contain this ingredient), hydromorphone (all), and carisoprodol. D.P. requested that Camacho complete the audits at all four of Adventist's pharmacy campuses. D.P. requested that the audits be provided to her by March 11, 2014. Camacho failed to provide D.P. with the requested documents by March 11, 2014.

44. On or about March 13, 2014, Inspector D.P. met with Respondent Camacho. During the meeting, D.P. instructed Camacho to immediately conduct an audit of all blank prescription pads for all four of Adventist's hospitals. D.P. requested from Camacho a statement on the blank prescription pad accountability and loss. On or about March 18, 2014, D.P. requested that Camacho's statement on the blank prescription pad accountability and loss for all four of

Adventist's hospitals be provided by March 21, 2014. D.P. did not receive all requested documents by March 21, 2014.

45. On or about March 19, 2014, Inspector D.P. met with Respondent Camacho. D.P. requested statements from Camacho regarding the discrepancy timeline (when Camacho discovered the discrepancies in controlled substance inventory that were attributable to E.C.), security surveillance video observations of E.C.'s theft of controlled substances from Respondent Hanford, and the prescription pad accountability procedure at Respondent Hanford's pharmacy. D.P. also requested an audit showing a comparison of delivery receipt vs. perpetual inventory entry at Adventist's Hanford (Respondent Hanford) and Selma pharmacies. D.P. requested that all documents be provided to her by March 26, 2014. Camacho failed to provide the requested documents by March 26, 2014.

46. During Inspector D.P.'s investigation, she discovered that Respondent Hanford's pharmacy, located more than one mile from Kerr Outpatient Surgical Center (Kerr), had delivered controlled substance medications to a nursing station at Kerr. Delivery records were labeled "KOC Surgery," "KOC Recovery," "KOC GI Lab," or "KOC PACU." No DEA Form 222 was completed for the supplied Schedule II controlled substance medications. Respondent Hanford's pharmacy provided Kerr controlled substance medications and other bulk medications for an extensive time period, at least well before December 2010. The location to which these medications were furnished did not have a license to obtain, receive, or maintain the medication. The medications provided were not by patient-specific prescriptions. On and between December 1, 2013 and May 30, 2014, the following quantities of controlled substance medications were delivered to Kerr:

Medication	**Total**
Acetaminophen with Cod. Elixir 120-12mg/5ml 5 ml size	5
Cocaine 4% solution 4 ml	39
Fentanyl 50 mcg/1ml 2 ml	450
Hydrocodone/APAP 5-325mg tabs	80
Hydrocodone/APAP 5-500mg tabs	10

Hydrocodone/APAP 10-325 mg tab	10
Hydrocodone/APAP 7.5-500mg Elixir 5 ml	20
Hydromorphone 2mg/1ml 1 ml carp	245
Ketamine 500mg/ml 10 ml vial	14
Meperidine 25mg/1ml 1ml syringe	229
Midazolam 5mg/ml 2ml inj	537
Morphine Sulfate 10mg/1ml 1ml syringe	10
Oxycodone-Acetaminophen 5-325mg tabs	50

47. On or about March 19, 2014, Inspector D.P. conducted an investigative inspection of Adventist's Central Valley General Hospital pharmacy. During this inspection, Respondent Camacho informed D.P. that she was not the pharmacist-in-charge of this location, however she used this location as her main office. Camacho stated that as the Pharmacy Director of all of Adventist's pharmacies, she could monitor the pharmacies via the computer webcams she had set up.

48. On or about April 29, 2014, Inspector D.P. received a copy of an e-mail that Respondent Camacho had sent to Adventist's pharmacy technician staff in June 2013. The e-mail stated that Camacho would take any employee found to be gossiping about co-workers to Adventist's human resources department "to discuss your future in our organization."

49. On or about June 11, 2014, Inspector D.P. interviewed B.E., the pharmacist-in-charge of Adventist's Central Valley General Hospital and staff pharmacist at Adventist's Medical Center Selma. B.E. stated that on or about February 21, 2014, he noticed there were odd quantities for some controlled substances signed out in the perpetual inventory logs at Adventist Medical Center Selma. B.E. said he ran a report of what was logged out to Omnicell compared to what was actually entered into Omnicell inventory, and discovered quite a number of discrepancies. B.E. composed a summarized list and e-mailed the audit to Respondent Camacho. B.E. also told Camacho about the suspicious entries in the perpetual inventory logs. Camacho told B.E. she had a suspicion on who could be involved.

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50. Respondent Camacho did not mention the February 21, 2014 audit, completed by B.E., during any of her earlier conversations with Inspector D.P.

51. On or about June 11 and 12, 2014, Inspector D.P. interviewed four pharmacists who worked at Respondent Hanford, including A.A-K. and J.T. A.A-K. told D.P. that a pharmacist was not scheduled inside the pharmacy from 7:30 a.m. to 11 a.m. daily. J.T. told D.P. that there was no pharmacist scheduled in the pharmacy from 6 a.m. to 9 a.m. daily.

52. On or about June 11 and 12, 2014, Inspector D.P. interviewed four pharmacy technicians that worked at Respondent Hanford, including B.J., T.T., and L.A. B.J., T.T., and L.A. all informed D.P. that they interpreted Respondent Camacho's June 2013 e-mail as pertaining to pharmacist E.C., and that their jobs would be in jeopardy if they said anything about E.C.

53. On or about June 12, 2014, Inspector D.P. interviewed Respondent Camacho, who stated that she did not encourage open communication among the pharmacy staff at Adventist if an employee had concerns for patient safety due to employee impairment.

54. At the conclusion of Inspector D.P.'s June 12, 2014 interview with Respondent Camacho, D.P. requested various documents from Camacho, including the audit of controlled substances that was prepared by B.E. D.P. informed Camacho that a response to her request was due by June 18, 2014. D.P. did not receive the requested documents by June 18, 2014.

55. During the course of Inspector D.P.'s investigation, D.P. requested the following documents from Respondent Camacho: (1) completed DEA 106 for Respondent Hanford's pharmacy within fourteen days to the Board; (2) complete and accurate records of the disposition of controlled substances to Kerr; and (3) accurate records of dispensing and controlled substance inventory. Camacho failed to provide any of these documents by the deadlines D.P. specified.

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RESPONDENT HANFORD

FIRST CAUSE FOR DISCIPLINE

(Furnishing Dangerous Drugs and Controlled Substances Without Prescription, In Bulk, to Unlicensed Facilities)

56. Respondent Hanford is subject to disciplinary action under sections 4029(b), 4059(a), 4059.5(b), and 4060 in that Hanford provided controlled substances, in bulk, without patient prescriptions, to Kerr, which is not licensed by the Board. The circumstances are described with more particularity in paragraph 46.

SECOND CAUSE FOR DISCIPLINE

(Failure to Directly Supervise Pharmacy Technicians)

57. Respondent Hanford is subject to disciplinary action under California Code of Regulations, title 16, section 1793.7(b), and Health and Safety Code section 11207(a), in that no pharmacist was scheduled to work in the pharmacy for at least three consecutive hours daily, during which time pharmacy technicians pulled medication from the shelf, prepared and labeled medication, and access the controlled substance locker (which only pharmacy technicians had access to). The circumstances are described with more particularity in paragraphs 37-39, and 41.

THIRD CAUSE FOR DISCIPLINE

(Lack of Security of Prescription Department)

58. Respondent Hanford is subject to disciplinary action under California Code of Regulations, title 16, section 1714(b), in that Hanford's facilities, space, fixtures, and equipment were not maintained so that drugs were safely and properly maintained, secured, and distributed. The circumstances are as follows:

59. On or about March 14, 2014, an audit of acquisition and disposition records for the time period of June 28, 2011 through March 7, 2014, conducted at Respondent Hanford's pharmacy revealed a loss of the following controlled substances:

a. 10 tabs of Morphine Sulfate 30mg tablet

b. 20ml of Hydromorphone 4mg/ml syringe

c. 277 ml of Hydromorphone 2mg/ml syringe

d. 104ml of Morphine 4mg/ml Carpuject

e. 352ml of Morphine 1mg/ml Vial P-F

f. 100ml of Hydromorphone 2mg/ml Vial

g. 100 of Oxycodone-APAP 7.5-325mg tab

60. The controlled substance loss was found to be theft by licensed pharmacist E.C.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Report Controlled Substance Theft by a Licensed Pharmacy Employee)

61. Respondent Hanford is subject to disciplinary action under section 4104(c) of the Code, and California Code of Regulations, title 16, section 1715.6, in that Hanford failed to provide to the Board, within fourteen days of receipt or development thereof, documentary evidence demonstrating theft, diversion, or self-use of dangerous drugs; and failed to report to the Board, within thirty days of discovery, a loss of controlled substances, including their amounts and strengths. The circumstances are described with more particularity in paragraphs 59-60 and as follows:

62. After discovery of the controlled substance loss described in paragraphs 59-60, Respondent Camacho, as the pharmacist-in-charge for Respondent Hanford, submitted a DEA 106. The form was dated March 14, 2014 (indicating the date the theft was discovered), however it was not submitted to the Board until June 18, 2014.

RESPONDENT CAMACHO

FIFTH CAUSE FOR DISCIPLINE

(Furnishing Dangerous Drugs and Controlled Substances Without Prescription, In Bulk, to Unlicensed Facilities)

63. Respondent Camacho is subject to disciplinary action under sections 4029(b), 4059(a), 4059.5(b), 4060, and 4113(c) of the Code, in that Camacho, as the pharmacist-in-charge of Respondent Hanford, provided or authorized the provision of controlled substances, in bulk, without a patient prescription, to Kerr, which is not licensed with the Board. The circumstances are described with more particularity in paragraph 46.

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SIXTH CAUSE FOR DISCIPLINE

(Lack of Security of Prescription Department)

64. Respondent Camacho is subject to disciplinary action under California Code of Regulations, title 16, section 1714(d), and section 4113(c) of the Code, in that Camacho, as the pharmacist-in-charge for Respondent Hanford, failed to ensure that Hanford's facilities, space, fixtures, and equipment were maintained so that drugs were safely and properly maintained, secured, and distributed. The circumstances are as follows described with more particularity in paragraphs 58-60.

SEVENTH CAUSE FOR DISCIPLINE

(Failure to Report Controlled Substance Theft by a Licensed Pharmacy Employee)

65. Respondent Camacho is subject to disciplinary action under sections 4104(c) and 4113(c) of the Code in that Camacho, as the pharmacist-in-charge of Respondent Hanford, failed to provide to the Board, within fourteen days of receipt or development thereof, documentary evidence demonstrating theft, diversion, or self-use of dangerous drugs; and failed to report to the Board, within thirty days of discovery, a loss of controlled substances, including their amounts and strengths. The circumstances are described with more particularity in paragraphs 59-62.

EIGHTH CAUSE FOR DISCIPLINE

(Failure to Directly Supervise Pharmacy Technicians)

66. Respondent Camacho is subject to disciplinary action under California Code of Regulations, title 16, section 1793.7(b), Health and Safety Code section 11207(a), and section 4113(c) of the Code, in that as the pharmacist-in-charge at Respondent Hanford, Camacho failed to schedule a pharmacist to work in Hanford's pharmacy for at least three consecutive hours daily, during which time pharmacy technicians pulled medication from the shelf, prepared and labeled medication, and accessed the controlled substance locker (which only pharmacy technicians had access to) without pharmacist supervision on site. The circumstances are described with more particularity in paragraphs 37-39, and 41.

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NINTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct—Gross Negligence)

67. Respondent Camacho is subject to disciplinary action under section 4301(c) of the Code in that as the pharmacist-in-charge of Respondent Hanford, Camacho failed to: (1) investigate discrepancies in a December 21, 2013 DEA Biennial inventory, which allowed an environment conducive to theft of controlled substances to exist; (2) provide an environment at Adventist where concerns regarding patient safety could be voiced and investigated; and (3) investigate employee impairment, which allowed theft of controlled substances to go undetected. The circumstances are described with more particularity in paragraphs 36, 40-42, and 52-53.

TENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct—Gross Negligence)

68. Respondent Camacho is subject to disciplinary action under section 4301(c) of the Code in that Camacho failed to provide for accountability of controlled substances at Adventist, which allowed an environment for theft of controlled substances to exist over a time period of several years. The circumstances are as follows:

69. Pharmacist E.C. diverted a large amount of controlled substances from Respondent Hanford's pharmacy. The controlled substance diversion dated back to 2012, as evidenced from the discovery of year-2012 supplier invoices for Adventist's Central Valley General Hospital pharmacy signed as received by E.C. but not entered into pharmacy inventory.

70. Respondent Camacho, as the Director of Pharmacy for Adventist, was responsible for scheduling all pharmacy staff at all four of Adventist's pharmacy locations.

71. Respondent Camacho's primary workplace was Adventist's Central Valley General Hospital pharmacy.

72. Respondent Camacho neglected to monitor controlled substance usage at Adventist's Central Valley General Hospital as evidenced by the receipt of 1,035 tablets of methadone 10mg tablets compared to 130 documented as dispensed (from July 7, 2011 through March 8, 2014), and receipt of 1,057 hydromorphone 2mg tablets compared to 150 documented as dispensed (from July 7, 2011 through March 8, 2014).

ELEVENTH CAUSE FOR DISCIPLINE

(Engaging in Conduct That Subverts an Investigation of the Board)

73. Respondent Camacho is subject to disciplinary action under section 4301(q) of the Code in that she engaged in conduct that subverted or attempted to subvert an investigation of the Board by failing to provide the following documents that were requested during the Board's investigation: (1) documentary evidence of Camacho's knowledge of the loss of controlled substances; (2) completed statements; (3) accurate controlled substance audits in the requested timeline; (4) accurate details of the discovery of the loss of controlled substances; (5) an audit of the prescription blanks at Adventist Medical Center Selma; and (6) an audit of supplier controlled substance invoices received by E.C. at Respondent Hanford's pharmacy compared to the controlled substances entered into inventory. The circumstances are described with more particularity in paragraphs 43-45, 54-55, and as follows:

74. During each of Inspector D.P.'s interviews and meetings with Respondent Camacho, Camacho's description regarding the discovery of the loss of controlled substances at Adventist changed as follows:

a. During Inspector D.P.'s first meeting with Respondent Camacho on March 7, 2014, Camacho stated that she had just been informed of some controlled substance discrepancies. Camacho said she had discovered discrepancies in tramadol inventory for Adventist's Selma campus, as well as questionable deductions from the perpetual inventory at Adventist's Central Valley General Hospital for methadone. Camacho stated that she suspected Adventist pharmacist E.C. of the theft. Camacho stated that after reviewing the records at Adventist's Selma campus, she asked a security officer to review video surveillance, and the security officer showed her video from the Selma campus, dated February 19, 2014, showing E.C. entering the pharmacy after it was closed, taking medication, and placing the medication in her bag.

b. On March 11, 2014, Respondent Camacho provided Inspector D.P. with a statement, signed under penalty of perjury, stating that on February 21, 2014, Camacho contacted R.L., the Manager of Adventist's Security Department, and told him she believed there was a

possible drug diversion problem at Adventist's Selma campus. Respondent Camacho told R.L. that she believed the pharmacist involved in the theft was E.C. On February 28, 2014, R.L. reviewed the security video for February 19, 2014, which showed E.C. entering the pharmacy after it was closed with a large bag and making entries in binders on top of the narcotic cabinet. R.L. advised Camacho of his findings. On March 7, 2014, R.L. received a request from Camacho to review video at Adventist's Central Valley General Hospital for February 25, 2014.

c. On June 12, 2014, Inspector D.P. interviewed Respondent Camacho. During this interview, Camacho stated that when she told pharmacist B.E. that she had a suspicion of who was causing the controlled substance discrepancies, when B.E. provided her with a controlled substance audit showing discrepancies on February 21, 2014, she said that she did not know who it was. Camacho said that as of February 21, 2014, her suspicion was that a pharmacy technician was responsible for the controlled substance discrepancies.

TWELFTH CAUSE FOR DISCIPLINE

(Failure to Produce Required Records)

75. Respondent Camacho is subject to disciplinary action under section 4332 of the Code, by and through section 4081 of the Code, in that Camacho failed to provide the following documents as requested for the Board's investigation: (1) documentary evidence of her knowledge of loss of controlled substances; (2) completed statements within the timeframe requested by Inspector D.P.; (3) accurate controlled substance audits in the requested timeframe; (4) accurate details of the discovery of the loss of controlled substances; (5) an audit of prescription blanks at Adventist's Medical Center Selma; (6) an audit of supplier controlled substance invoices received by E.C. at Adventist's Hanford (Respondent Hanford) and Medical Center Selma pharmacies compared to controlled substances entered into inventory; (7) completed DEA 106 for Adventist's Hanford (Respondent Hanford) and Medical Center Selma pharmacies within fourteen days to the Board; (8) complete and accurate records of the disposition of controlled substances to Kerr; and (9) accurate records of dispensing and controlled substance inventory. The circumstances are described with more particularity in paragraphs 43-45 and 54-55.

THIRTEENTH CAUSE FOR DISCIPLINE

(Failure to Report Dispensing Information of Controlled Substances to the Department of Justice)

76. Respondent Camacho is subject to disciplinary action under section 4068(a)(4) of the Code, by and through California Health Safety Code section 11165, in that Respondent Camacho, as the Director of Pharmacy for Adventist, allowed Adventist's Reedley pharmacy to dispense controlled substances to emergency room patients without retaining the dispensing information. The circumstances are as follows:

77. On or about October 23, 2012, Inspector D.P. inspected Adventist's Medical Center, Reedley, and discovered that outpatient dispensing of controlled substances occurred from the hospital after the hospital pharmacy was closed for the day. After the inspection, D.P. informed Respondent Camacho and pharmacist-in-charge R.W. of the pharmacy law requirements for outpatient controlled substance medication dispensing from the emergency room. Camacho and R.W. told D.P. emergency room controlled substance medication dispensing would cease at that time.

78. On or about April 28, 2014, Inspector D.P. re-inspected Adventist Medical Center, Reedley's pharmacy. This re-inspection revealed that outpatient emergency room controlled substance medication dispensing continued to occur from October 23, 2012 through April 28, 2014. A one-year accounting of outpatient controlled substance dispensing information showed 1,045 prescriptions were dispensed. Adventist Medical Center Pharmacy Reedley did not report the dispensing information of controlled substance medication as required to the Department of Justice.

FOURTEENTH CAUSE FOR DISCIPLINE

(Lack of Security of Prescription Department) (Respondent Hanford's Location)

79. Respondent Camacho is subject to disciplinary action under California Code of Regulations, title 16, section 1714(d), in that an audit of controlled substances revealed a substantial loss of controlled substances, as well as that E.C. had the ability to steal controlled substances. The circumstances are as follows:

80. On or about March 14, 2014, an audit of acquisition and disposition records for the time period of June 18, 2011 through March 7, 2014, conducted at Adventist's Central Valley General Hospital's pharmacy revealed a loss of the following controlled substances:

a. 200 tabs of Carisoprodol 350mg

b. 127 tabs of Carisoprodol 350mg

c. 899 tablets of Hydromorphone 2mg

d. 21 vials of Hydromorphone PCA (.2mg/ml)

e. 497 tablets of Meperidine 50mg

f. 346ml of Meperidine 50mg/ml (as Demerol 50mg/ml)

g. 13ml of Meperidine 10mg/ml cartridge

h. 77ml of Meperidine 100mg/ml (as Demerol 100mg/ml) syringe

i. 905 tablets of Methadone HCL 10mg

j. 17 vials of Morphine PCA (1mg/ml)

k. 186 tablets of Oxycodone IR 5mg

l. 400 tablets of Oxycodone HCL 5mg

m. 191 tablets of Oxycodone-APAP 5-325

n. 200 tablets of Oxycodone APAP 5-325

o. 600 tablets of Oxycodone-APAP 5-325 (as Percocet 5-325mg)

81. The controlled substance theft was found to be theft by pharmacist and Adventist employee E.C.

FIFTEENTH CAUSE FOR DISCIPLINE

(Failure to Report Controlled Substance Theft by a Licensed Pharmacy Employee)

82. Respondent Camacho is subject to disciplinary action under section 4104(c) of the Code in that Camacho failed to report and provide to the Board within fourteen days of receipt or development thereof, any documentary evidence demonstrating theft, diversion, or self-use of dangerous drugs. The circumstances are described with more particularity in paragraphs 79-82 and as follows:

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83. After discovery of the controlled substance loss described in paragraphs 80-81, Respondent Camacho, as the Director of Pharmacy for Adventist, submitted a DEA 106. The form was dated March 14, 2014 (indicating the date the theft was discovered), however it was not received by the Board until June 18, 2014.

SIXTEENTH CAUSE FOR DISCIPLINE

(Lack of Security of Prescription Department) (Adventist's Selma Location)

84. Respondent Camacho is subject to disciplinary action under California Code of Regulations, title 16, section 1714(d), by and through section 4113(c) of the Code, in that an audit of controlled substances revealed a substantial loss of controlled substances. The circumstances are as follows:

85. On or about March 14, 2014, an audit of acquisition and disposition records for June 28, 2011 through March 7, 2014, conducted at Adventist's Medical Center-Selma revealed a loss of the following controlled substances:

a. 263 tabs of Carisoprodol 350mg
b. 609 of Hydrocodone/APAP 10-325
c. 1,163 of Hydrocodone-APAP 10-325
d. 81 of Hydromorphone 2mg/ml
e. 33 of Hydromorphone 4mg/ml
f. 1,496 tablets of Hydromorphone 2mg
g. 50 of Hydromorphone 10mg/ml vial
h. 850 tablets of Meperidine 50mg
i. 346ml of Meperidine 50mg/ml (as Demerol 50mg/ml)
j. 1,363 tablets of Methadone HCL 10mg
k. 1,000ml of Methadone 1mg/ml
l. 140 of Morphine Sulfate 30mg SA
m. 50 of Morphine Sulfate ER 30mg ER
n. 9ml of Morphine 20mg/ml
o. 48ml of Morphine 4mg/ml

p. 767 tablets of Oxycodone IR 5mg

q. 1,000 tablets of Oxycodone HCL 5mg

r. 26 of Oxycodone ER 10mg (as Oxycontin 10mg)

s. 20 of Oxycodone ER 20mg (as Oxycontin 20mg)

t. 290 of Oxycodone ER 80mg (as Oxycontin 80mg)

u. 191 tablets of Oxycodone-APAP 5-325

v. 1,163 tablets of Oxycodone-APAP 5-325

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 Hospital Pharmacy License Number HSP 30446, issued to Hanford Community Hospital dba Adventist Medical Center;

2. Revoking or suspending Original Pharmacist License Number RPH 41441, issued to Deborah Ann Camacho;

3. Ordering Hanford Community Hospital and Deborah Ann Camacho 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

4. Taking such other and further action as deemed necessary and proper.

DATED: 10/20/15

VIRGINIA HEROLD
Executive Officer
Board of Pharmacy
Department of Consumer Affairs
State of California
Complainant

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