KAMALA D. HARRIS
Attorney General of California
LINDA L. SUN
Supervising Deputy Attorney General
HELENE E. ROUSE
Deputy Attorney General
State Bar No. 130426
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 620-3005
Facsimile: (213) 897-2804
Attorneys for Complainant

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

In the Matter of the Accusation Against: **HARRY SANDS** 3261 Veteran Ave. Los Angeles, CA 90034 **Pharmacist License No. RPH 31031** Respondent.	Case No. 5818 **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 July 29, 1977, the Board of Pharmacy issued Pharmacist License Number RPH 31031 to Harry Sands (Respondent Sands). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2016, unless renewed.

JURISDICTION

3. 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.

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4. Section 4011 provides that the Board shall administer and enforce both the Pharmacy Law [Bus. & Prof. Code, § 4000 et seq.] and the Uniform Controlled Substances Act [Health & Safety Code, § 11000 et seq.].

5. Under Section 4300, the Board may discipline any license, for any reason provided in the Pharmacy Law, (i.e., Sections 4000 et. seq.).

6. 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.

7. Section 4402, subdivision (a) provides that any pharmacist license that is not renewed within three years following its expiration may not be renewed, restored, or reinstated and shall be canceled by operation of law at the end of the three-year period. Under Section 4402, subdivision (d), the Board has authority to proceed with an accusation that has been filed prior to the expiration of the three-year period.

STATUTORY PROVISIONS

8. Section 4022 states, in pertinent part:

> "Dangerous drug" or "dangerous device" means any drug .or device unsafe for self-use in humans or animals, and includes the following:
>
> (a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.
>
> (b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.
>
> (c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

9. Section 4059(a) states, in pertinent part:

> 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.

10. Section 4060 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, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either Section 4052.1 or 4052.2. 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.

11. Section 4301 states, in pertinent part:

The board shall take action against any holder of a license who is guilty of unprofessional conduct . . . 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.

* * * *

(g) Knowingly making or signing any certificate or other document that falsely represents the existence or nonexistence of a state of facts.

* * * *

(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, of 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

pharmacy, including regulations established by the board or by any other state or federal regulatory agency.

12. Section 4327 states: "Any person who, while on duty, sells, dispenses or compounds any drug while under the influence of any dangerous drug or alcoholic beverages shall be guilty of a misdemeanor."

13. Section 11170 of the Health and Safety Code states: "No person shall prescribe, administer, or furnish a controlled substance for himself."

14. Section 11171 of the Health and Safety Code states: "No person shall prescribe, administer, or furnish a controlled substance except under the conditions and in the manner provided by this division."

COST RECOVERY

15. Section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation of the licensing act to pay a sum not to exceed its reasonable costs of investigation and enforcement.

DANGEROUS DRUGS/CONTROLLED SUBSTANCES

16. **Morphine** is a dangerous drug under Section 4022 and a controlled substance under Health & Safety Code section 11055. It is prescribed to treat severe pain.

17. **Hydromorphone** (brand name - Dilaudid) is a dangerous drug under Section 4022 and a controlled substance under Health & Safety Code section 11055. It is prescribed to treat severe pain.

FACTS SUPPORTING CAUSES FOR DISCIPLINE

18. On or about July 28, 2015, B.N., who was the pharmacist-in-charge (PIC) at Santa Monica-UCLA Medical Center & Orthopaedic Hospital (SMH) from at least July 28, 2014 through November 11, 2015, sent the Board a letter indicating that Respondent had been placed on an investigatory leave for suspicion of possible controlled substance abuse. The letter also stated that SMH's investigation was ongoing.

19. On or about August 21, 2015, the Board received another letter from B.N., stating that inventory had been recovered on Respondent, but that an audit of the inventory for hydromorphone 50 mg/5 ml from May 21, 2015 through July 16, 2015 showed no variance. The

events which occurred on July 15, 2015 were reported to the University of California Police Department.

20. B.N. included a signed statement under penalty of perjury dated August 9, 2015, which explained that a staff member, P.P., alerted management on July 15, 2015 at 11:15 a.m. that he had witnessed Respondent enter the controlled substance vault, exit the vault leaving the door cracked open, and return to the pharmacy for a syringe and needle. He then went immediately into the bathroom. B.N. and a staff pharmacist confirmed that Respondent left the vault door ajar, but it did not appear anything had been removed, upon review of the C2 safe (the electronic controlled substance/narcotics storage safe/vault). The management team suspected that Respondent was removing wasted vials of controlled substances which might contain medication from the "sharps" disposal container. Respondent entered the vault, removed a vial of hydromorphone 50 mg/5 ml, and a staff member then saw him grab a syringe and needle and go into the bathroom at 12:13 p.m. Respondent was in the bathroom/locker area for 15 minutes and then left on a meal break.

21. When Respondent returned from his break, he was taken to the Emergency Department and, due to his nervous behavior, security requested him to empty his pockets. After a few minutes, he produced an unopened vial of hydromorphone 50 mg/5 ml, stating that it was for a patient. However, inquires to the patient's nurse and the I.V. Additives staff disproved that there were any requests made for an IV drip requiring this drug. Respondent refused a request to submit to a urine drug test. After he was escorted out of the building, Respondent unsuccessfully attempted to log into the Care Connect system (the electronic medical system used by physicians, pharmacists and nurses) five times. Respondent was unable to do so because his access to the system had already been deleted. Respondent was placed on an investigatory leave.

22. An Emergency Room Charge Nurse reported that Sands' veins appeared to be scarred and had track marks.

23. A copy of an audit of hydromorphone 50 mg/5 ml showed a zero variance. Cameras in the narcotic vault and core pharmacy recorded Respondent on the date of the incidents of July

15, 2015 removing a vial of hydromorphone 50 mg/5 ml from the C2 safe, grabbing papers from the C2 printer, shuffling and returning them, and walking into the locker room.

BOARD INVESTIGATION - OCTOBER 29, 2015

24. On or about October 29, 2015, a Board Inspector drove to SMH and met with B.N. and the Pharmacy Director, D.Z., who oversees all of the UCLA pharmacies. B.N. stated that Respondent began working for SMH on April 15, 2000 and worked only at the licensed, main pharmacy (SMH Pharmacy). In 2007, Respondent self-referred into the Pharmacist Recovery Program (PRP) due to a substance abuse problem, and completed six months of inpatient treatment. He was in the PRP for four years, which he successfully completed.

25. On or about July 17, 2015, the UCLA Police Department was dispatched to Respondent's home and Respondent was placed on a Welfare & Institutions 5150 psychiatric hold for being a danger to himself.

26. The Board's Inspector reviewed the hydromorphone inventory record for the audit, beginning on May 21, 2015. B.N. indicated that this concentration of hydromorphone 50 mg/5 ml is only used to compound continuous infusion drips for a specific patient. Each withdrawal of hydromorphone from the C2 cabinet should designate a corresponding patient as well as the Pyxis cabinet that received the drip or a signed Controlled Substance Order & Transport Sheet (CSOT). For each withdrawal made by Respondent, there was neither a corresponding compounding log, a receiving Pyxis cabinet[1] or a CSOT identified.

27. B.N. produced a C2 Pyxis cabinet report specific to Respondent for his removal of hydromorphone 50 mg/5 ml from July 28, 2014 through July 15, 2015, which did indicate a patient on some of the withdrawals. However, B.N.'s review showed there were no corresponding compounding logs or receiving Pyxis cabinets for the hydromorphone he removed, to support that hydromorphone drips were ever sent to the patient floors.

28. B.N. provided a "Narcotic Vault Access Report" from May 21, 2015 through July 15, 2015, which showed that Respondent accessed cabinet 7 in the C2 safe that stored morphine 15

[1] "Pyxis" is a computerized management, storage, recordkeeping and medication dispensing system/machine.

mg/20 ml vials, and cabinet 8 which stored narcotics pending destruction. B.N. also provided an all Pyxis Activity report specific to Respondent, from May 21, 2014 through October 26, 2015, which showed there were several days when Respondent opened up the expired medications in Pyxis cabinet S2RAD (Radiology) containing morphine 15 mg/5 ml vials within about one hour. Respondent was assigned to check the expired medications for Pyxis cabinet S2RAD; however, this activity would be expected once a month only. Any waste left in a vial is documented on the compounding log sheet and the entire vial is dropped into the pharmaceutical waste container kept in the C2 safe.

29. The Board's Inspector interviewed an employee of SMH, P.P., who noticed Respondent on three different occasions take a syringe and single small bottle of sterile water, in the same month. Specifically, on July 15, 2015, P.P. observed Respondent walking in the pharmacy with a single syringe in one hand and a needle in the other hand. He followed Respondent and saw him walk past the open narcotics room door and into the bathroom. He reported Respondent's suspicious activity to his supervisor, a staff pharmacist.

30. On October 30, 2015, the Board's Inspector received an email from B.N. forwarding an email from Respondent, tendering his resignation from SMH, effective November 2, 2015. During SMH's investigation, Respondent was not in communication with SMH and did not comply with its investigation. The Inspector also received two separate certified incident/investigation reports from the UCLA Police Department regarding a drug embezzlement crime. A report indicated that a pharmacy supervisor told B.N. that Respondent signed out a vial of Dilaudid (hydromorphone) from the vault to compound an IV drip, but that she was the IV pharmacist and had no request for a hydromorphone IV drip. She checked with the other IV pharmacist and he also had not received any request for a hydromorphone IV drip. Respondent removed a Dilaudid 50 mg/5 ml vial from the C2 safe at 12:13 hours.

31. At around 13:15 hours, Respondent was escorted to the ER for a urine sample for drug testing, which he refused. Respondent emptied his pockets and produced an unopened vial of hydromorphone which he said was for patient B.S., but he "forgot" he had the vial. B.N. later

checked with the nurse caring for patient B.S., who stated he did not request a narcotic drip for this patient. B.N. also verified this with her other staff.

32. Video surveillance of Respondent showed him looking twice behind the vault door where the "sharps" disposal container is located. The container is supposed to have a one-way top where items can be wasted, but not retrieved. The top of the container, however, had been tampered with, so that drugs could now be retrieved. B.N. provided documentation that Respondent had requested hydromorphone from the narcotic vault 13 times from June 15, 2015 to July 15, 2015.

33. On or about December 16, 2015, a Board Inspector received an email from B.N. with additional documentation which she had requested from her on November 23, 2015. Between July 28, 2014 and July 15, 2015, there were 57 times (64 vials) Respondent withdrew hydromorphone 50 mg/5 ml from the C2 cabinet in which B.N. could not find corresponding documentation to support that it was administered to a patient.

34. On January 8, 2016, a Supervising Inspector and Inspector from the Board met with Respondent and his attorney about his alleged diversion of drugs from his employer. Respondent said he agreed to submit to a drug screen, but when he arrived at the ER, he was unable to give a urine sample. He provided a blood sample, which he believed was normal. Respondent admitted he had a vial of hydromorphone in his pocket when in the ER, but said that he withdrew the vial from the C2 safe after receiving a notice from a nurse that a new drip was needed for a patient. After Respondent withdrew the vial, he was called into B.N.'s office and did not have time to give it to the IV room pharmacist. Upon further questioning, Respondent said it was possible that he went to lunch after withdrawing the medication and before being escorted to the E.R. He denied using controlled substances and said the vial was unopened. Respondent also indicated he never compounded or prepared any sterile compounded products himself when he was assigned to the day shift. In addition, he said he would never need to retrieve a single syringe and diluent.

35. During the interview with the Board's Inspector, Respondent admitted that he diverted the waste and overfills from the morphine multi-dose vials in the C2 Safe from the sharps container for about two to three months before his resignation. He was asked what drugs

he diverted form the sharps container; hydromorphone, fentanyl and morphine and he replied "all of them." He said it was possible he had diverted 64 vials of hydromorphone 50 mg/5 ml over the past year. Respondent also admitted he took the vials for self-use and administered the drugs to himself at home. He said he did not contact the PRP because he thought they would tell him he was "too messed up" because he had relapsed, after becoming sober when previously participating in the PRP. He said he did not feel healthy enough to work in a pharmacy and would remain retired until he felt ready.

36. The Board's Inspector obtained Respondent's ER medical record from July 15 2015, in which he used the alias "Jim Castillo". His record indicates that his primary symptoms included agitation and intoxication. The clinical impression was "substance abuse". He did not submit a urine sample for drug testing, but did submit a blood sample, which screened for salicylates, acetaminophen, alcohol, benzodiazepines and tricyclic antidepressants. His drug test was essentially within normal limits. However, the blood sample was not tested for oxycodone and opiates, because this is usually tested for in a urine specimen.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Dishonesty)

37. Respondent is subject to disciplinary action under Section 4301, subdivisions (f) and (j), in that while working as a pharmacist at SMH Pharmacy, Respondent engaged in acts involving moral turpitude, dishonesty and fraud, by diverting controlled substances from his employer and initially denying that he had taken them for self-use. The circumstances are set forth above in Paragraphs 18 through 36, which are incorporated herein by reference.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Self-Furnishing of Controlled Substances)

38. Respondent is subject to disciplinary action under Section 4301, subdivision (h), in that Respondent withdrew 64 vials of hydromorphone 50 mg/5 ml, a controlled substance, from SMH's pharmacy inventory, between July 28, 2014 and July 15, 2015, for self-use. His self-administration of a controlled substance was dangerous or injurious to himself and/or other persons, and impaired his ability to practice pharmacy with safety to the public. The

circumstances are set forth above in Paragraphs 18 through 36, which are incorporated herein by reference.

THIRD CAUSE FOR DISCIPLINE

(Unlawful Possession of a Controlled Substance)

39. Respondent is subject to disciplinary action under Sections 4301 subdivision (o) and 4060, in that while employed as a pharmacist at SMH Pharmacy, Respondent possessed controlled substances without a prescription, in violation of applicable state and federal laws and/or regulations. The circumstances are set forth above in Paragraphs 18 through 36, which are incorporated herein by reference.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Falsely Representing Facts)

40. Respondent is subject to disciplinary action under Section 4301, subdivision (g) in that while on duty as a pharmacist at SMH Pharmacy, Respondent knowingly made or signed documents that falsely represented the existence or nonexistence of facts. More specifically, between July 28, 2014 and June 29, 2015, he withdrew 64 vials of hydromorphone 50 mg/5 ml from the pharmacy inventory, which he documented was for administration to patients in the hospital, but which he stated he withdrew for his own use. There was no documentation that any of the patients he designated for the hydromorphone ever received it. The circumstances are set forth above in Paragraphs 18 through 36, which are incorporated herein by reference.

FIFTH CAUSE FOR DISCIPLINE

(Dispensing While Under the Influence of Drugs)

41. Respondent is subject to disciplinary action under Section 4327 in that, while on duty as a pharmacist at SMH Pharmacy, between July 28, 2014 and July 15, 2015, he withdrew 64 vials of hydromorphone 50 mg/5 ml from the pharmacy inventory, which he diverted for self-use. In addition, during his work shift on July 15, 2015, a clinical evaluation by a physician indicated that Respondent was intoxicated. The circumstances are set forth above in Paragraphs 18 through 36, which are incorporated herein by reference.

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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 Pharmacist License Number RPH 31031, issued to Harry Sands;

2. Ordering Harry Sands 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: 10/14/16

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

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