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

In the Matter of the Accusation Against: **CORNELIUS CRISTIAN SEULEAN** 11225 Ramway Road Riverside, CA 92505 Pharmacy Technician License No. TCH 22736 Respondent.	Case No. 3418 OAH No. 2009110330

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Pharmacy as its Decision in the above-entitled matter.

This decision shall become effective on March 9, 2011.

It is so ORDERED February 7, 2011.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By _____
STANLEY C. WEISSER
Board President

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

In the Matter of the Accusation Against:	Case No. 3418
CORNELIUS CRISTIAN SEULEAN,	OAH No. 2009110330
Respondent.	

PROPOSED DECISION

Donald P. Cole, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on October 20 and 21, 2010, in Riverside, California.

Marichelle S. Tahimic, Deputy Attorney General, Department of Justice, represented complainant Virginia Herold, Executive Officer of the Board of Pharmacy.

Fredrick M. Ray, Attorney at Law, represented respondent Cornelius Seulean, who was present throughout the hearing.

The matter was submitted on October 21, 2010.

FACTUAL FINDINGS

Jurisdictional Matters

1. On June 16, 1997, the board issued to respondent Original Pharmacy Technician Registration No. TCH 22736. Respondent's registration is in full force until August 31, 2012.

2. On October 12, 2009, complainant signed the accusation in her official capacity. On October 20, 2009, the accusation and other required jurisdictional documents were served on respondent. On November 2, 2009, respondent signed and thereafter filed a notice of defense. On April 1, 2010, complainant served on respondent a notice of continued hearing.

3. On October 20, 2010, the record was opened and jurisdictional documents were received. On October 20 and 21, 2010, sworn testimony was given and documentary

evidence was introduced. On October 21, 2010, closing arguments were presented and the matter was submitted.

Summary of Decision

4. The accusation alleged that between April 2007 and August 2008, respondent, a lead pharmacy technician at Loma Linda University Medical Center (Loma Linda), diverted 6,540 tablets of several controlled substances from the hospital pharmacy's electronic vault/dispensing system. The accusation stated four causes for discipline: (i) unprofessional conduct, commission of an act involving dishonesty, fraud, or deceit; (ii) unprofessional conduct, obtaining controlled substances by fraud, deceit, misrepresentation or subterfuge, or by concealment of a material fact; (iii) unprofessional conduct, furnishing a controlled substance without a prescription; and (iv) unprofessional conduct, possession of a controlled substance without a prescription.

The evidence established that respondent diverted over 6,000 tablets of controlled substances. The imposition of discipline is thus authorized pursuant to Business and Professions Code section 4301. Outright revocation of respondent's registration is required for the protection of the public.

The Loma Linda Controlled Substances Storage System

5. From January 2007 through August 2008, Loma Linda stored controlled substances in an electronic (computerized) vault, called the McKesson[1] NarcStation, which was located inside a locked room in the hospital pharmacy. Smaller storage units, called AcuDose machines, were located at nursing stations on the various hospital floors. The NarcStation and AcuDose machines were interconnected electronically through a software program.

Access to the NarcStation was via a technician's unique user identification and password. The user identification was apparently assigned based on the individual's name. A technician could choose her own permanent password, but only after she was logged into the system via a temporary password apparently provided or entered by another individual, such as a lead technician.

Controlled substances could be withdrawn from the NarcStation for two primary purposes, "daily issues" and "manual issues." About 50 pharmacy technicians had access to the NarcStation for the purpose of manual issues; only about four technicians—narcotics technicians—had access to the NarcStation for the purpose of daily issues. Respondent was a narcotics technician, and was also a lead technician.[2]

---

[1] McKesson is the manufacturer of the device.

[2] It may be that the two terms were synonymous, but the record was not entirely clear on that point. Respondent was one of several narcotics technicians who usually (but, according to hospital records received at the hearing, not always) worked on weekends.

Daily Issues

6. In essence, "daily issues" referred to the regular, daily restocking of nursing unit AcuDose machines with needed controlled substances stored centrally in the NarcStation. Each morning, a Loma Linda narcotics technician was responsible to refill each AcuDose machine with these daily issues. The process for determining what quantities of which medications had to be refilled in the respective AcuDose machines was called "polling." Daily issue polling occurred just once per day, in the morning.

The first step in the polling procedure was for the narcotics technician to enter his or her user identification and password into the NarcStation. The technician then selected "daily issue" from a menu on the computer screen. A list of all Loma Linda AcuDose machines appeared on the screen. The technician selected each AcuDose machine, one at a time. The NarcStation communicated with the selected AcuDose machine via the software program and downloaded a list of all controlled medications, including their quantities, that needed to be refilled in that particular AcuDose machine. After the technician had selected all of the AcuDose machines, the technician selected "process," the NarcStation doors for each medication opened, and the technician removed from NarcStation bins the amounts of the particular medications needed to refill all AcuDose machines. The NarcStation also printed a sheet listing the medications and quantities needed to refill each AcuDose machine. The technician filled individual ziplock bags for each AcuDose machine using the medications identified and quantities specified on the printed sheet, which was placed in the bag. The technician labeled the bags and the contents of each bag was verified by a pharmacist. A technician then took the bags to the respective AcuDose machines to be refilled. On weekdays, the narcotics technician handed the medications off to a "floor" technician, who delivered the drugs to the AcuDose machines; on weekends, the narcotics technician himself delivered the drugs to the AcuDose machines.

7. Once a technician delivered a daily issue to a particular AcuDose machine, the NarcStation automatically closed out that transaction, so that it no longer appeared as "open" on the NarcStation screen, i.e., it "fell off the radar." Conversely, if a technician did *not* deliver to the AcuDose machine the precise daily issue dispensed by the NarcStation, the NarcStation did not automatically close out the transaction. In such a case, the transaction would remain open on the NarcStation screen, so that any individual using the NarcStation would be alerted to the fact that there was an open transaction. However, the system permitted technicians to manually close out daily issue transactions that had not been automatically closed out by virtue of a successful delivery to the AcuDose unit.

8. One way to manually close out an open transaction was by entering a "zero return" into the system, which indicated that a zero quantity of the medication in question was being returned to the NarcStation. Once a zero return was entered into the NarcStation, the transaction would be closed out, and it would drop off of the NarcStation screen, so that a user of the NarcStation would not be alerted to the fact that a daily issue dispensed from the NarcStation had *not* delivered to the designated AcuDose machine. The system as it then functioned thus facilitated the improper diversion of controlled substances. While a careful review of NarcStation records (as in fact ultimately occurred in this case) would reveal

improper activity, the NarcStation would not alert hospital personnel to the need for such a review, since there would be no open transactions to indicate the existence of a potential problem. There might be an occasional legitimate need to use a zero return to close out a manual issues; such a legitimate use did not, however, obtain for daily issues.

A zero return could be accomplished in as little as a minute or so. It could only be performed from the NarcStation itself, i.e., it could not be performed from AcuDose machines on the various nursing floors.

Manual Issues

9. "Manual issues," in contrast to "daily issues," referred to essentially ad hoc withdrawals from the NarcStation of generally small quantities (e.g., one or two tablets) of particular controlled substances to be administered as needed to a particular patient, which medications were not stored as a matter of course in the AcuDose machines. In contrast to daily issues, not only narcotics technicians, but other pharmacy technicians as well, had the authority via their login identification to withdrawn manual issues from the NarcStation. As with a daily issue, once the medication was withdrawn from the NarcStation, it had to be inspected by a pharmacist. It was then delivered to a registered nurse in the hospital unit in question. The technician then returned to the NarcStation to close out the transaction, i.e., it did not close out automatically since it was not dispensed to the AcuDose machine.

As with daily issues, a manual issue could be closed out via a zero return. In that case, again as with daily issues, the transaction would no longer appear as open on the NarcStation screen and an individual using the NarcStation would not be alerted to the fact that controlled substances withdrawn from the NarcStation for a manual issue had not been delivered to the nursing station in question.

Respondent's Alleged Drug Diversion

10. On Monday August 4, 2008, when long-time Loma Linda narcotics technician Linda Jean Lipskey logged into the NarcStation, she noticed that there were several open daily issues appearing on the screen, i.e., daily issues that had not yet been delivered to the AcuDose machines over the preceding weekend. Respondent was listed as the staff who had initiated those daily issues. To determine why these daily issues were listed as still open, Lipskey ran a narcotics transaction report. The reports reflected several irregularities, including daily issues twice in the same day and zero returns entered manually within one to two minutes after daily issues were initiated. Lipskey focused in particular on a 30-Norco unit destined for nursing station 6100 that was never delivered there. She ran a refill activity report, which reflected that none of the 30 Norco tablets had been refilled.

11. Lipskey contacted Michael Virtue, another senior Loma Linda lead technician, who ran an AcuDose restock report and determined that none of the Norco tablets issued over the weekend under respondent's login with zero returns had been delivered to the AcuDose machines. Virtue and supervisor Dan Kardasinski then ran a six-month NarcStation activity report for respondent's activity on the system. Multiple zero returns

under respondent's login were discovered. By comparing the dates and times of these entries against Loma Linda attendance records, it was determined that respondent was on duty on each occasion.

On August 5, 2008, Virtue, Kardasinski and other staff met with respondent. They asked respondent about the 30-Norco transaction involving station 6100. Respondent told them that he withdrew the Norco by daily issue to that station, but that when he arrived at the AcuDose machine there, he discovered that the prescription was supposed to be for Vicodin. He therefore went back downstairs to the NarcStation, returned the Norco, withdrew Vicodin, and brought it back to the AcuDose machine in station 6100.[3] Staff also showed respondent the six-month report that had been run on his transactions. Respondent was asked to review the report, but he declined to do so.[4]

Virtue later investigated respondent's claim that he had mistakenly withdrawn Norco instead of Vicodin. Virtue determined that no Vicodin had been issued from the NarcStation on the date in question for unit 6100, and that no Norco had been returned to the NarcStation.

12. After the August 5, 2008, meeting with respondent, Virtue ran and examined NarcStation reports back to January 2007 for respondent, and for another pharmacy technician, Safwat Hanna.[5] These reports (which were received in evidence) indicated that on about 50 dates between April 2007 and August 3, 2008, a total of over 5,400 controlled substance tablets were withdrawn from the NarcStation under respondent's user name, mostly in connection with daily issues, which withdrawals were associated with zero returns. In most instances, the zero returns were entered within three to four minutes after the drug was withdrawn from the NarcStation; in some instances, the time differential was less than a minute.[6] The often very short time differential was significant, because it would take longer than one to two minutes to withdraw medication from the NarcStation and deliver it to AcuDose machines or to staff on the different nursing units.

---

[3] Respondent testified that he did not recall telling Virtue he had mistakenly withdrawn Norco, instead of Vicodin, from the NarcStation on the weekend of August 2 and 3, 2008. To the extent respondent's testimony may be deemed to contradict that of Virtue, the latter is credited, as it is difficult to conceive how Virtue could have mistakenly believed or recalled respondent telling him that, and the evidence did not suggest a motive for Virtue to have lied about this.

[4] Respondent's testimony that he recalled being shown a report of about 20 pages listing various transactions under his username, and that he glanced at but did not read the full 20 pages, is deemed to be substantially consistent with Virtue's testimony.

[5] During the course of Virtue's initial investigation, he uncovered suspicious transactions under Hanna's username similar to those attributed to respondent.

[6] On a number of other occasions, the time lag was several hours.

By comparing the NarcStation reports with cabinet refill reports, Virtue determined that in all of these instances, the medication had not been delivered to the AcuDose machines. By reviewing employee time clock documentation, Virtue also determined that respondent was on duty on each of the occasions in question for which such attendance records were available.[7]

The NarcStation reports Virtue ran for Hanna reflected that a total of about 800 controlled substance tablets were withdrawn from the NarcStation on about 40 dates between April 18, 2007, and July 3, 2008, and were associated with zero returns. In all cases, these transactions were manual issues.[8] Again, restock records reflected that the drugs were not delivered to the nursing units indicated. Further, on all of the occasions for which attendance records were available, respondent was on duty; Hanna himself, however, was only on duty in about three-fourths of the instances in question.

13. Until the foregoing matters came to light, Loma Linda personnel did not realize that a technician could manipulate the NarcStation by withdrawing medication and then entering a zero return, thus causing the transaction to close even though the medication was neither delivered to a nursing unit nor returned to the NarcStation itself. In other words, as a result of the investigation of respondent's activity, Loma Linda discovered a "glitch" in the system that provided a means of diverting narcotic drugs.

14. Respondent was the only narcotics technician who worked on the weekend of August 2 and 3, 2008. Hanna was also on duty that weekend, but since he was not a narcotics technician, he could not poll daily issues from the NarcStation; he could, however, perform manual issues.

15. Hanna was on leave from his position as a Loma Linda pharmacy technician from 2006 until March 2007. When he returned to work, respondent was his lead technician. Respondent assisted Hanna in some manner with securing a NarcStation password.[9] Both respondent and Lipskey were involved in training Hanna in the use of the NarcStation. Hanna, who testified at the hearing, denied that he diverted any drugs.

---

[7] A summary table was received in evidence at the hearing, that provided the dates and times of the zero return transactions and the clock-in times for respondent and Hanna. In some instances, there was no entry for the clock in time. It is inferred that records for those instances no longer existed. However, the records indicated respondent's presence on duty on all occasions for which these attendance records existed.

[8] Since Hanna was not a narcotics technician, daily issues could not be instituted under his login.

[9] Hanna's testimony was unclear and reflected the lack of a strong recollection as to exactly what respondent did in this regard. At one point, he stated that respondent gave him his password. He also stated that respondent was sitting next to him when he got his password, which suggests he entered a password on his own. He also said that he first had a temporary password and then had a new one six months later.

16. Respondent testified that he was asked to retrain Hanna in February or March 2007, after the latter's return from medical leave. Hanna's password had expired, and respondent gave Hanna a new, temporary password. Respondent denied that he knew Hanna's new password. Respondent documented his training of Hanna in an email he sent on April 25, 2007, to Dan Kardasinski. The email stated that the training had taken place that same day.

Respondent denied diverting drugs from the NarcStation. He added that during 2007 and 2008, his family's finances were excellent.

17. The wholesale value (i.e., the cost to Loma Linda) of the over 6,000 tablets at issue in this case was about $7,600. Evidence as to the retail value was not proffered at the hearing.

18. The evidence established that over 6,000 controlled substance tablets were diverted between April 2007 and August 2008, and that respondent was the individual who diverted them.

With regard to whether the controlled substances were in fact diverted, the documentary evidence, while circumstantial, overwhelmingly established that diversion took place. Quite simply, that documentation established: (i) that the drugs were withdrawn from the NarcStation; (ii) that the drugs were never delivered to the designated AcuDose machine (daily issue) or the nursing station (manual issue); and (iii) that the drugs were never returned to the NarcStation. That the zero returns often took place within as little as one to two minutes after withdrawal from the NarcStation further supported the conclusion that diversion had taken place. Further, zero return transactions were not used for daily issues. That the transactions in question at times constituted a second daily issue on a particular date further demonstrated that the transactions were not legitimate. Finally, the sheer number of transactions precluded an inference that they represented innocent error or anomaly.

With regard to whether it was respondent who was responsible for the diversion, the obvious starting point is that about 80% of the total number of diverted tablets occurred under his login. He was on duty on all occasions for which time clock attendance records were available. No evidence was presented that any other individual knew his password. His patently false explanation at the August 5, 2008, meeting is further evidence that it was he who diverted the drugs, as was his apparent lack of interest in examining carefully the documentation brought to that meeting. As far as the small portion of drugs diverted under Hanna's login is concerned, Hanna was only on duty about three-quarters of the time when those transactions took place; respondent, on the other hand, was present on each such occasion for which appropriate attendance records were available. Further, the evidence at least suggested a means by which respondent could have secured Hanna's password. In addition, it seemed nearly inconceivable that Hanna, who had just returned to work after an extended medical leave, would have immediately discovered the glitch in the system that would enable him to begin diverting massive quantities of controlled substances. Moreover, no evidence was presented as to how he could have acquired respondent's password.

Finally, no evidence was presented to even remotely suggest that any other individual was responsible for the diversion.

Respondent offered a number of arguments in support of his position that he did not divert drugs, e.g., that he was not caught in the act, that no drugs were ever found in his possession, that no attempt was made to videotape him, that it did not make sense for him to use his own login name if Hanna's was in fact available to him, that drug inventory records were not produced at the hearing, that (absent any evidence that respondent abused drugs) no motive for diversion existed, and that the absence of unique control numbers for each transaction rendered the correlation between particular NarcStation withdrawals and zero returns ambiguous. In light of the overwhelming evidence summarized above, none of these (or respondent's other) arguments, either individually or collectively, was availing.

Background, Rehabilitation, and Present Circumstances

19. Respondent was first employed by Loma Linda in the out-patient pharmacy, in 2002. In October 2004, he was reassigned to the in-patient pharmacy. In 2005, he was promoted to lead pharmacy technician. He was discharged in August 2008, as a result of the matters at issue in this proceeding. Since December 2008, respondent has been employed as a pharmacy technician at Riverside Community Hospital. His employee evaluations at Riverside have been good.

In 2006, respondent passed the Pharmacy Technician Certification Board exam.

While employed at Loma Linda, respondent twice scheduled and conducted pharmacy tours for San Joaquin Valley College pharmacy technician students. His tours were well received by the students.

In 2007, the City of Riverside issued to respondent a municipal volunteer recognition certificate of appreciation in connection with respondent's volunteer work with the Public Works Department.

20. Respondent's wife, Christina Seulean, testified that she and respondent have been married for 11 years and have two children, ten years and ten months old. She described respondent as a loving, caring family man. She had no knowledge of any illegal drug use by respondent.

Respondent's younger brother, Dumitru Johnny Seulean, testified that respondent is always "there" for his family and friends. He described a recent occasion when respondent helped him out financially, taking him into his (respondent's) home to help him get back on his feet. Seulean had no knowledge of any illegal drug use by respondent. Seulean did not believe that respondent would steal drugs.

Bryan Sherman, a friend of respondent since high school, testified that he and respondent get together once or twice per week, and that he had no knowledge of any illegal

drug use by respondent. He described respondent as a loving father and husband who would do anything for family and friends. Sherman did not believe respondent would steal drugs.

Costs of Investigation and Prosecution

21. Complainant submitted a certification of investigative costs, in which costs totaling $3,442.50 were claimed for 33.75 hours of investigative services at a rate of $102 per hour.

Complainant's counsel submitted a certification of prosecution costs. The certification stated, and it is found, that total charges billed by the Department of Justice to the board through October 15, 2010, were in the amount of $8,220 for 48.50 hours of work, including pleading preparation, evidentiary preparation, discovery, trial preparation, and other matters. The vast majority of this work was billed by the deputy attorney general who tried the case. The declaration stated that counsel would incur an anticipated additional four hours of trial preparation time after the date on which the declaration was executed. Counsel thus claims total prosecutorial costs in the amount of $8,900.

All costs claimed were reasonably incurred.

LEGAL CONCLUSIONS

1. The basic reason for disciplinary action against occupational licensees is the protection of the public against unethical and dishonest conduct on the part of those engaged in the licensed activity. (*Small v. Smith* (1971) 16 Cal.App.3d 450, 456, quoting from *Marks v. Watson* (1952) 112 Cal.App.2d 196, 200.)[10] "The purpose of an administrative proceeding concerning the revocation or suspension of a license is not to punish the individual; the purpose is to protect the public from dishonest, immoral, disreputable or incompetent practitioners." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

2. Absent a statute to the contrary, the burden of proof in disciplinary administrative proceedings rests upon the party making the charges. (*Parker v. City of Fountain Valley* (1981) 127 Cal.App.3d 99, 113; Evid. Code, § 115.) The burden of proof in this proceeding is thus on complainant.

3. Pharmacy technicians are professionals, and according the clear and convincing standard of proof is applicable to this proceeding. (*Ettinger v. Board of Medical Quality Assurance* (1982) 139 Cal.App.3d 853, 856-857; *Furman v. State Bar* (1938) 12 Cal.2d 212, 229; *James v. Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1105.)

---

[10] *Small* involved a real estate broker's license. The same principle should apply to other kinds of licenses, including pharmacy technician registrations.

4. "The key element of clear and convincing evidence is that it must establish a high probability of the existence of the disputed fact, greater than proof by a preponderance of the evidence." (*People v. Mabini* (2001) 92 Cal.App.4th 654, 662.) This standard is less stringent than proof beyond a reasonable doubt. (*Ettinger v. Board of Medical Quality Assurance, supra*, 135 Cal.App.3d at 856.)

5. Business and Professions Code section 4301 provides in 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:

* * *

(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.

* * *

(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."

6. Business and Professions Code section 4059 provides in part:

"(a) 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."

7. Business and Professions Code section 4060 provides in part:

"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."

8. Business and Professions Code section 11173 provides in part:

"(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

(b) No person shall make a false statement in any prescription, order, report, or record, required by this division.

(c) No person shall, for the purpose of obtaining controlled substances, falsely assume the title of, or represent himself to be, a manufacturer, wholesaler, pharmacist, physician, dentist, veterinarian, registered nurse, physician's assistant, or other authorized person."

(d) No person shall affix any false or forged label to a package or receptacle containing controlled substances."

9. The board's Manual of Disciplinary Guidelines and Model Disciplinary Orders sets forth three categories of violations. The most serious are in Category III, which includes "knowing or willfully violating laws or regulations pertaining to dispensing or distributing dangerous drugs or controlled substances,""drug shortages," and "fraudulent acts committed in connected with the licensee's practice." Business and Professions Code section 4301, subdivision (j) is explicitly included within Category III. The minimum penalty under the guidelines for Category III offenses is stayed revocation, a 90-day suspension, and three to five years probation on standard and appropriate optional terms. The maximum penalty is straight revocation.

In determining whether the minimum, maximum, or an intermediate penalty is to be imposed in a given case, factors to be considered include actual or potential harm to the public or to any consumer, prior disciplinary record, prior warnings of record, number and/or variety of current violations, nature and severity of the acts under consideration, mitigating and rehabilitation evidence, time passed since the acts, whether the conduct was intentional or negligent, and financial benefit to the respondent from the misconduct. No single or combination of the above factors is required to justify the minimum and maximum penalty as opposed to an intermediate one. Respondent has the burden of demonstrating rehabilitation.

Further:

"The board files cases against pharmacy technicians where the violation(s) involve significant misconduct on the part of the licensee. The board believes that revocation is the appropriate penalty when grounds for discipline are found to exist. Grounds for

discipline include, but are not limited to the following violation(s) of law(s) involving:

- Possession of dangerous drugs and/or controlled substances
- Use of dangerous drugs and/or controlled substances
- Possession for sale of dangerous drugs and/or controlled substances
- Personal misuse of drugs or alcohol

If revocation is not imposed, the board recommends a minimum of a Category III level of discipline be imposed on the pharmacy technician. This would include suspension and probation."

10. By reason of Findings 1 through 20 and Conclusions 1 through 9, respondent has engaged in unprofessional conduct: (i) pursuant to Business and Professions Code section 4301, subdivision (f); and (ii) pursuant to Business and Professions Code section 4301, subdivision (j), by violating Business and Professions Code sections 4059, 4060 and 11173.

11. By reason of Findings 1 through 20 and Conclusions 1 through 10, cause exists to revoke respondent's registration. Pursuant to the board's guidelines, revocation is normally the appropriate discipline to impose on pharmacy technicians. Further, respondent's violations were intentional, serious, and pervasive. Finally, respondent, who denied that he had committed any wrongful act, provided no evidence of actual rehabilitation. It is concluded that no measure of discipline short of outright revocation is sufficient to protect the public.

12. Business and Professions Code section 125.3 provides in pertinent part:

"(a) . . . in any order issued in resolution of a disciplinary proceeding before any board within the department . . . 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 the reasonable costs of investigation and enforcement of the case.

* * *

(d) The administrative law judge shall make a proposed finding of the amount of the reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). . . ."

13. As noted above, all claimed costs were reasonably incurred. Further, the Deputy Attorney General who represented complainant was very well prepared, exhibited great skill, and conducted herself in an exemplary professional manner throughout the course of the hearing.

Cause exists under Business and Professions Code section 125.3 to issue an order requiring respondent to pay the total amount of investigative and prosecutorial costs claimed, i.e., $12,345.50.

Accordingly, there is hereby issued the following:

ORDER

Technician Registration No. TCH 22736, issued to respondent Cornelius Cristian Seulean on June 16, 1997, is revoked. Respondent shall relinquish his pocket technician registration to the board within ten days of the effective date of this decision. Respondent may not petition the board for reinstatement of his revoked technician registration for three years from the effective date of this decision.

A condition of reinstatement shall be that the respondent is certified by the Pharmacy Technician Certification Board (PTCB) and provides satisfactory proof of certification to the board.

A further condition of reinstatement shall be that prior to reinstatement of his technician registration, respondent shall have reimbursed the board for its costs of investigation and prosecution in the amount of $12,345.50. If the respondent fails to pay the amount specified, his or her technician registration shall remain revoked.

DATED: November 22, 2010

DONALD P. COLE
Administrative Law Judge
Office of Administrative Hearings

EDMUND G. BROWN JR.
Attorney General of California
LINDA K. SCHNEIDER
Supervising Deputy Attorney General
MARICHELLE S. TAHIMIC
Deputy Attorney General
State Bar No. 147392
110 West "A" Street, Suite 1100
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-3154
Facsimile: (619) 645-2061
Attorneys for Complainant

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

In the Matter of the Accusation Against: **CORNELIUS CRISTIAN SEULEAN** **11225 Ramway Road** **Riverside, CA 92505** **Pharmacy Technician License No. TCH 22736** Respondent.	Case No. 3418 **ACCUSATION**

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 June 16, 1997, the Board of Pharmacy issued Pharmacy Technician license Number TCH 22736 to Cornelius Cristian Seulean (Respondent). The Pharmacy Technician license was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2010, 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.

4. Section 4300 of the Code states:

> (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.
>
> ....

5. Section 118, subdivision (b), of the Code provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY PROVISIONS

6. 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.
>
> ...
>
> (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.
>
> ....

///

7. Section 4059, subdivision (a) of the Code states:

(a) A person may not furnish any dangerous drug, except upon the prescription of a physician, dentist, podiatrist, optometrist, or veterinarian. A person may not furnish any dangerous device, except upon the prescription of a physician, dentist, podiatrist, optometrist, or veterinarian.

8. 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, or 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, a 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, physician, podisatrist, dentist, 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, or a physician assistant, or a naturopathic doctor, to order his or her own stock of dangerous drugs and devices.

9. Section 11173, subdivision (a) of the California Health and Safety Code states:

"(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact."

COST RECOVERY

10. Section 125.3 of the Code states, in pertinent part, that the 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.

DRUGS

11. **Alprazolam**, the generic name for Xanax, is a Schedule IV controlled substance under California Health and Safety Code section 11057(d)(1), and is classified as a dangerous drug pursuant to Business and Professions Code section 4022. Alprazolam tablets are indicated for the management of anxiety disorder or the short-term relief of symptoms of anxiety.

12. **Tylenol with codeine** (acetaminophen with codeine) is a Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(2).

13. **Restoril**, a brand name for temazepam, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(29), and is a dangerous drug pursuant to Business and Professions Code section 4022. Restoril is a central nervous depressant used to treat insomnia and sleep disorders.

14. **Dronabinol**, the generic name of Marinol, is a Schedule III controlled substance as designated by Health and Safety Code section 11056(h), and is a dangerous drug pursuant to Business and Professions Code section 4022.

15. **Hydrocodone bitartate/acetaminophen**, also known by the brand names Vicodin, Norco, Zydone, Maxidone, Lortab, Lorcet, Hydrocet, Co-Gesic, and Anexsia, is a narcotic Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(4), and is a dangerous drug pursuant to Business and Professions Code section 4022. Hydrocodone is used as a narcotic analgesic in the relief of pain.

16. **Oxycodone**, also sold under the brand name OxyContin, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(N), and is a dangerous drug pursuant to Business and Professions Code section 4022.

17. **Diazepam**, sold under the brand name Valium, is a Schedule IV controlled substance as designated by Health and Safety Code Section 11057(d)(9), and is a dangerous drug pursuant to Business and Professions Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct in the Commission of an Act Involving Dishonesty, Fraud, Deceit)

18. Respondent is subject to disciplinary action under Business and Professions Code section 4301, subdivision (f) for committing an act involving moral turpitude, dishonesty, fraud or deceit in that during the period from April, 2007 through August, 2008, while Respondent was employed as a lead pharmacy technician at Loma Linda University Medical Center, Respondent diverted 6,540 tablets of various controlled substances, including diazepam, Norco, Marinol,

temazepam, acetaminophen with codeine, Vicodin, Xanax, and Oxycontin, from the hospital pharmacy's electronic vault/dispensing system. The facts are as follows:

19. Between January, 2007 and August, 2008, Loma Linda University Medical Center (the "hospital") kept controlled substances in a central area in the pharmacy. The hospital's controlled substances were kept in an electronic vault in the pharmacy called the McKesson NarcStation ("NarcStation"). The hospital floors have smaller AcuDose machines in which smaller doses of controlled substance were kept. The AcuDose machines were refilled from "daily issues" obtained by the Narcotics Technician from the NarcStation. During this period, Respondent was the Narcotic Technician on weekends. "Daily issues" were done once a day, in the morning. The process for obtaining batch refills of "daily issues" was that the technician began by entering his user identification and his pass code to access the NarcStation and then selected "daily issue" from the screen. A list of all the hospital's AcuDose machines appeared on the screen and the Narcotics Technican selected which AcuDose machine to refill. The NarcStation would then connect to the selected AcuDose machine and downloaded a list of all the controlled medication that needed to be refilled. Once the technician selected "Process" on the screen, the doors of the vault opened to each medication and the technician would remove the entire amount dispensed to refill all of the AcuDose machines. When this process was completed, the NarcStation printed a sheet listing the narcotics and quantities to refill each AcuDose machine. The technician then filled individual Ziplock bags for each AcuDose machine using the narcotics identified and quantities specified on the printed sheet. The bags were labeled and the contents of each Ziplock bag were verified by a pharmacist. The bags were subsequently taken to the respective AcuDose machines to be refilled. This was the "batch refill" procedure.

20. On August 4, 2008, L.L., the Narcotic Room Technician, discovered that there was a "daily issue" of Norco removed by Respondent for AcuDose Unit 6100 on August 3, 2008, which was not used to refill the AcuDose machine. L.L. ran a NarcStation transaction report for Norco for the period August 2-August 4, 2008 to determine why this transaction had not been completed properly. The report revealed irregularities: 1) there were two "daily issues" on both August 2 and August 3, 2008, when "daily issues" should occur only once each morning for all the

AcuDose machines; and, 2) a "zero return" was processed a minute after the second "daily issue" was entered on both days.

21. Transactions requiring a "zero return" to complete occur when: 1) narcotics were signed out to an individual patient; 2) narcotics were used to refill units that do not have AcuDose machines; 3) manual issues were obtained to add to an AcuDose machine's inventory; and, 4) when the person delivering the narcotics did not use the batch refill option, as described in paragraph 17. However, there was a "glitch" in this system in that using a zero return after narcotics were withdrawn "closed" or completed the transaction even though the narcotics withdrawn were not delivered to the AcuDose machines. Therefore, no discrepancy in withdrawals and refills to the AcuDose machines appeared in the narcotics count of the NarcStation.

22. L.L.'s discovery of the open Norco transaction prompted additional investigation that subsequently revealed that there were multiple withdrawals of Norco, Oxycontin, Vicodin, Tylenol with codeine, Dronabinol, Percocet, Lorazepam and Alprazolam from the NarcStation, followed immediately by zero returns beginning in April, 2007 until August 3, 2008. The only withdrawals which had zero returns were made by Respondent and another employee, S.H. However, time and attendance records showed that S.H. was not clocked in during the transactions made under S.H.'s user identification and pass code. On the other hand, Respondent was the only employee clocked in at the time of every zero return transaction that resulted in diversion.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Violation of Health and Safety Code section 11173(a))

23. Respondent is subject to disciplinary action under Business and Professions Code section 4301, subdivision (j) for violating Health and Safety Code section 11173(a) in that Respondent obtained controlled substances by fraud, deceit, misrepresentation, or subterfuge or by the concealment of a material fact when Respondent used the "zero return" glitch in Loma Linda University Medical Center's NarcStation to obtain 6,540 tablets of various controlled

substances from the hospital pharmacy's electronic vault/dispensing system from April 2007 through August 3, 2008, as more fully set forth in paragraphs 16-20, above.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Furnishing a Controlled Substance Without a Prescription)

24. Respondent is subject to disciplinary action under Business and Professions Code section 4301, subdivision (j) for violating Business and Professions Code section 4059(a) in that Respondent obtained controlled substances without a prescription when he used the "zero return" glitch in Loma Linda University Medical Center's NarcStation to obtain 6,540 tablets of various controlled substances from the hospital pharmacy's electronic vault/dispensing system from April 2007 through August 3, 2008, as more fully set forth in paragraphs 16-20, above.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Possession of a Controlled Substance Without a Prescription)

25. Respondent is subject to disciplinary action under Business and Professions Code section 4301, subdivision (j) for violating Business and Professions Code section 4060 in that Respondent possessed controlled substances without a prescription by using the "zero return" glitch in Loma Linda University Medical Center's NarcStation to obtain 6,540 tablets of various controlled substances from the hospital pharmacy's electronic vault/dispensing system from April 2007 through August 3, 2008, as more fully set forth in paragraphs 16-20, above.

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 Number TCH 22736, issued to Cornelius Cristian Seulean.

2. Ordering Cornelius Cristian Seulean 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;

///

///

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

DATED: 10/12/09

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

SD2009312038
70213404.doc