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

| | |
|---|---|
| **In the Matter of the Accusation Against:**<br><br>**LOS ANGELES COUNTY/USC MEDICAL CENTER**<br>1200 North State St. RM A1C109<br>Los Angeles, CA 90033<br><br>**Pharmacy Permit No. PHE 49214**<br><br>And<br><br>**ALAN R. SIU**<br>1990 Del Mar Avenue<br>San Marino, CA 91108<br><br>**Pharmacist License No. RPH 38427**<br><br>Respondents. | Case No. 5883<br><br>**AS TO LOS ANGELES OUNTY/USC MEDICAL CENTER ONLY** |

## DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order for Public Reproval is hereby adopted by the Board of Pharmacy, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective at 5:00 p.m. on May 5, 2017.

It is so ORDERED on April 5, 2017.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By _____
Amy Gutierrez, Pharm.D.
Board President

XAVIER BECERRA
Attorney General of California
LINDA L. SUN
Supervising Deputy Attorney General
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*Attorneys for Complainant*

**BEFORE THE**
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**STATE OF CALIFORNIA**

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| In the Matter of the Accusation Against:<br><br>**LOS ANGELES COUNTY/USC MEDICAL CENTER**<br>1200 North State St. RM A1C109<br>Los Angeles, CA 90033<br><br>**Pharmacy Permit No. PHE 49214**<br><br>And<br><br>**ALAN R. SIU**<br>1990 Del Mar Avenue<br>San Marino, CA 91108<br><br>**Pharmacist License No. RPH 38427**<br><br>Respondent. | Case No. 5883<br><br>**STIPULATED SETTLEMENT AND DISCIPLINARY ORDER FOR PUBLIC REPROVAL AS TO LOS ANGELES COUNTY/USC MEDICAL CENTER ONLY**<br><br>**[Bus. & Prof. Code § 495].** |

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Virginia Herold (Complainant) is the Executive Officer of the Board of Pharmacy (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Helene E. Rouse, Deputy Attorney General.

2. Respondent County of Los Angeles, dba Los Angeles County/USC Medical Center, Bonnie Bilitch, Interim Chief Executive Officer (Respondent) is represented in this proceeding by James A. Johnson, Deputy County Counsel, whose address is: 648 Kenneth Hahn Hall of Administration, 500 West Temple Street, Los Angeles, California 90012-2713 (telephone: (213) 974-0693).

JURISDICTION

3. On or about August 25, 2008, the Board issued Pharmacy Permit No. PHE 49214 to County of Los Angeles, dba Los Angeles County/USC Medical Center, Bonnie Bilitch, Interim Chief Executive Officer (Respondent). The Pharmacy Permit was in full force and effect at all times relevant to the charges brought in Accusation No. 5883 and will expire on November 1, 2017, unless renewed.

4. Accusation No. 5883 was filed before the Board of Pharmacy (Board), Department of Consumer Affairs and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on November 9, 2016. Respondent timely filed its Notice of Defense contesting the Accusation. A copy of Accusation No. 5883 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 5883. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order for Public Reproval.

6. Respondent is fully aware of its legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at its own expense; the right to confront and cross-examine the witnesses against them; the right to present evidence and to testify on its own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Accusation No. 5883. Respondent agrees that its Pharmacy Permit is subject to discipline and it agrees to be bound by the Disciplinary Order below.

CONTINGENCY

9. This stipulation shall be subject to approval by the Board of Pharmacy. Respondent understands and agrees that counsel for Complainant and the staff of the Board of Pharmacy may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or its counsel. By signing the stipulation, Respondent understands and agrees that they may not withdraw its agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order for Public Reproval shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

10. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order for Public Reproval, including Portable Document Format (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

11. This Stipulated Settlement and Disciplinary Order for Public Reproval is intended by the parties to be an integrated writing representing the complete, final, and exclusive embodiment of their agreement. It supersedes any and all prior or contemporaneous agreements, understandings, discussions, negotiations, and commitments (written or oral). This Stipulated Settlement and Disciplinary Order for Public Reproval may not be altered, amended, modified, supplemented, or otherwise changed except by a writing executed by an authorized representative of each of the parties.

12. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

## DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Pharmacy Permit No. PHE 49214 issued to Respondent County of Los Angeles, dba Los Angeles County/USC Medical Center, Bonnie Bilitch, Interim Chief Executive Officer (Respondent) shall be publicly reproved by the Board of Pharmacy under Business and Professions Code section 495 in resolution of Accusation No. 5883, attached as Exhibit A.

IT IS FURTHER ORDERED that Respondent shall comply with the terms and conditions as set forth below. Any violation of the terms and conditions shall constitute unprofessional conduct and grounds for further disciplinary action.

**Cost Recovery.** Respondent shall pay $3,621.62 to the Board for its costs associated with the investigation and enforcement of this matter. Respondent shall be permitted to pay these costs in a payment plan approved by the Board. If Respondent fails to pay the Board costs as ordered, Respondent shall not be allowed to renew their Pharmacy Permit until Respondent pays costs in full.

## ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order for Public Reproval and have fully discussed it with my attorney, James A. Johnson. I understand the stipulation and the effect it will have on my Pharmacy Permit. I enter into this Stipulated Settlement and Disciplinary Order for Public Reproval voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: 2/7/2017

COUNTY OF LOS ANGELES, DBA LOS ANGELES COUNTY/USC MEDICAL CENTER, BONNIE BILITCH, INTERIM CHIEF EXECUTIVE OFFICER
*Respondent*

I have read and fully discussed with Respondent County of Los Angeles, dba Los Angeles County/USC Medical Center, Bonnie Bilitch, Interim Chief Executive Officer the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order for Public Reproval. I approve its form and content.

DATED: 2/8/2017

JAMES A. JOHNSON, DEPUTY COUNTY COUNSEL
*Attorney for Respondent*

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order for Public Reproval is hereby respectfully submitted for consideration by the Board of Pharmacy of the Department of Consumer Affairs.

Dated: ~~February~~ March 7, 2017

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
LINDA L. SUN
Supervising Deputy Attorney General

HELENE E. ROUSE
Deputy Attorney General
*Attorneys for Complainant*

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**Exhibit A**

**Accusation No. 5883**

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*Attorneys for Complainant*

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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 (Board).

2. On or about August 24, 2008, the Board issued Pharmacy Permit No. PHE 49214 to County of Los Angeles to do business as Los Angeles County/USC Medical Center (LAC/USC Medical Center and/or Respondent), a pharmacy located at 1200 North State St. RM A1C109,

Los Angeles, CA 900033. The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on November 1, 2017, unless renewed.

3. On or about March 23, 1984, the Board issued Pharmacist License RPH No. 38427 to Alan H. Siu (Respondent Siu), which License was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2018, unless renewed. From April 1, 2011 through April 1, 2015, Respondent Siu was the Pharmacist-in-Charge (PIC) for Respondent LAC/USC Medical Center.

## JURISDICTION

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

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 4024 states, in pertinent part:

(a) Except as provided in subdivision (b), "dispense" means the furnishing of drugs or devices upon a prescription from a physician, dentist, optometrist, podiatrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or upon an order to furnish drugs or transmit a prescription from a certified nurse-midwife, nurse practitioner, physician assistant, naturopathic doctor pursuant to Section 3640.5, or pharmacist acting within the scope of his or her practice.

10. Section 4036.5 states that "'Pharmacist-in-charge' means a pharmacist proposed by a pharmacy and approved by the board as the supervisor or manager responsible for ensuring the pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy."

11. Section 4059 states, in pertinent part, that "(a) A person may not furnish any dangerous drug, except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor . . .".

12. Section 4060 of the Code states, in pertinent part, that "A person shall not possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, veterinarian . . . or furnished pursuant to a drug order issued by a certified nurse-midwife, nurse practitioner, or a physician assistant."

13. Section 4105 of the Code states, in pertinent part, that "(a) All records or other documentation of the acquisition and disposition of dangerous drugs and dangerous devices by any entity licensed by the board shall be retained on the licensed premises in a readily retrievable form."

14. Section 4113 states, in pertinent part, that "(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."

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15. Section 4126.5 states, in relevant part, that:

(a) A pharmacy may furnish dangerous drugs only to the following:

(1) A wholesaler owned or under common control by the wholesaler from whom the dangerous drug was acquired.

(2) The pharmaceutical manufacturer from whom the dangerous drug was acquired.

(3) A licensed wholesaler acting as a reverse distributor.

(4) Another pharmacy or wholesaler to alleviate a temporary shortage of a dangerous drug that could result in the denial of the health care. A pharmacy furnishing dangerous pursuant to this paragraph may only furnish a quantity sufficient to alleviate the temporary shortage.

(5) A patient or to another pharmacy pursuant to a prescription or as otherwise authorized by law.

(6) A health care provider that is not a pharmacy but is authorized to purchase dangerous drugs.

(7) To another pharmacy under common control.

16. Section 4301 of the Code 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:

* * * *

(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.

17. Health and Safety Code section 11152 states that "No person shall write, issue, fill, compound, or dispense a prescription that does not conform to this division."

18. Health and Safety Code section 11153 provides as follows:

(a) A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. Except as authorized by this division, the following are not legal prescriptions: (1)

an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of controlled substances, which is issued not in the course of professional treatment or as part of any authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use.

19. Health and Safety Code section 11157 provides that "No person shall issue a prescription that is false or fictitious in any respect."

20. Health and Safety Code section 11158, subdivision (a), states:

Except as provided in Section 11159 or in subdivision (b) of this section, no controlled substance classified in Schedule II shall be dispensed without a prescription meeting the requirements of this chapter. Except as provided in Section 11159 or when dispensed directly to an ultimate user by a practitioner, other than a pharmacist or pharmacy, no controlled substance classified in Schedule III, IV, or V may be dispensed without a prescription meeting the requirements of this chapter.

21. Health and Safety Code section 11164, subdivision (a), states "Except as provided in Section 11167, no person shall prescribe a controlled substance, nor shall any person fill, compound, or dispense a prescription for a controlled substance, unless it complies with the requirements of this section.

22. Health and Safety Code section 11171 provides that no person shall prescribe, administer, or furnish a controlled substance except under the conditions and in the manner provided by this division.

## REGULATORY PROVISIONS

23. California Code of Regulations, title 16, section 1709.1 provides that: "(a) The pharmacist-in-charge of a pharmacy shall be employed at that location and shall have responsibility for the daily operation of the pharmacy."

24. California Code of Regulations, title 16, section 1714, subdivisions (b) and (d) provides that:

* * * *

(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.

25. California Code of Regulations, title 16, section 1761 provides:

(a) No pharmacist shall compound or dispense any prescription which contains any significant error, omission, irregularity, uncertainty, ambiguity or alteration. Upon receipt of any such prescription, the pharmacist shall contact the prescriber to obtain the information needed to validate the prescription.

(b) Even after conferring with the prescriber, a pharmacist shall not compound or dispense a controlled substance prescription where the pharmacist knows or has objective reason to know that said prescription was not issued for a legitimate medical purpose.

## COST RECOVERY

26. 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.

## CONTROLLED SUBSTANCES/DANGEROUS DRUGS

27. **"Norco"** (hydrocodone bitartrate and acetaminophen) 10mg/325 mg is an opioid which is used to treat moderate to severe pain, and is a brand name for Hydrocodone. Hydrocodone is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, and a dangerous drug pursuant to Section 4022.

## FACTS SUPPORTING CAUSES FOR DISCIPLINE

28. On April 28, 2014, the Board received a letter from Respondent Siu, who was serving as the PIC of LAC/USC Medical Center at that time, notifying the Board an employee of the medical center had filled, altered and/or forged controlled substance prescriptions through the pharmacy over a two-year period. On June 19, 2014, in response to a request from the Board, Respondent Siu sent the Board a copy of the U.S. Department of Justice, Drug Enforcement Administration (DEA), Office of Diversion Control online report, listing a total quantity loss of 8,850 hydrocodone/acetaminophen 10/325 mg tablets. The report also states the narcotics were suspected to have been fraudulently taken by a hospital employee over a two-year period of time.

29. Respondent Siu also provided a written statement about the fraudulent activity, which stated that on March 19, 2014, a pharmacy clerk, M.P. had notified Pharmacy Service Chief II, S.D., that she was concerned about an employee, L.L., who was working as a ward clerk on Ward 3C (the OB-GYN ward) of the hospital, because L.L. was coming to the pharmacy and picking up patient prescriptions. When M.P. became suspicious of L.L. and started asking questions, L.L. would not talk to M.P. and waited for other employees to conduct her transactions. M.P. requested other pharmacy staff make copies of L.L.'s signed receipts. S.D.'s investigation revealed that all of the patients L.L. picked up medications for were receiving Norco and were from Ward 3H (OB triage unit) of the hospital. In addition, S.D.'s investigation revealed that the physicians on Ward 3H do not normally write prescriptions for Norco because they prefer writing prescriptions for Percocet. The Human Resources Department removed L.L. from Ward 3C and notified the Los Angeles Sheriff's Department. S.D. was notified by the L.A. Sheriff's Department that they found blank prescriptions in L.L.'s possession. A statement from staff pharmacist L.L. documented that he had preformed an audit of generic Norco 10/325 tablets for the audit period from February 17, 2014 through March 25, 2014, which showed a loss of 298 tablets, or a difference of 2%.

30. On March 4, 2015, a Board Inspector conducted an inspection at LAC/USC Medical Center's Outpatient Pharmacy (the pharmacy). She met with PIC Siu and he informed the Inspector that the Department of Health Services (DHS) conducted a full investigation and would have additional information about the diversion case. The Inspector interviewed M.P., who confirmed that a clerk from Ward 3C would often state she was picking up medication for the patient to speed up the discharge process. L.L. had the appropriate patient identification cards to drop off the prescriptions and sometimes signed the patient's name instead of her own name. M.P. grew more suspicious of L.L. and receipts which L.L. signed for the patient prescriptions were copied. M.P. noticed L.L. began to "avoid" her help at the prescription intake window. After one of the prescriptions which L.L. picked up for a patient required a payment to the finance office, which L.L. was willing to pay for, M.P. notified S.D.

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31. Respondent Siu told the Inspector that S.D. conducted an investigation in conjunction with the nursing staff and he believed L.L. was placed on administrative leave or suspended from her job, pending the outcome of the DHS investigation. A new "Discharge Medication Pickup by Nursing Staff" Policy, #251, was instituted shortly after the incident to help prevent similar, future diversions of drugs. In addition, they acquired a new computer system in order to integrate the exchange of information between various departments of the hospital. The Inspector obtained a copy of Policy #251. The Inspector also obtained copies of 55 original prescriptions suspected of either being diverted, altered, or forged by the ward clerk.

32. On March 10, 2015, the Board's investigator spoke with DHS Investigator A.H., who informed him that he obtained information about the diversion from all different departments of the hospital and found shortfalls in the policies and procedures at various levels. A.H. stated the ward clerk, L.L., had access to patient prescriptions and would alter them from Percocet to Norco herself. L.L. may have obtained a controlled substance prescription pad from past resident doctors who were no longer at the facility. A.H. also indicated that L.L. was arrested by the L.A. Sheriff's Department, but no criminal charges were filed by the L.A. City attorneys (or L.A. District Attorney's Office). L.L. was placed on administrative leave and she filed a request to resign her position, effective March 31, 2015. Furthermore, A.H. found a policy allowing pharmacy staff access to a physician's directory to look up current resident doctors; however, this directory had not been properly maintained/updated and the amount of residents coming and going from the hospital made it extremely difficult to research current resident doctors. Also, it was common practice for younger resident physicians to write or make corrections to prescriptions adding to the potential confusion of prescription writing styles and causing there to be multiple types of ink on the prescriptions themselves.

33. The Board's Investigator subsequently requested and received a redacted copy of the DHS report related to L.L.'s diversion of drugs, which documented various violations, including but not limited to pharmacy supervision, in failing to ensure pharmacists were thoroughly screening controlled prescriptions for accuracy, for allowing non-pharmacists to pick up controlled substance medications, for failing to furnish drugs only to a patient with a

legitimate prescription, and the pharmacist's corresponding responsibility to ensure a prescription for a controlled substance is issued only for a legitimate medical purpose. The DHS report concluded that L.L. admitted to altering and forging prescriptions allowing her to obtain Norco from the pharmacy. L.L. was able to obtain Norco because the pharmacy released controlled substances to a non-licensed employee, in violation of LAC/USC Medical Center Department of Nursing Services Policy #922. Moreover, the report concluded that the unmaintained electronic database of clinician credentialing information was operational, but was not routinely utilized by pharmacists and pharmacy staff when screening and verifying prescribers' credentialing information before approving prescriptions.

34. Furthermore, the DHS report indicated that 38 of the 51 prescriptions appeared to have been forged and 13 appeared to have been altered. The dates on the prescriptions were often backdated and did not correlate with the dates the patients were seen at the medical center. The fraudulent prescriptions were written by 19 past and present LAC/USC Medical Center physician post-graduates assigned to the OB-GYN 3C and 3H ambulatory care areas where L.L. worked. None of the patients complained that they did not receive their medications.

35. Between April 7, 2015 and April 17, 2015, the Board's Investigator requested and received additional information and documents from Respondent Siu related to LAC/USC Medical Center pharmacy's policies and procedures related to the processing of prescriptions.

36. The prescriptions obtained from LAC/USC Medical Center involved 62 total prescriptions, the majority of which were written for, or altered to, Norco 10/325 mg, and were dated between February 2, 2012 and February 22, 2014. The evidence appeared to show that L.L. gained possession of the controlled prescription pads of multiple physicians to forge 37 prescriptions for Norco 10/325 mg and two prescriptions for Colace 100 mg (a stool softener).

37. Prescription RX# 0121871884600 for Patient I.R. dated June 23, 2012 was changed from Colace to Norco 10/325 mg of 60 tablets with an additional refill. The date on the prescription appears to have been altered. These two combined items make for a potentially erroneous or uncertain prescription which required further investigation by a pharmacist to verify the prescription's legitimacy, which apparently was not done. Similarly, Prescription RX#

0121531800 for Patient R.R. dated June 27, 2012 was originally written for Colace and altered by the addition of Norco 10/325 mg to the prescription and an alteration to the date. The majority of the altered prescriptions had the intended controlled substance (Percocet 5/325 mg) crossed out and Norco 10/325 mg written into the next empty box of the prescription. In each case, the Percocet was written for a quantity between 30-50 tablets with no additional refills, and the addition of the Norco were all written for a quantity of 60 tablets and three additional refills. These alterations make for a potentially erroneous or uncertain prescription requiring further investigation by the pharmacist to verify their legitimacy.

38. Because all of the altered prescriptions appear to have the changes made in a different handwriting and, in some instances, a different colored ink pen, they make for a potentially erroneous or uncertain prescription requiring further investigation by the pharmacist to verify their legitimacy. After reviewing all of the prescription data and summarizing the total quantity of controlled substances available (original quantity and additional refills), the Board's Investigator prepared the following table:

| Drug | Diverted Rx | Altered Rx | Forged Rx | Total No. of Tablets |
|---|---|---|---|---|
| Norco 10/325 mg | 245 | 2,100 | 7,020 | 9,365 |
| Percocet 5/325 mg | 20 | 0 | 0 | 20 |

39. On May 6, 2015, the Board's Investigator had a conference call with Respondent Siu, Pharmacy Director S.M. and Pharmacy Supervisors S.D. and B.B. for the purpose of having them explain the steps which they took to investigate L.L.'s theft/diversion of the hydrocodone and provide updated findings and documentation about the final count of 8,895 tablets. Respondent Siu indicated that refills for prescriptions could have been called into the automated refill line and the generic patient ID cards (no picture ID was required for medications schedule CIII or below) could have been generated on the ward where L.L. worked and had access to the patients' records. In addition, prior to the audit, all stock bottles with schedule CIII and below were stored in a locked cabinet in the Main Pharmacy with numerous "open" bottles on the pharmacy dispensing line. The medications were inventoried on a monthly basis. After the audit on or

about March 25, 2014, the number of "open" bottles were limited, inventory checks were increased to every other week, and specific "controlled substance cabinet" pharmacists were assigned per shift with key access to the cabinet, among other changes.

40. On May 15, 2015, the Board's Investigator received an e-mail from Respondent Siu, with various reports attached, including but not limited to a summary which lists the final, updated count of Norco 10/325 mg dispensed to L.L. by way of diversion, alteration or forgery as 8,895 tablets.

41. The Board's Investigator prepared an updated table related to the quantity of controlled substances which were diverted, altered and/or forged by L.L., based upon a comparison of LAC/USC Medical Center's dispensing data and original prescriptions, as follows:

| Drug | Diverted Rx | Altered Rx | Forged Rx | Total No. of Tablets |
|---|---|---|---|---|
| Norco 10/325 mg | 15 | 1,980 | 6,900 | 8,895 |
| Percocet 5/325 mg | 0 | | | 0 |

42. On June 10, 2015, in response to the Board's Investigator's e-mail, Respondent Siu replied to his e-mail with additional information. Respondent Siu stated that the pharmacists did not report any of the prescriptions at issue to the Quantifi computer system and the pharmacists did not realize these prescriptions were forged at the time of dispensing.

43. The Board's investigation confirmed that there were similar violations of policy and procedure by pharmacy staff as those documented in the DHS report. The pharmacy staff failed to ensure the security of the prescription department against the potential diversion of medications by not utilizing the file of credentialed LAC/USC Medical Center clinicians, per Pharmacy Department Policy and Procedure Manual #605, and by not verifying the authenticity of any of L.L.'s questionable prescriptions as required by their Pharmacy Department Policy and Procedure Manual, #240 (Pharmacy Interventions) and #205 (Outpatient Prescription Guidelines). In addition, the pharmacy staff should have been educated on Nursing Services Police #922 (controlled substances will be handled only by licensed staff), and should not have allowed L.L. to "transport" controlled substance discharge medications of the hospital because she was employed as an unlicensed ward clerk.

**FIRST CAUSE FOR DISCIPLINE**
**(Respondents LAC/USC Medical Center and Siu - Prescriptions Containing Errors, Omissions, Irregularities, Uncertainties and/or Alterations)**

44. Respondent LAC/USC Medical Center and Respondent Siu, while employed as the PIC of LAC/USC Medical Center, have subjected their pharmacy permit and pharmacist license, respectively, to discipline for unprofessional conduct pursuant to Sections 4301, subdivisions (j) and/or (o), in conjunction with Sections 4059, 4060 and 4113, Health and Safety Code sections 11152, 11153, 11157, 11158, subdivision (a), 11164, 11167 and 11171, and California Code of Regulations, title 16, sections 1709.1, 1716 and 1761, subdivisions (a) and (b), in that for a two-year period ending on April 22, 2014, an unlicensed ward clerk of LAC/USC Medical Center was able to alter 13 prescriptions for hydrocodone/ acetaminophen 10/325 mg, a narcotic controlled substance, in an amount totaling approximately 1,980 tablets, due to the pharmacy staff failing to uphold the pharmacy department's policies and procedures to determine the legitimacy of the altered prescriptions. The underlying facts and allegations are set forth with more particularity above, in Paragraphs 28-43, which are incorporated by reference.

**SECOND CAUSE FOR DISCIPLINE**
**(Respondent LAC/USC Medical Center - Failure to Maintain Effective Control and Security of Dangerous Drugs)**

45. Respondent LAC/USC Medical Center is subject to disciplinary action under Section 4301, subdivisions (o) and/or (j), in that Respondent violated California Code of Regulations, title 16, section 1714, subdivision (b), by failing to provide effective control and security against the loss or diversion of dangerous drugs/controlled substances. Specifically, an audit of LAC/USC Medical Center revealed a total loss of 298 tablets of hydrocodone/acetaminophen 10/325 mg, a controlled substance, by an unknown origin between the period of time from approximately February 17, 2012 and March 25, 2014, a variance of 2.1 percent, as set forth above in Paragraphs 28-43, which are incorporated by reference.

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**THIRD CAUSE FOR DISCIPLINE**
**(Respondent Siu – Operational Standards and Security)**

46. Respondent Siu is subject to disciplinary action under Section 4301, subdivisions (o) and (j) in that, while employed as the PIC of LAC/USC Medical Center, Respondent Siu violated Section 4113, subdivision (e) and California Code of Regulations, title 16, section 1714, subdivision (d), by failing to provide effective control and security against the loss or diversion of dangerous drugs/controlled substances from the pharmacy department. During an approximate two-year period ending on April 22, 2014, an unlicensed ward clerk of LAC/USC Medical Center was able to divert, alter and forge prescriptions for hydrocodone/ acetaminophen 10/325 mg, a controlled substance, in an amount totaling 8,895 tablets. In addition, a LAC/USC Medical Center audit revealed a total loss of 298 tablets of hydrocodone/acetaminophen 10/325 mg, by an unknown origin between approximately February 17, 2012 and March 25, 2014, a variance of 2.1%, as set forth above in Paragraphs 28-43, which are incorporated here by reference.

**FOURTH CAUSE FOR DISCIPLINE**
**(Respondents LAC/USC Medical Center and Siu - Furnishing Drugs Without a Prescription)**

47. Respondent LAC/USC Medical Center and Respondent Siu are subject to disciplinary action under Sections 4300 and 4301, subdivisions (j) and (o), on the grounds of unprofessional conduct, for violating Sections 4059, subdivision (a), 4126.5, subdivision (a) and 4113, and Health and Safety Code sections 11152, 11153, 11157, 11158, subdivision (a), 11164, subdivision (a), 11167 and 11171, for furnishing drugs/controlled substances without a legitimate prescription, as more fully set forth above in Paragraphs 28-43, and incorporated by reference.

**DISCIPLINE CONSIDERATIONS**

48. To determine the degree of discipline, Complainant alleges as follows:

a. On or about September 23, 2014, the Board issued administrative Citation No. CI 2013 59355 against Respondent LAC/USC Medical Center for failing to ensure that prescriptions were dispensed in containers correctly labeled with the strength of the drug(s) dispensed, in violation of Sections 4076, subdivision (a)(7) and 4077, subdivision (a). No fine was issued with the citation.

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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 Pharmacy Permit PHE No. 49214, issued to County of Los Angeles dba Los Angeles County/USC Medical Center;

2. Revoking or suspending Pharmacist License RPH No. 38427, issued to Alan R. Siu;

3. Ordering Respondent Alan R. Siu 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: 11/4/16

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