IN THE MATTER OF	*	**BEFORE THE**
FRANK LEUNG, P.D.	*	**STATE BOARD**
License No. 15395	*	**OF PHARMACY**
Respondent	*	**CASE NUMBER: 05-058**

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ORDER FOR SUMMARY SUSPENSION

Pursuant to Md. State Govt. Code Ann. §10-226 (c)(1999 Repl. Vol.), the State Board of Pharmacy (the "Board") hereby suspends the license to practice pharmacy in Maryland issued to Frank Leung, P.D., (the "Respondent"), under the Maryland Pharmacy Act (the "Act"), Md. Health Occ. Code Ann. § 12-101, et seq., (2000 Repl. Vol.). This Order is based on the following investigative findings, which the Board has reason to believe are true:

BACKGROUND

1. At all times relevant hereto, the Respondent was licensed to practice pharmacy in Maryland. The Respondent was first licensed on October 20, 1999. The Respondent's license expires on June 28, 2005.

2. At all times relevant hereto, the Respondent was employed as a dispensing pharmacist at Suburban Hospital in Bethesda, Maryland, in Montgomery County.

3. On or about September 7, 2004, it was discovered by a pharmacy technology specialist (Pharm Tech) that, on September 6, 2004, the Respondent had removed from

the PYXIS[1] machine three tablets of Oxycontin, 40 mg[2], as expired, but the pills were not returned to the pharmacy vault as required by hospital policy.

4. On September 8, 2004, the Respondent gave the Pharm Tech two Oxycontin, 40 mg, tablets and said they were in a return bin in the main pharmacy area. The Pharm Tech returned them to the vault.

5. After speaking with the Assistant Director of Pharmacy, the Pharm Tech realized that the returned pills were not expired. Thereupon the Pharm Tech and the Assistant Director of Pharmacy performed an inventory of the Oxycontin, 40 mg, tablets and found that none of the pills had expired. Upon further checking for any other discrepancies, the Pharm Tech identified the following:

A. Multiple inventories existed for several narcotics;

B. Many of the Controlled Dangerous Substances (CDS) had been listed as outdated;

C. There was a failure to return purported outdated drugs to the pharmacy vault;

D. There were two instances where the Respondent indicated that he dispensed from the Pyxis certain medication, but no indication on the Medication

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1 A Pyxis is an automated medication dispenser. To use it, a code is entered by an individual who has a password. That individual pulls the medication from the Pyxis. It also automatically records the time of withdrawal of medication, the name of the individual, the name of the patient for who it is being withdrawn, and the dosage amount. In addition, the Pyxis records the wasting of medication by an individual and who witnessed it. It records if medication has been returned to the Pyxis or if an individual mistakenly withdrew medication that is not needed. All the information comes in a printout. It is an objective way to keep records of the narcotic access rather than having individuals' doing a hand count.

2 OxyContin contains oxycodone HCL, an opioid agonist with an addiction potential similar to that of morphine. Opioid agonists are substances that act by attaching to specific proteins called opioid receptors, which are found in the brain, spinal cord, and gastrointestinal tract. When these drugs attach to certain opioid receptors in the brain and spinal cord they can effectively block the transmission of pain messages to the brain.

Administration Record (MAR) that these patients were actually given those meds at that time.

6. Thereafter, the Pharm Tech ran a controlled drug activity report for the Pyxis for the Respondent from 8/11-9/1/04 and found multiple events showing that the Respondent had removed narcotics and a few non-controlled medications using the outdate function, yet none of these had been returned to the vault.

7. The following is a list of medicines that were removed by the Respondent from 8/11/-9/10/04 from the Pyxis as expired but not returned to the pharmacy vault:

Percocet 10/325 mg tablets	–	50 tabs
Percocet 5/325 mg tablets	–	6 tabs
Oxycontin 20 mg tablets	–	43 tabs
Oxycontin 40 mg tablets	–	11 tabs
Morphine 30 mg Immediate Rel. Tabs	–	3 tabs
Morphine 30 mg Ext. Rel. Tabs	–	1 tab

8. The Pharm Tech then ran a report showing all medications dispensed directly to patients from the pharmacy, where no entries for these medications showing that same had been dispensed to them and/or no orders were found for these medicines:

Percocet 10/325 mg tablets	–	69
Oxycontin 10 mg	–	2
Oxycontin 20 mg	–	4
Oxycontin 40 mg	–	10
Oxycontin Oral Syringes 20 mg/ml	–	6

9. A listing of the total medications and costs follows:

Percocet 10/325 = 119 tabs total cost	$215.39
Percocet 5/325 = 6 tabs total cost	.60
Oxycontin 10 mg = 2 tabs total cost	1.72
Oxycontin 20 mg = 47 tabs total cost	76.71
Oxycontin 40 mg = 21 tabs total cost	59.85
Oxycodone Oral Syr = 6 syringes cost	2.76
Morphine 30mg IR = 3 tabs	1.86
Morphine 30 mg Ext. Rel = 1 tab cost	.05
	$358.94

10. Following this report, the Pharm Tech, Assistant Director and Director of the Pharmacy met with the Human Resources person and the Respondent, where this information was disclosed. The Respondent denied knowledge of how the discrepancies had occurred, whereupon the Respondent was suspended for three days, pending further hospital investigation.

11. Thereafter, the hospital investigated back to June 2004, when the Respondent first began employment there, and further discrepancies were discovered, such as more removals of pills as expired, but the pills could not be located.

12. As a result of these discoveries, a second meeting was held on September 16, 2004 with the Respondent and the individuals present at the first meeting, with the exception of the Pharm Tech. At that meeting, the Respondent denied taking the pills and indicated that he did not use them, but he could not provide a clear answer as to where he had put the pills when he removed them from the machine. The Respondent acknowledged that he had removed expired drugs from the machine. The Respondent was informed that, unless the missing drugs could be found, a report would be sent to the Board and to the Drug Enforcement Administration (DEA) as required. The Respondent continued to insist that he did not know what had happened to the missing drugs. Thereupon the meeting was closed, and the Respondent, and the Director and Assistant Director left the Human Resources Office.

13. After leaving the Office, however, the Director again asked the Respondent whether there was anything he needed to state in order to get "some closure." At that time, the Respondent said the he did have something to tell them, if they could speak in private.

14. Thereupon, the Respondent stated that he had been forced to resign from his previous job at CVS due to missing narcotics, which he stated that he had filled for his friends without valid prescriptions and/or refills. The Respondent also admitted taking narcotics from the pharmacy for himself, although he insisted that he was not addicted and not a regular user. The Respondent then apologized for lying.

15. The Respondent admitted that he was taking narcotics for his wife who had begun using them after she had lost a baby two years ago. The Respondent further admitted that he removed the narcotics from Suburban for his wife, friends and for himself, although he still denied having a drug addiction. The Respondent asked that he not be reported to the Board and stated that he wanted to get help for himself and his wife.

16. Thereafter, the three of them returned to the Human Resources Office where the above information was repeated. The Human Resources person contacted the Director of Occupational Health/Safety, who came to the Office and explained to the Respondent the next steps in the rehabilitation process. The Respondent was escorted to the Occupational Health/Safety Office for a drug screen and to be given information about the drug treatment program offered by Suburban.

17. As a result of the above, the Respondent was terminated from employment at Suburban and the Director filed a complaint with the Board.

FINDINGS OF FACT

1. As set forth above, the unauthorized taking of narcotics from one's employer and the unauthorized use of said drugs, as well as the fraudulent record-keeping regarding these drugs is a threat to the public health, welfare or safety.

2. The above actions also constitute violations of the Act. Specifically, the Respondent violated the following provisions of §12-313:

> (b) Subject to the hearing provisions of §12-315 of this subtitle, the Board, on the affirmative vote of a majority of its members then serving, may deny a license to any applicant, reprimand any licensee, place any licensee on probation; or suspend or revoke a license if the applicant or licensee:
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> (2) Fraudulently or deceptively uses a license;
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> (6) Willfully makes or files a false report or record as part of practicing pharmacy;
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> (14) Dispenses any drug, device, or diagnostic for which a prescription is required without a written, oral, or electronically transmitted prescription from an authorized prescriber;
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> (20) Is professionally, physically, or mentally incompetent;
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> (24) Violates any rule or regulation adopted by the Board[;].

The Board further charges the Respondent with violation of Code Md. Regs. tit. 10, 34.10 (November 12, 2001):

> .01 Patient Safety and Welfare.
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> A. A pharmacist shall:
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> (1) Abide by all federal and State laws relating to the practice of pharmacy and the dispensing, distribution, storage, and labeling of drugs and devices, including but not limited to:
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> (a) United States Code, Title 21,
> (b) Health-General Article, Titles 21 and 22, Annotated Code of Maryland,
> (c) Health Occupations Article, Title 12, Annotated Code of Maryland,
> (d) Criminal Law Article, Title 5, Annotated Code of Maryland, and
> (e) COMAR 10.19.03[;].

CONCLUSIONS OF LAW

Based on the foregoing, the Board finds that the public health, safety or welfare imperatively requires emergency action, pursuant to Md. St. Govt. Code Ann. ' 10-226(c)(2) (1999 Repl. Vol. and 2004 Supp.).

ORDER

Based on the foregoing, it is therefore ordered this 8th of November by majority vote of a quorum of the State Board of Pharmacy, by authority granted by the Board by Md. St. Govt. Code Ann. ' 10-226(c)(2) (1999 Repl. Vol. and 2004 Supp.), that the license held by the Respondent to practice pharmacy in Maryland, License No. 15395, is hereby **SUMMARILY SUSPENDED;** and be it further

ORDERED, that upon the Board's receipt of a written request from the Respondent, a Show Cause Hearing shall be scheduled within thirty days of said request, at which the Respondent will be given an opportunity to be heard as to whether the Summary Suspension should be lifted/terminated, regarding the Respondent's fitness to practice pharmacy and the danger to the public; and be it further

ORDERED, that the Respondent shall immediately turn over to the Board his wall certificate and wallet-sized license to practice pharmacy issued by the Board; and be it further

ORDERED, that this document constitutes a final Order of the Board and is therefore a public document for purposes of public disclosure, as required by Md. State Govt. Code Ann. §10-617(h) (1999 Repl. Vol. and 2004 Supp.).

Melvin N. Rubin, President
Board of Pharmacy

NOTICE OF HEARING

A Show Cause hearing to determine whether the Summary Suspension shall be lifted/terminated will be held before the Board at 4201 Patterson Avenue, Baltimore, 21215 following a written request by the Respondent for same.