IN THE MATTER OF

UGOCHUKWU AHUBELEM

Respondent

License No.: 27027

BEFORE THE

MARYLAND STATE

BOARD OF PHARMACY

Case No.: 22-356

ORDER FOR SUMMARY SUSPENSION

The Maryland State Board of Pharmacy (the "Board") hereby SUMMARILY SUSPENDS the license of UGOCHUKWU AHUBELEM (the "Respondent"), License Number 27027, to practice as a pharmacist in the State of Maryland. The Board takes such action pursuant to its authority under Md. Code Ann., State Gov't ("State Gov't") § 10-226(c)(2) (2021 Repl. Vol.) and Md. Code Regs. ("COMAR") 10.34.01.12, having concluded that the public health, safety, or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

Based on information received by, and made known to the Board, and the investigatory information obtained by, received by, and made known to and available to the Board, including the instances described below, the Board has reason to believe that the following facts are true: 1

- At all times relevant hereto, the Respondent was licensed to practice as a pharmacist in 1. the State of Maryland. The Respondent was first licensed as a pharmacist in Maryland on or about December 3, 2019. The Respondent's license expires on May 31, 2023.
- 2. At all times relevant hereto, the Respondent was employed as a Pharmacy Manager at a national chain pharmacy (the "Pharmacy")² located in Waldorf, Maryland.

¹ The statements regarding the Respondent's conduct are only intended to provide the Respondent with notice of the basis for the Board's action. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in this matter.

- 3. Prior to his position as a Pharmacy Manager, the Respondent had been employed by the Pharmacy for over 10 years first as a Pharmacy Services Associate, then progressing from Pharmacy Technician, to Pharmacy Intern, to Staff Pharmacist to his promotion as Pharmacy Manager on January 26, 2020.
- 4. On or about May 2, 2022, the Board received a <u>Controlled Substance Theft/Significant</u>

 <u>Loss One Business Day Notification</u> (the "Notice") from the Pharmacy. The Notice stated that on May 2, 2022, the Pharmacy had an occurrence it had classified as "employee pilferage."
- 5. By correspondence dated June 1, 2022, the Board received a <u>DEA (Drug Enforcement Agency) 106 Report of Theft or Loss of Controlled Substances</u> (the "Report") from the Pharmacy related to the loss referenced in the Notice.
- 6. The Report listed the controlled dangerous substances ("CDS") that were lost/stolen as:

Trade Name	NDC Number	Dosage Str.	Quality Lost/Stolen
Oxycodone HCL 10 MG Tablet	10702005601	10 MG	120
Oxycodone HCL 15 MG Tablet	107020000801	15 MG	112

7. The Report listed the value of the lost CDS as \$287.00.

Pharmacy Internal Investigation

8. In April 2022, the Pharmacy's District Asset Protection Leader ("DAPL") initiated an internal investigation after receiving information that the Respondent may be involved in CII drug diversion.

² For confidentiality and privacy purposes, the names of individuals and facilities involved in this case are not disclosed in this document. Upon written request, the Administrative Prosecutor will provide the information to the Respondent.

- 9. The DAPL reviewed video surveillance and records from the Pharmacy. The DAPL identified several points of concern:
 - a. On April 15, 2022, at approximately 1:47 p.m., the Respondent was observed on surveillance removing paper prescriptions from his back pocket.
 - b. On April 15, 2022, at approximately 1:50-1:56 p.m., the Respondent was observed entering the three prescriptions he pulled from his back pocket into the computer. The three prescriptions were later determined to be from a doctor located in Northwest Washington, DC ("Doctor 1").³ Doctor 1 is known to have disciplinary actions on his medical license from both Maryland and the District of Columbia following a conviction for Health Care Fraud and Tax Evasion and was currently under investigation by the Pharmacy.
 - c. On April 15, 2022, at approximately 1:57 p.m., the Respondent was observed on video folding the three paper prescriptions in his hand then walking back to the prescription bays and putting the folded paper prescriptions into his pants pocket.
 - d. On April 15, 2022, at approximately 3:54 p.m., the Respondent was observed on video searching through the filled CII prescriptions.
 - e. On April 15, 2022, at approximately 3:56 p.m., the Respondent was observed on video walking back to his workstation with two paper prescriptions that were pulled from the filling area.

³ The distance between Doctor 1's office and the Pharmacy was approximately 40 miles.

- f. On April 15, 2022, at approximately 4:06 p.m. 4:10 p.m., the Respondent was seen entering the information from the two paper prescriptions pulled from the filling area and as he does, he places a backtag that printed into his front pocket.
- g. On April 15, 2022, at approximately 4:10 p.m., the Respondent is observed on video placing the CII prescriptions he data entered back into the filling area.
- h. On April 16, 2022, at approximately 5:23 p.m., a female customer picks up two of the questionable CII prescriptions RX1 (Patient CN) and RX2 (Patient TP).
- i. On April 16, 2022, at approximately **5:30 p.m.**, a customer in the drive-thru picks up two of the questionable CII prescriptions RX3 (Patient JF) and RX4 (Patient JC).
- j. On April 16, 2022, at approximately **5:46 p.m.**, a male customer picks up the last questionable CII prescription RX5 (Patient DB).
- k. On April 26, 2022, the DAPL visited the Pharmacy to view the hard copies of the five questionable CII prescriptions only two of the hard copies were located. The DAPL then viewed the scans of the three missing prescriptions in order to pull the patient profiles for the questionable CII prescriptions.
- The DAPL determined that the two hard copies that were located had backtags that did not match the current fill and were found to have been used to fill multiple prescriptions.

- m. The DAPL also noted that many of the patient profiles had significant errors when compared to the hard copies and the scans of the hard copies:
 - a. RX1/Patient CN new profile the first name is spelled differently than the prescription; the prescriber listed in the profile is incorrect, and there is an obvious difference between the writing on the prescription and the pill count (there are questionable marks/alterations of the pill count).
 - b. RX2/Patient TP new profile there is already an established patient profile that contains the information that matches the prescription the last name is completely different from the prescription; the date of birth is different from the prescription; the address listed on the profile is completely different from the prescription.
 - c. RX3/Patient JF new profile there is an obvious difference between the writing on the prescription and the pill count (there are questionable marks/alterations of the pill count).
 - d. RX4/Patient JC new profile there is already an established patient profile that contains the information that matches the prescription, the last name is spelled differently than the prescription, the date of birth is different from the prescription, the address is different than what is written on the prescription.

- e. RX5/Patient DB new profile the first name is spelled differently than the prescription, the date of birth is different from the prescription, the prescriber listed in the profile is incorrect, and there is an obvious difference between the writing on the prescription and the pill count (there are questionable marks/alterations of the pill count).
- 10. On April 26, 2022, the DAPL interviewed the Respondent regarding the identified issues.
 The Respondent stated that while he remembers filling three prescriptions for the same drug and pill count from Doctor 1, he did not remember pulling prescriptions from his back pocket.
- 11. When the DAPL asked the Respondent if he noticed any red flags with the recent CII prescriptions, the Respondent stated that "it was very busy at that time, I was not looking for red flags." The Respondent added that the Pharmacy "is known for filling high quantity medication."
- 12. When the DAPL noted that in four of the five CII prescriptions he created profiles that contained names, dates of birth, and addresses that did not match the prescription, the Respondent stated that those errors "would've been a red flag if I caught it. It was probably my oversight. A medication error occurred because of [the] wrong name and DOB it happens due to lack of help or other distractions."
- 13. The DAPL asked the Respondent why he filled two prescriptions that had already been filled and filed. The Respondent stated, "there must have been a reason for that, but I do not recall."

- 14. When the DAPL asked if the Respondent validated any of the CII prescriptions on April 15, 2022, the Respondent explained, "No I did not. If we have to validate every single script that come[s] our way, nothing will get done. We use our professional judgment to determine scripts." The Respondent added that in the past he called to validate a prescription for promethazine with codeine because the computer "prompted me to." The Respondent noted that "promethazine with codeine is a drug that has a high rate of forgery, so I am always cautious at all times because I get a lot of forgeries every day."
- 15. At the conclusion of the interview, the Respondent added: "I've been with the company for a while to know better. Whatever I've done wrong was out of stress and not focused."
- 16. On or about May 10, 2022, the Pharmacy terminated the Respondent's employment.

Criminal Charges

- 17. On or about June 15, 2022, in the District Court for Charles County, Maryland the Respondent was charged with four (4) criminal misdemeanor counts related to the theft from the Pharmacy. The Respondent was charged with the following: two (2) counts of Forgery-Prescription and two (2) counts of Issue Forged Prescription. On September 6, 2022, the matter went to trial and all four counts were placed on the Stet docket.
- 18. Based on the above information, the Board has reason to believe that the Respondent knowingly participated in the diversion of CII drugs from his place of employment.

CONCLUSIONS OF LAW

Based on the foregoing investigative findings, the Board concludes as a matter of law that the public health, safety, or welfare imperatively require emergency action in this case, pursuant to State Gov't § 10-226(c)(2) and COMAR 10.34.01.12.

ORDER

Based on the foregoing Investigative Findings and Conclusions of Law, it is this 19th day of 10th 2022, by a majority of the quorum of the Board, hereby

ORDERED that pursuant to the authority vested in the Board by State Gov't § 10-226(c)(2) (2021 Repl. Vol.), the Respondent's license to practice as a pharmacist in the State of Maryland under license number 27027 is hereby **SUMMARILY SUSPENDED**; and it is further

ORDERED that the Respondent is prohibited from practicing as a pharmacist in the State of Maryland; and it is further

ORDERED that the Respondent shall immediately return all copies of his license to the Board; and it is further

ORDERED that the Respondent has the opportunity to appear before the Board for a post-deprivation show cause hearing. A request for a post-deprivation show cause hearing must be in writing and be made **WITHIN THIRTY (30) DAYS**; and it is further

ORDERED that if the Respondent fails to request a post-deprivation show cause hearing in writing in a timely manner, or if the Respondent requests a post-deprivation show cause hearing but fails to appear when scheduled, the Respondent's license will remain **SUSPENDED**; and it is further

ORDERED that this ORDER FOR SUMMARY SUSPENSION is a PUBLIC DOCUMENT pursuant to Md. Code Ann., Gen. Prov. §§ 4-101 et seq. (2019).

10-18-22

Deena Speights-Napata, M.A.

Executive Director, for

Jennifer L. Hardesty, Pharm.D.

President

Maryland Board of Pharmacy