2024R00188/CDC

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA	:	Hon. James B. Clark, III
	:	
v.	:	Mag. No. 24-12286
	:	
DAVID L. SHAEFFER	:	**CRIMINAL COMPLAINT**
	:	
	:	**FILED UNDER SEAL**

I, Timothy Ford, being duly sworn, state the following is true and correct to the best of my knowledge and belief:

SEE ATTACHMENT A

I further state that I am a Task Force Officer with the United States Drug Enforcement Administration, and that this complaint is based on the following facts:

SEE ATTACHMENT B

continued on the attached pages and made a part hereof.

/s/ *Timothy Ford*

Timothy Ford, Task Force Officer
U.S. Drug Enforcement
Administration

TFO Timothy Ford attested to this Affidavit by telephone pursuant to F.R.C.P. 4.1(B)(2)(A) on this 31st day of October, 2024.

/s/ *James B. Clark, III*

Hon. James B. Clark, III
United States Magistrate Judge

ATTACHMENT A

Count 1
(Unlawfully Acquiring or Obtaining Possession of a Controlled Substance By Misrepresentation, Fraud, Forgery, Deception and Subterfuge)

From on or about January 22, 2024 through on or about February 14, 2024, in Hudson County, in the District of New Jersey, and elsewhere, the defendant,

DAVID L. SHAEFFER,

did knowingly and intentionally acquire and obtain possession of a controlled substance, namely, fentanyl, a Schedule II controlled substance, by misrepresentation, fraud, forgery, deception, and subterfuge.

In violation of Title 21, United States Code, Section 843(a)(3).

ATTACHMENT B

I, Timothy Ford, am a Task Force Officer of the United States Drug Enforcement Administration ("DEA"). The information contained in this complaint is based upon my personal knowledge, as well as information obtained from other sources, including: (a) statements made or reported by various witnesses with knowledge of relevant facts; (b) my review of publicly available information; and (c) my review of evidence, including video surveillance, business records, reports, and other documents. Because this complaint is being submitted for a limited purpose, I have not set forth every fact that I know concerning this investigation. Where the contents of documents and the actions and statements of others are reported, they are reported in substance and in part, except where otherwise indicated. Where I assert that an event took place on a particular date, I am asserting that it took place on or about the date alleged.

The Controlled Substances Act

1. The Controlled Substances Act ("CSA"), 21 U.S.C. § 801 *et seq*., and regulations promulgated thereafter, classify controlled substances in five schedules depending on a drug's acceptable medical use, if any, and its potential for abuse.

2. Pursuant to Title 21, C.F.R. 1306.11(a) and 1306.21(a), controlled substances listed in Schedules II, III, IV, or V, that are prescription drugs, as determined under the Food, Drug, & Cosmetics Act, 21 U.S.C. § 301 *et seq*., may be dispensed only if prescribed by an authorized practitioner, that is, a licensed medical practitioner who is registered with the United States Drug Enforcement Administration ("DEA") and authorized to dispense controlled substances in the usual course of his or her professional medical practice for legitimate medical purposes.

3. Fentanyl is classified as a Schedule II controlled substance. 21 C.F.R. § 1308.12(c)(9).

4. In addition to other requirements imposed by the State of New Jersey, prescribing physicians or practitioners must also obtain and maintain a registration with the DEA authorizing them to prescribe controlled substances, in the Schedules in which they are registered. 21 C.F.R. § 1306.03. The DEA provides these practitioners with a unique DEA Registration Number ("DEA Number").

5. Federal regulations generally require written prescriptions for Schedule II controlled substances. 21 C.F.R. § 1306.11(a). However, oral prescriptions for Schedule II controlled substances are permitted by an authorized practitioner in case of an "emergency situation," as defined in 21 C.F.R. § 290.10. 21 C.F.R. § 1306.11(d).

6. Title 21, C.F.R. § 1306.04(a) sets forth the purpose of the issuance of a prescription. It says, in pertinent part, in order for "[a] prescription for a controlled substance to be effective, [it] must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice."

Background of the Investigation

7. At all times relevant to this Complaint, the defendant, DAVID L. SHAEFFER ("SHAEFFER"), was a registered nurse licensed in New Jersey, Florida, and Pennsylvania.

8. At no time relevant to this Complaint was SHAEFFER registered with the DEA as an individual authorized to prescribe controlled substances.

9. From at least as early as in or around September 2020 through at least as recently as in or around June 2024, SHAEFFER worked as a traveling nurse in the Interventional Radiology Unit at numerous hospitals, including but not limited to: a hospital in New Jersey (the "New Jersey Hospital"); a hospital in Florida (the "Florida Hospital"); and a hospital in Pennsylvania (the "Pennsylvania Hospital") (collectively, "Hospitals").

10. The DEA has been investigating thefts of fentanyl from the Hospitals by SHAEFFER. During the investigation, SHAEFFER was identified as engaging in a scheme where he used his position as a nurse to fraudulently acquire and steal vials of fentanyl while employed at the Hospitals. Specifically, during his employment at the Hospitals, SHAEFFER dispensed vials of liquid fentanyl from the Hospitals' automated dispensing cabinets ("ADCs")[1] for specified patients without the requisite doctor's order for the administration of fentanyl. Upon dispensing the fentanyl, SHAEFFER failed to either administer the fentanyl to the patient and/or failed to waste[2] the fentanyl. Law enforcement believes that

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[1] ADCs are computerized medicine cabinets in hospitals and healthcare facilities. ADCs store and dispense medication to authorized hospital employees for the administration to specified patients in patient care units. ADCs, such as Pyxis and Omnicell machines, require biometric and password login for authorized employees to access medication. Each ADC maintains an electronic record including documentation of each user access and all user entries, (*e.g.*, noting the date, time, and amount of medication removed, administered, and "wasted" (or, discarded), as well as the patient for whom the medication was prescribed). As an authorized employee, SHAEFFER was an authorized user of the ADCs and therefore had access to medication and controlled substances within the Hospitals' ADCs.

[2] Per hospital policy, a dispensed controlled substance that either exceeded the amount prescribed to a patient or was not administered to a patient must be "wasted,"

SHAEFFER did not waste the fentanyl but instead kept the fentanyl contained in the vials and wasted an unknown substance in the presence of the observation nurses in an attempt to conceal the thefts.

SHAEFFER Fraudulently Obtained Fentanyl from the New Jersey Hospital's ADCs

11. From on or about January 21, 2024 through on or about February 14, 2024, SHAEFFER was employed as a nurse in the Interventional Radiology Unit at the New Jersey Hospital.

12. On or about February 14, 2024, the New Jersey Hospital terminated SHAEFFER after an internal investigation revealed SHAEFFER stole hundreds of 100mcg/2mL vials of liquid fentanyl.

13. Based on the investigation to date, law enforcement has learned that, during his employment at the New Jersey Hospital, SHAEFFER logged into the ADCs and dispensed fentanyl approximately 143 times from numerous ADCs throughout the hospital; often from ADCs in patient care units outside of his assigned unit. ADC and hospital records revealed that SHAEFFER dispensed the fentanyl without the required doctor's order. The hospital records further revealed that SHAEFFER used an override to bypass the doctor order requirement and prescribed the fentanyl himself to a specified patient. In total, SHAEFFER dispensed approximately 29,300mcg/29.3mL of fentanyl between on or about January 22, 2024 and on or about February 14, 2024.

14. During the approximately 143 fentanyl pulls, SHAEFFER would: (1) dispense fentanyl and fail to administer the fentanyl to the specified patient or waste the fentanyl altogether; (2) dispense fentanyl and later waste the fentanyl but did not do so immediately as per hospital policy, and (3) dispense fentanyl for patients who had been discharged from the New Jersey Hospital. When SHAEFFER did waste fentanyl, he used various nurses to observe him wasting fentanyl. Law enforcement has learned that observation nurses reported that SHAEFFER purportedly wasted fentanyl in their presence from an unlabeled syringe. ADC records revealed that in several instances SHAEFFER pulled fentanyl and purportedly wasted the same amount of fentanyl.

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or discarded. For example, if a patient requires 50mcg of fentanyl that is stored in 100mcg vials, upon administering 50mcg of fentanyl, the nurse must "waste" the remaining 50mcg. Nurses are to "waste" medication in the presence of another nurse, or observation nurse. ADCs also record the identity of the observation nurse per waste.

Dispensing Fentanyl and Failing to Either Administer It to Patients or Waste It Altogether

15. For example, patient records reveal on or about January 29, 2024, SHAEFFER dispensed fentanyl for Patient-1 from an ADC in the Trauma unit: a unit outside of SHAEFFER's assigned unit. Patient-1 was neither prescribed fentanyl by a doctor nor was the fentanyl administered to Patient-1. Hospital surveillance footage confirmed SHAEFFER was the individual who dispensed the vials of fentanyl on this occasion.

16. On or about February 6, 2024, at approximately 5:19 p.m., SHAEFFER dispensed 300mcg of fentanyl for Patient-2 in the Emergency Department: an area outside of SHAEFFER's assigned unit. A review of hospital surveillance appears to show SHAEFFER motioning as if he were placing vials into his jacket pocket; however, he stops attempting to place the vials in his pocket once he observes the camera. SHAEFFER appears to keep the vials in his hand. Surveillance footage then shows SHAEFFER in the hallway of the Emergency Department and it appears that he does not have any vials in his hand. Patient-2 was never administered the fentanyl SHAEFFER dispensed.

Dispensing Fentanyl and Failing to Immediately Waste It

17. On or about February 6, 2024, at approximately 4:05 p.m., SHAEFFER dispensed 200mcg of fentanyl for Patient-3 from an ADC in the Emergency Department: an area outside of SHAEFFER's assigned unit. Hospital surveillance showed that at approximately 4:08 p.m., SHAEFFER entered the room with the ADC, and removed a vial from one drawer and another vial from a second drawer. SHAEFFER then exited the room and took supplies from a cart in the Emergency Department. At this time, it appears there are no vials in SHAEFFER's hands. At approximately 4:11 p.m., SHAEFFER is observed walking in the hallway with supplies in both hands. At approximately 4:15 p.m., SHAEFFER enters a bathroom with nothing in his hands but there appears to be items in his rear pants pocket. SHAEFFER remained in the bathroom for approximately 10 minutes. SHAEFFER did not administer any fentanyl to Patient-3, and purportedly wasted the fentanyl one-and-one-half hours later.

Dispensing Fentanyl for Discharged Patients

18. On or about January 22, 2024, Patient-4 was discharged from the New Jersey Hospital. ADC and patient records revealed that on or about the following day, January 23, 2024, at approximately 2:52 p.m., SHAEFFER dispensed 100mcg of fentanyl for Patient-4 after they were discharged. SHAEFFER dispensed the fentanyl for Patient-4 without the requisite doctor's order and used an override in the ADC to bypass the doctor's order requirement.

19. On or about February 7, 2024, Patient-5 was discharged from the New Jersey Hospital. On or about the following day, February 8, 2024, at approximately 8:44 a.m., SHAEFFER dispensed approximately 200mcg of fentanyl for Patient-5 after they were discharged. SHAEFFER dispensed the fentanyl for Patient-5 without the requisite doctor's order and used an override in the ADC to bypass the doctor's order requirement.

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21. The following represents the approximately 143 occasions where SHAEFFER dispensed fentanyl from ADCs at the New Jersey Hospital on or about January 22, 2024 through on or about February 14, 2024:

Approximate Date	**Approximate Amount Dispensed (mcg)**	**Approximate Amount Purportedly Wasted (mcg)**	**Approximate Amount Administered (mcg)**	**Approximate Amount Unreconciled[3] (mcg)**	**Approximate Amount Returned[4] (mcg)**
1/22/2024	100	100	0	0	0
1/23/2024	500	400	100	0	0
1/24/2024	900	900	0	0	0
1/25/2024	1100	1000	100	0	0
1/26/2024	1300	1300	0	0	0
1/29/2024	1300	1275	25	0	0
1/30/2024	1800	1600	0	200	0
1/31/2024	1900	1900	0	0	0
2/1/2024	1800	1600	0	200	0
2/5/2024	1900	1850	50	0	0
2/6/2024	2500	2375	125	0	0
2/7/2024	2200	2000	0	200	0
2/8/2024	2400	2400	0	0	0
2/9/2024	1200	1100	0	100	0
2/12/2024	3000	2800	0	200	0
2/13/2024	2600	2600	0	0	0
2/14/2024	2800	2800	0	0	0
Total:	**29,300**	**28,000**	**400**	**900**	**0**

[3] "Approximate Amount Unreconciled" reflects the approximate amount of fentanyl that was dispensed but not administered, wasted, or returned to the ADC and therefore its whereabouts are unknown.

[4] "Approximate Amount Returned" reflects the approximate amount of fentanyl that was returned to the ADC.

SHAEFFER Fraudulently Obtained Fentanyl from the Florida Hospital's ADCs

22. The investigation also revealed from in or around February 2022 to in or around May 2022, SHAEFFER was employed as a nurse in the Interventional Radiology Unit at the Florida Hospital.

23. During this period, SHAEFFER dispensed fentanyl for patients and purportedly wasted the fentanyl without administering it to patients. For example, on or about February 21, 2022, at approximately 3:51 p.m., SHAEFFER dispensed 100mcg of fentanyl for Patient-6 although Patient-6 had not been prescribed fentanyl by a doctor. SHAEFFER did not administer the fentanyl to Patient-6 and wasted it approximately 35 minutes later. Also, on or about April 29, 2022, at approximately 10:27 a.m., SHAEFFER dispensed 100mcg of fentanyl for Patient-7, who was an outpatient at the hospital for an ultrasound. SHAEFFER did not administer the fentanyl to Patient-7 and instead purportedly wasted the fentanyl approximately 11 minutes later.

24. Patient records also revealed that on at least one occasion, SHAEFFER dispensed fentanyl and failed to either administer or waste it. Specifically, on or about May 24, 2022, SHAEFFER dispensed 100mcg of fentanyl to Patient-8. However, the fentanyl dispensed was neither administered to Patient-8 nor wasted.

25. In total, this investigation has established that SHAEFFER unlawfully dispensed approximately 19,700mcg/19.7mL of fentanyl from the Florida Hospital.

26. The following represents the occasions where SHAEFFER dispensed fentanyl from ADCs at the Florida Hospital on or about February 9, 2022 through on or about May 27, 2022:

Approximate Date	**Approximate Amount Dispensed (mcg)**	**Approximate Amount Purportedly Wasted (mcg)**	**Approximate Amount Administered (mcg)**	**Approximate Amount Unreconciled[5] (mcg)**	**Approximate Amount Returned[6] (mcg)**
2/9/22	200	50	150	0	0
2/10/22	100	25	75	0	0
2/15/22	200	50	150	0	0
2/16/22	500	200	300	0	0
2/17/22	200	100	100	0	0
2/18/22	100	0	0	0	100
2/21/22	400	250	150	0	0
2/22/22	300	250	50	0	0
2/23/22	300	50	125	25	100
2/28/22	300	200	100	0	0
3/1/22	400	175	175	50	0
3/2/22	200	50	150	0	0
3/3/22	400	0	475	-75	0
3/4/22	200	75	25	100	0
3/13/22	100	50	50	0	0
3/14/22	300	125	175	0	0
3/16/22	100	0	100	0	0
3/17/22	300	25	225	50	0
3/18/22	600	300	300	0	0
3/21/22	700	350	350	0	0
3/23/22	300	50	250	0	0
3/24/22	700	350	350	0	0
3/25/22	400	200	125	75	0
3/28/22	300	200	50	50	0
3/30/22	300	150	150	0	0
3/31/22	400	200	200	0	0
4/1/22	500	250	0	250	0
4/6/22	500	150	350	0	0

[5] "Approximate Amount Unreconciled" reflects the approximate amount of fentanyl that was dispensed but not administered, wasted, or return to the ADC and therefore its whereabouts are unknown.

[6] "Approximate Amount Returned" reflects the approximate amount of fentanyl that was returned to the ADC.

Approximate Date	Approximate Amount Dispensed (mcg)	Approximate Amount Purportedly Wasted (mcg)	Approximate Amount Administered (mcg)	Approximate Amount Unreconciled (mcg)	Approximate Amount Returned (mcg)
4/8/22	200	150	0	50	0
4/11/22	400	150	250	0	0
4/12/22	200	175	25	0	0
4/13/22	200	75	125	0	0
4/14/22	300	200	100	0	0
4/15/22	300	200	100	0	0
4/16/22	200	200	0	0	0
4/18/22	500	225	275	0	0
4/19/22	200	150	50	0	0
4/21/22	500	200	300	0	0
4/22/22	400	300	100	0	0
4/25/22	300	250	50	0	0
4/26/22	400	225	175	0	0
4/27/22	100	75	25	0	0
4/28/22	500	425	75	0	0
4/29/22	500	200	300	0	0
5/3/22	700	250	450	0	0
5/4/22	200	125	50	25	0
5/5/22	100	100	0	0	0
5/6/22	500	125	375	0	0
5/9/22	400	150	250	0	0
5/10/22	1000	425	525	50	0
5/12/22	100	25	75	0	0
5/13/22	200	125	75	0	0
5/17/22	300	225	75	0	0
5/18/22	600	500	100	0	0
5/19/22	200	75	125	0	0
5/23/22	100	50	0	50	0
5/24/22	100	0	0	100	0
5/25/22	300	275	25	0	0
5/27/22	400	300	100	0	0
Total:	**19,700**	**9,825**	**8,875**	**800**	**200**

SHAEFFER Fraudulently Obtained Fentanyl from the Pennsylvania Hospital's ADC

27. Additionally, from on or about June 24, 2024 through on or about June 27, 2024, SHAEFFER was employed as a nurse in the Interventional Radiology

Unit of the Pennsylvania Hospital. SHAEFFER worked in the unit with one other nurse ("Nurse-1").

28. ADC records[7] revealed that on or about June 26, 2024, medication was dispensed from a machine that was neither administered nor wasted. As this is a sign of diversion, the hospital pharmacy then investigated the medication pull. The hospital investigation and ADC records revealed that at approximately 3:27 p.m., an individual using Nurse-1's log-in information dispensed 100mcg/2ml of fentanyl from the ADC for Patient-9. At the time, Patient-9 was no longer in the Interventional Radiology Department and was not prescribed fentanyl. The individual used an override to bypass the doctor order requirement to dispense the fentanyl.

29. The hospital investigation also revealed that Nurse-1 clocked out of work at approximately 3:26 p.m. that day; one minute before the fentanyl was dispensed under their login. SHAEFFER was the only other nurse present in the unit at the time. SHAEFFER clocked out and left work after approximately 3:27 p.m., the time when the fentanyl was dispensed.

30. Through this investigation, law enforcement has learned that Nurse-1 was assigned to train SHAEFFER in the Interventional Radiology Unit. On or about June 26, 2024, Nurse-1 and SHAEFFER were the only two employees in the unit. Nurse-1 logged into the ADC to dispense a non-narcotic medication. Law enforcement has further learned that the system kept Nurse-1 logged in but entered sleep mode, leaving Nurse-1's account still accessible. Nurse-1 then cared for a patient until approximately 3:00 p.m. Nurse-1 then remained in the unit with SHAEFFER until they clocked out at 3:26 p.m. The following day, Nurse-1 was interviewed by the Pennsylvania Hospital staff for its investigation into the fentanyl that was dispensed the previous day and denied having done so. Pursuant to hospital policy, Nurse-1 was required to take a drug test. Nurse-1 took and passed the drug test.

31. Law enforcement has learned that when Nurse-1 returned to the unit after the drug test, Nurse-1 announced to all unit employees, including SHAEFFER, that all unit employees would be drug tested and that the surveillance footage in the ADC would be reviewed. Law enforcement has also learned that SHAEFFER appeared nervous and asked Nurse-1 questions about the camera in the ADC. Approximately five minutes later, SHAEFFER stated he was not feeling well and was leaving. He stated that he notified his supervisor about his exit for the day.

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[7] This brand of ADCs, Omnicell, create exception reports for investigation if medication is pulled and neither administered nor wasted.

32. Hospital staff attempted to contact SHAEFFER to interview him and ask him to take a drug test. The staff learned that SHAEFFER unexpectedly left for the day. SHAEFFER stated to hospital staff that he left work early and advised his supervisor that he would be leaving early. The Pennsylvania Hospital checked with hospital supervisors and all confirmed that SHAEFFER did not advise anyone that he would be leaving early.

33. After that date, SHAEFFER never returned to work at the Pennsylvania Hospital and never contacted the hospital again.