KAMALA D. HARRIS
Attorney General of California
KAREN B. CHAPPELLE
Supervising Deputy Attorney General
WILLIAM D. GARDNER
Deputy Attorney General
State Bar No. 244817
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-2114
Facsimile: (213) 897-2804
Attorneys for Complainant

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

In the Matter of the Accusation Against: **WEST VAL PHARMACY, INC.** **5353 Balboa Blvd.** **Encino, CA 91316** **Pharmacy Permit No. PHY 11433,** **and** **SUSAN BENTOW** **182 Dapplegray Road** **Bell Canyon, CA 91307** **Pharmacist License No. RPH 35541** Respondent.	Case No. 4850 **A C C U S A T I O N**

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 February 1, 1984, the Board of Pharmacy issued Pharmacy Permit Number PHY 11433 to West Val Pharmacy, Inc. (Respondent Pharmacy). The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on February 1, 2014, unless renewed.

3. On or about August 18, 1980, the Board of Pharmacy issued Pharmacist License Number RPH 35541 to Susan Bentow (Respondent Bentow). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2014, unless renewed. Respondent Bentow is and has been the Secretary/Treasurer of Respondent Pharmacy since 1984.

JURISDICTION

4. This Accusation is brought before the Board of Pharmacy (Board), Department of Consumer Affairs, under the authority of the following laws.

5. **Section 4300** of the Business and Professions Code provides, in pertinent part, that every license issued by the Board is subject to discipline, including suspension or revocation.

6. **Section 4300.1** of the Business and Professions Code 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 4302** of the Business and Professions Code states:

"The board may deny, suspend, or revoke any license of a corporation where conditions exist in relation to any person holding 10 percent or more of the corporate stock of the corporation, or where conditions exist in relation to any officer or director of the corporation that would constitute grounds for disciplinary action against a licensee."

BUSINESS AND PROFESSIONS CODE

8. **Section 4059**, subdivision (a), of the Business and Professions Code states:

"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."

///

9. **Section 4063** of the Business and Professions Code states:

"No prescription for any dangerous drug or dangerous device may be refilled except upon authorization of the prescriber. The authorization may be given orally or at the time of giving the original prescription. No prescription for any dangerous drug that is a controlled substance may be designated refillable as needed."

10. **Section 4081** of the Business and Professions Code states, in pertinent part:

"(a) All records of manufacture and of sale, acquisition, or disposition of dangerous drugs or dangerous devices shall be at all times during business hours open to inspection by authorized officers of the law, and shall be preserved for at least three years from the date of making. A current inventory shall be kept by every manufacturer, wholesaler, pharmacy, veterinary food-animal drug retailer, physician, dentist, podiatrist, veterinarian, laboratory, clinic, hospital, institution, or establishment holding a currently valid and unrevoked certificate, license, permit, registration, or exemption under Division 2 (commencing with Section 1200) of the Health and Safety Code or under Part 4 (commencing with Section 16000) of Division 9 of the Welfare and Institutions Code who maintains a stock of dangerous drugs or dangerous devices.

"(b) The owner, officer, and partner of any pharmacy, wholesaler, or veterinary food-animal drug retailer shall be jointly responsible, with the pharmacist-in-charge or representative-in-charge, for maintaining the records and inventory described in this section."

11. **Section 4105** of the Business and Professions Code states:

"(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.

"(b) The licensee may remove the original records or documentation from the licensed premises on a temporary basis for license-related purposes. However, a duplicate set of those records or other documentation shall be retained on the licensed premises.

"(c) The records required by this section shall be retained on the licensed premises for a period of three years from the date of making.

///

"(d) Any records that are maintained electronically shall be maintained so that the pharmacist-in-charge, the pharmacist on duty if the pharmacist-in-charge is not on duty, or, in the case of a veterinary food-animal drug retailer or wholesaler, the designated representative on duty, shall, at all times during which the licensed premises are open for business, be able to produce a hard copy and electronic copy of all records of acquisition or disposition or other drug or dispensing-related records maintained electronically.

"(e) (1) Notwithstanding subdivisions (a), (b), and (c), the board may, upon written request, grant to a licensee a waiver of the requirements that the records described in subdivisions (a), (b), and (c) be kept on the licensed premises.

(2) A waiver granted pursuant to this subdivision shall not affect the board's authority under this section or any other provision of this chapter.

. . . .

12. **Section 4113**, subdivision (c), of the Business and Professions Code states:

"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."

13. **Section 4301** of the Business and Professions 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:

. . .

"(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.

. . .

"(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.

. . . .

14. **Section 4306.5** of the Business and Professions Code states:

"Unprofessional conduct for a pharmacist may include any of the following:

(a) Acts or omissions that involve, in whole or in part, the inappropriate exercise of his or her education, training, or experience as a pharmacist, whether or not the act or omission arises in the course of the practice of pharmacy or the ownership, management, administration, or operation of a pharmacy or other entity licensed by the board.

(b) Acts or omissions that involve, in whole or in part, the failure to exercise or implement his or her best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances, dangerous drugs, or dangerous devices, or with regard to the provision of services.

(c) Acts or omissions that involve, in whole or in part, the failure to consult appropriate patient, prescription, and other records pertaining to the performance of any pharmacy function.

(d) Acts or omissions that involve, in whole or in part, the failure to fully maintain and retain appropriate patient-specific information pertaining to the performance of any pharmacy function."

HEALTH AND SAFETY CODE

15. Health and Safety Code **section 11153**, subdivision (a) states:

"(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 an 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."

16. **Section 11179** of the Health and Safety Code states:

"A person who fills a prescription shall keep it on file for at least three years from the date of filling it."

17. **Section 11200**, subdivision (c), of the Health and Safety Code states:

"No prescription for a Schedule II substance may be refilled."

CALIFORNIA CODE OF REGULATIONS

18. California Code of Regulations, title 16, **section 1707.1**, states:

"(a) A pharmacy shall maintain medication profiles on all patients who have prescriptions filled in that pharmacy except when the pharmacist has reasonable belief that the patient will not continue to obtain prescription medications from that pharmacy.

(1) A patient medication record shall be maintained in an automated data processing or manual record mode such that the following information is readily retrievable during the pharmacy's normal operating hours.

(A) The patient's full name and address, telephone number, date of birth (or age) and gender;

(B) For each prescription dispensed by the pharmacy:

1. The name, strength, dosage form, route of administration, if other than oral, quantity and directions for use of any drug dispensed;

2. The prescriber's name and where appropriate, license number, DEA registration number or other unique identifier;

3. The date on which a drug was dispensed or refilled;

4. The prescription number for each prescription; and

5. The information required by section 1717.

(C) Any of the following which may relate to drug therapy: patient allergies, idiosyncracies, current medications and relevant prior medications including nonprescription medications and relevant devices, or medical conditions which are communicated by the patient or the patient's agent.

(D) Any other information which the pharmacist, in his or her professional judgment, deems appropriate.

(2) The patient medication record shall be maintained for at least one year from the date when the last prescription was filled.

19. California Code of Regulations, title 16, **section 1715.6,** states:

"The owner shall report to the Board within thirty (30) days of discovery of any loss of the controlled substances, including their amounts and strengths."

20. California Code of Regulations, title 16, **section 1716,** states in pertinent part:

"Pharmacists shall not deviate from the requirements of a prescription except upon the prior consent of the prescriber or to select the drug product in accordance with Section 4073 of the Business and Professions Code."

CONTROLLED SUBSTANCES AND DANGEROUS DRUGS

21. **Alprazolam**, a generic name for Xanax, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(1), and is a dangerous drug pursuant to Business and Professions Code section 4022.

22. **Carisprodol,** a generic name for Soma, is a Schedule IV controlled substance pursuant to 21 Code of Federal Register section 1308.14, subdivision (e)(6), and is a dangerous drug pursuant to Business and Professions Code section 4022.

23. **Dextroamphetamine/amphetamine**, a generic name for Adderall, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d)(1), and is a dangerous drug pursuant to Business and Professions Code section 4022.

24. **Dilaudid** is a brand name for Hydromorphone, which is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(J), and is categorized as a dangerous drug pursuant to section 4022.

25. **Hydrocodone/acetaminophen**, a generic name for Lortab, Vicodin, and Norco, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056(e)(4), and is a dangerous drug pursuant to Business and Professions Code section 4022.

26. **Oxycodone**, a generic name for Oxycontin, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and is a dangerous drug pursuant to Business and Professions Code section 4022.

27. **Modafinil,** a generic name for Provigil, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (f)(3), and is a dangerous drug pursuant to Business and Professions Code section 4022.

28. **MS Contin** is a brand name morphine sulfate, which is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(L), and is categorized as a dangerous drug pursuant to section 4022.

COST RECOVERY

29. **Section 125.3** of the Business and Professions 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.

FACTUAL BACKGROUND

30. On August 31, 2011, the Board received a complaint from W.K. stating that her son, Patient B.K., had died of an overdose, in January 2010. W.K. found 660 tablets from Respondent Pharmacy filled for her son from October 12, 2009 through December 23, 2009. The drugs included Soma, Adderall, Xanax, Oxycontin and Vicodin. The prescriber was Dr. L.G.. W.K. indicated that Dr. L.G., was being investigated by the Medical Board.

31. Dr. L.G., D.O., was the prescriber of the prescriptions that Patient B.K had filled at Respondent Pharmacy. On March 4, 2011, the Osteopathic Medical Board of California filed an Accusation against Dr. L.G. for repeated acts of negligence. However Dr. L.G. committed suicide before the matter was resolved.

32. On March 15, 2013, a Board inspector conducted an inspection at Respondent Pharmacy where she met with Respondent Bentow and her father, Stanley Goldenberg, president of Respondent Pharmacy. Mr. Goldenberg notified the Board inspector that Dr. L.G. committed suicide because he was being investigated by the Medical Board. In preparation for the

inspection, the Board inspector reviewed CURES[1] data for the pharmacy from October 2008 to January 2010 and chose eleven (11) pharmacy patients, including Patient B.K., to review for controlled substance dispensing.

33. During the March 15, 2013 inspection, the Board inspector asked Respondent Bentow to provide some basic information about each patient. Among other things, Respondent Bentow stated that she did not know anything at all about two of the patients, including Patient B.K.

34. During the inspection, the inspector also showed Respondent Bentow a CURES report indicating that between October 2008 and January 2010, Respondent Pharmacy had filled 4,586 controlled substance prescriptions written by Dr. L.G., which constituted 14% of all controlled substance prescriptions filled by Respondent Pharmacy during that time. The inspector asked Respondent Bentow if she ever called Dr. L.G. or his office to confirm any of these prescriptions, and Respondent Bentow replied that she had not.

35. During the inspection, Respondent Bentow informed the inspector that she had a loss of controlled substances which was not reported to the Board. Prior to the Board's inspection on March 15, 2013, neither Respondent Bentow nor Respondent Pharmacy had reported the theft of these drugs to the Board as required by state law.

36. At the conclusion of the on-site inspection, the inspector gave Respondent Bentow a copy of the inspection report and a list of questions seeking, among other things, information on each of the 11 patients she had previously identified, including all original prescriptions related to the patients, information on the pharmacy's relationship with Dr. L.G., information on what steps taken to decide whether or not to fill a prescription, and information on the previously unreported theft of drugs from the pharmacy. The Board investigator also asked for a printout for Dr. K.T., a

[1] Controlled Substance Utilization Review and Evaluation System, C.U.R.E.S, is a database that contains over 100 million entries of controlled substance drugs that were dispensed in California. CURES is part of a program developed by the California Department of Justice, Bureau of Narcotic Enforcement, which allows access to the Prescription Drug Monitoring Program (PDMP) system. The PDMP allows pre-registered users including licensed healthcare prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards to access patient controlled substance history information.

physician whose name came up while she was going through the prescriptions filled by the Respondents.

37. On April 2, 2013, the Board received a fax from Respondent Pharmacy which included a statement from Respondent Bentow stating she enclosed CURES reports for the two patients on the list she still serviced. Respondent Bentow stated the following "[W]hen we consult for pain medications, we review instructions with the patients, including information regarding constipation. We make sure patients receive their refills no sooner than 28 or 29 days. If a patients comes in for a controlled [RX], we check the CURES report if we feel that there is any issue regarding the dates filled, multiple doctor usage, or filling at other pharmacies. We will also check the CURES report if a patient is receiving a combination of drugs in excess, such as Phenergan with Codeine. We will only fill a controlled prescription if the doctor is in our area or if the patient lives near out location. We verify that the patient's driver's license is valid, using our credit card machine. Diagnosis for the patient is put on each prescription. Each patient must pick up their own prescription from the pharmacy. Some quantities may seem large, but these patients have been on this treatment plan for years and may require it. At this point in our practice, we have included a new step in consultation, which is filling out a patient consultation form for each new patient we receive."

38. Respondent Bentow stated further "[D]r. L.G. practiced in the building next door to our pharmacy. His practice specialty was pain management, but he also treated patients with blood pressure medication and antibiotics as well. When his patients came to our pharmacy, we took the standard procedure with what we have written. The majority of his patients were treated for years with the same dosages, not needed us [sic] to call him. We would call his office and verify his prescription, if for any reason we felt the dosages were changed incorrectly. If we had any doubts about the prescription, we would call and verify the prescription with the office. Dr. L.G. had surgery on his back and ended up getting hooked on pain medications and committed suicide."

39. Respondent Bentow included a police report for a loss of controlled substances on June 4, 2012, which included Oxycodone products. This loss was not reported to the Board. The last report of a loss from West Val Pharmacy was on August 25, 2011.

40. On April 22, 2013, the Board inspector received the prescriptions for the 11 patients she requested. In reviewing the patient profiles and prescriptions for the patients, the Board inspector discovered the following:

(a) **Patient F.A:** Respondent Bentow informed the Board inspector that this patient died and had seizures. On April 22, 2013, Respondent Bentow wrote "[P]t. has fibromyalgia and was delusional.. We kept track of his refills to fill every 28-29 days. He passed away from a seizure after his doctor wouldn't refill his Lexapro." Patient F.A. brought two prescriptions for Dilaudid 8 mg to West Val Pharmacy, one was written on January 17, 2012, and one was written on January 19, 2012. Both were prescribed by Dr. L.G. Respondent Pharmacy did not fill both, however, there is no documentation about why the patient would have two prescriptions for the same drug written two days apart. Board inspector determined that Respondent Pharmacy provided early prescription fills for Xanax on January 19, 2012, and May 9, 2011; Respondent Pharmacy provided early prescription fills for Oxycontin August 28, 2012, and July 5, 2012, April 12, 2012 and November 23, 2011; Respondent Pharmacy refilled RX# 675768, RX# 653019, RX# 640641 and RX# 619611 when said prescriptions did not have refills ordered; Respondent Pharmacy filled an oral prescription (RX# 640641) without documenting who authorized the oral prescription; Respondent pharmacy failed to provide to the Board inspector RX# 699498 and RX# 695750.

(b) **Patient K.D.:** Respondent Bentow informed the Board inspector that Patient K.D. stopped coming to West Val Pharmacy. On April 22, 2013, Respondent Bentow wrote "[W]e made sure to keep track of her refills to a minimum of 28-29 days." Looking at Patient K.D.'s history, the Board inspector discovered the following:

- unauthorized refills (RX #620238 on September 1, 2011;
- early prescription fills for RX# 641875, #620238, #623813 and #619348;

- evidence of two fills on the same day for the same prescription (RX #676017 on April 13, 2011;
- not all prescriptions were provided to the Board inspector (RX #662364, #662363, #650918 and # 634169);
- RX #644383 was taken as an oral prescription for Provigil 200 mg #30 with no refills, however, it was filled for 60 tablets with 2 refills;
- In January 2012, Patient K.D. was prescribed a medication for sleep (Temazepam), but a day later was prescribed a CNS stimulant to help the patient stay alert or awake (Provigil). There is no documentation of why the same physician would prescribe a medication for sleep, thereafter prescription another medication to help the patient to stay awake. Dr. L.G. mentioned on one prescription (RX #665967 for Roxicodone) that Patient K.D. failed on Morphine Sulfate Immediate Release (MSIR), however, there was no record of Patient K.D. taking MSIR. There was no documentation showing whether Respondent Pharmacy called to clarify the patient's drug history.
- Further, RX #621120 which was written by the physician to be filled on April 21, 2011, was in fact filled on April 18, 2011, 3 days before said prescription was authorized.

(c) **Patient S.W.:** Respondent Bentow informed the Board inspector that Patient S.W. passed away. On April 22, 2013, Respondent Bentow wrote "[P]t. fell off at a building and also had diabetes. He eventually passed away." Review of the patient history revealed an early dispensing of RX# 662187 on January 23, 2012, unauthorized refill of RX #654931 on December 12, 2011, and one prescription was not provided (RX #652399). Further, Patient S.W. had two medications for sleep filled days apart, however, Respondent Pharmacist did not question or document why this patient would need two medications for sleep, which would result in additive effects if the patient takes both.

(d) **Patient K.A.:** Respondent Bentow told the Board inspector that Patient K.A. was "messed up." On April 22, 2013, Respondent Bentow wrote "P]t. has sever back pain and spasms. We made sure to keep track of his refills to a minimum of 28-29 days." Review of the patient profile showed Patient K.A. received Dilaudid, Soma and MS Contin every month from

2009 to 2013. Every month the prescription got filled several days earlier. Although each time it is not more than 4 days early, over time, filling the prescription early allows the patient to obtain more medications, for example, from November 23, 2010 to April 10, 2012 (a total of 504 days) Patient K.A. received about 600 day supply of medications, meaning that he had a surplus of 96 days of medication. Further, prescription RX #682352 which was void after May 10, 2012 was filled on May 28, 2012.

(e) **Patient P.R.:** Respondent Bentow explained to the Board investigator that this patient had surgery. On April 22, 2013, Respondent Bentow wrote "[P]t. had 2 total knee replacements, back problems, and lymphedema, which causes pain in the lower extremities. Further patient P.R. also had fibromyalgia and severe arthritis." Review of the patient's history revealed that Patient P.R. used multiple physicians to obtain Oxycontin (Oxycodone). From 2012 to 2013, Patient P.R. saw Dr. S., Dr. N., Dr. H., Dr. Sc. and Dr. L.G.. Sometimes the physicians are seen on dates close to each other, i.e., this patient was seen by Dr. H. on December 27, 2012 and Dr. N. on January 2, 2013. Each time a prescription was written for Oxycontin and Oxycodone for 20 to 30 day supply, Respondent Pharmacy filled both prescriptions. Patient P.R. received different doses of Oxycodone, i.e., on December 27, 2012, this patient received 40 mg of Oxycodone and received 80 mg of Oxycodone on January 2, 2013. There is no documentation showing why Patient P.R. saw a different physician and received a different strength, and why it was filled even though the patient just filled a prescription days before. Further, Patient P.R. was prescribed the Oxycontin against normal recommended dosing. Pursuant to its manufacturer, Oxycontin should not be used as prn (as needed) analgesic. The initial dosing is 10 mg every 12 hours. The dose may be increased, as a guideline the total daily dose can be increased by 25% to 50% of the current dose. There are no well controlled studies evaluating the safety and efficacy with dosing more frequently than every 12 hours. The 60 mg and 80 mg Oxycontin tablets are only be used in opioid tolerant patients. The physicians prescribed Oxycontin for P.R. as a prn, every 4 hour drug, which is against the recommendations. There is no documentation showing why Oxycontin being given prn or as often as every 4 hours. Oxycontin is a slow release drug, which is why it is dosed every 12 hours. Opana ER is also dosed at 12 hour intervals, yet, Dr.

L.G. prescribed it every 4 or 6 hours. There is no documentation substantiating that Respondent Pharmacy spoke or clarified the dosing for this patient for Opana or Oxycontin. Further, Patient P.R. received early fills for the following prescriptions: RX #724094 on February 20, 2013, RX # 715205 on January 2, 2013, RX #715204 on January 2, 2013, RX #677593 on April 25, 2012, RX #677592 on April 25, 2012, RX #676753 on April 20, 2012, RX #673498 on March 30, 2012, RX #673497 on March 30, 2012, RX #673133 on March 28, 2012.) It should be noted that the respondent did not provide all prescriptions the Board inspector requested during her March 15, 2013 inspection.

(f) **Patient K.W.**: Respondent Bentow stated "[W]e made sure to keep track of her refills to a minimum of 28 to 29 days." Patient K.W. is registered nurse. She received Percocet and Lortab at the same time prescribed by the same physician. These two drugs both have Acetaminophen, which in large amounts over a period of time, can cause liver damage. Pharmacist should know the total daily dose of Acetaminophen should not be over 3 grams per day. Patient K.W. received over 4 grams per day of Acetoaminophen for years. Further, Respondent Bentow included a CURES printout she did for this patient in May of 2011 which showed the patient used two different pharmacies in April 2011 to get Hydrocodone/apap prescriptions. This should have been red flags for Respondent Bentow. Further, in February of 2011, Respondent Bentow filled two 30 day prescriptions for Alprazolam for this patient. Respondents failed to provide all of Patient K.W.'s prescriptions to the Board's investigator during her March 15, 2013 inspection. Further, there were early fills for this patient (RX #611818 on February 27, 2011.)

(g) **Patient V.S.:** Respondent Bentow told the Board investigator that the patient stopped coming to the pharmacy. On April 22, 2013, Respondent Bentow wrote "[W]e made sure to keep track of her refills to a minimum of 28 to 29 days. Pharmacy law allows a prescription for a Schedule II controlled substance to be filled once. However, RX #652422 and #647987 were filled on different dates, but using the same prescription blank. RX #642495 was filled on September 15, 2011, using two different prescription blanks. RX #597940 was filled twice on the

same day, same prescription blank, and two labels on the back signed by two people. Board inspector was not given RX #616404 during her March 15, 2013 inspection.

(h) **Patient B.K.**: Respondent Bentow told the Board investigator that she did not know about Patient B.K. Respondent Bentow wrote to the Board investigator on April 22, 2013"[W]e have not serviced him since 2009 and no prescriptions were submitted to you." The Board of Pharmacy ran a CURES report on Patient B.K. from June 1, 2008 to October 11, 2011. CURES report showed in 2009, Patient B.K. used the following pharmacies: 1) Kanan Pharmacy & Medical; 2) West Val Pharmacy; 3) Longs Drugs; 4) Costco; 5) CVS; and 6) Rite Aid. Patient B.K. saw Dr. L.G., Dr. K., Dr. M. and Dr. St. in 2009. This patient was doctor shopper and used multiple pharmacies. If Respondent Pharmacy used CURES information for Patient B.K., it would have shown that he was getting the same prescriptions filled for the same drug on the same day at two different pharmacies, i.e., Oxycontin 80 mg #32 and Norco 10/325 #156 was filled at Kanan Pharmacy on November 12, 2009, and Oxycontin 80 mg #45 and Norco 10/325 #156 was filled at Respondent Pharmacy on the same day. On October 12, 2009 Respondent Pharmacy filled Norco 10/325 #210 and Kanan filled Norco 10/325 #210 on October 29, 2009. On November 30, 2009, Respondent Pharmacy filled Amphetamine salt combo 20 mg #60 (30 day supply) and on December 7, 2009, CVS filled Amphetamine salt combo 30 mg #60 (30 day supply). On December 23, 2009 Respondent Pharmacy filled Amphetamine salt combo 20 mg #60 (30 day supply) and on January 6, 2010 Costco Amphetamine salt combo 30 mg #60 (30 day supply. On May 29, 2013, Board investigator obtained a copy of the death certificate for Patient B.K. He passed away on January 12, 2010 at the age of 26. The cause of death was listed as Oxycodone intoxication. Board investigator determined that Respondent Pharmacy filled 460 Oxycodone containing tablets, filled over 7 months from May 6, 2009 to December 21, 2009. It should be noted that Respondent Pharmacy filled the last Oxycodone prescription before Patient B.K. passed away.

///

///

RESPONDENTS' RESPONSES TO THE NOTICE OF NON-COMPLIANCE; AND BOARD INVESTIGATOR'S EVALUATIONS

41. On August 26, 2013, Respondent Bentow sent the Board's inspector a response to the Notice of Non-Compliance issued on May 31, 2013. The response included additional information about the patients the Board investigator inquired. Board investigator reviewed the supplemental documents and issued a supplemental report based upon the additional information provided by Respondent Bentow.

42. Respondent Bentow admitted to the Board investigator that she reported the drug loss to the DEA, however, she neglected to notify the Board of Pharmacy, which is a violation of pharmacy law.

43. Respondent Bentow explained that RX #611818 was changed from **RX #610796** requiring another fill for the patient since the physician ordered the wrong strength. The Board's inspector found that RX #610796 was for Xanax 1 mg with a total of 2 tablets (2 mg) taken per day. The prescriber wrote for a month's supply. However, five days later, the changed RX #611818 is for Xanax 2 mg, #30, has no directions, however, #30 was given. Respondent Bentow has no documentation showing why patient's prescription changed from Xanax 1 mg twice a day to Xanax 2 mg, five days later. The prescriber, Dr. L.G. wrote both prescriptions. Respondent Bentow should have followed up with Dr. L.G. and the patient.

44. Respondent Bentow explained that **RX #724094** was a wrong prescription number. The Board investigator acknowledged that RX #724094 should read RX #724076. The first prescription stated that the patient could take the medication eight to nine times a day, as needed. If the patient used the medication nine times a day, said prescription would last 27 days. However, the second prescription was written and filled six days before the prescription would have run out. Respondents failed to document why the prescription was filled early. Further, the patient had also used several different physicians in 2012, which should have alerted Respondent Bentow.

45. Respondent Bentow explained that RX #715205 was filled because previous **RX #714411** was for #30 and only lasted until January 2, 2013 since the patient needed to take eight

to nine times a day. Board's Inspector found RX #714411 was prescribed as once a day as needed, therefore, it should have lasted 30 day. If the patient brought in a prescription a week later from another physician, with directions to now take the medication eight to nine times a day, Respondent Bentow should have questioned the patient and the physician the reason why the dosage was increased by 8-9 fold. Further, Respondent should have documentation that she spoke to the physician and the patient to justify her filling the prescription. The patient had been seeing Dr. N. who prescribed the medication eight to nine times a day, in November of 2012. Thereafter, Dr. H. wrote a prescription for Oxycodone, once a day as needed. Respondents failed to produce any documentations explaining why Dr. H. was consulted or why Dr. H. changed the dosage. Thereafter, the patient had a prescription from Dr. N. again in January of 2013. Respondent Bentow should have contacted Dr. N. and inquired why the dose was being modified or inquired whether he knew that Dr. H. was treating the same patient. Many physicians will either continue the same medication that the patient was previously taking, or change it slightly, however, few will increase or decrease the dose drastically 8 to 9 fold. Respondent Bentow had no documentation to explain the above.

46. Respondent Bentow explained that RX #715204 was filled on January 2, 2013 since previous **RX #714412** was for only #60 and patient needed to take it 5 to 6 times a day. There was a large increase in dosage and it only lasted her until January 2, 2013. The Board's Inspector found RX #714412 was prescribed as 60 tablets, to be taken twice a day, as needed. It should have been a 30 day supply. When Respondent Bentow found out that the patient was being prescribed a stronger Oxycontin dose (to be taken 5-6 times a day), she should have questioned the patient and the physician to inquire whether the patient was abusing the medication, or whether the physician was aware that the patient was taking a smaller dose to avoid withdrawal or overdose. However, Respondent Bentow had no documentation in support of the above.

47. Respondent Bentow explained that **RX #677593** was filled on April 25, 2012. The previous prescription for Oxycontin 80 mg was filled on March 30, 2012, filled 5 days earlier, not 25 days. The Board's Inspector found that patients take "long" acting pain medication such as Oxycontin around the clock, i.e., twice a day to control their pain. When the pain is agonizing,

the patients can take "shorter" acting pain medications. This patient was on short acting and long acting Oxycontin. Oxycontin is usually given twice a day. The prescription on March 30, 2012 stated that the patient could take Oxycontin 80 mg every 4 hours, which is above the recommended dosage. Respondent Bentow should have questioned this prescription. The prescriber was Dr. Singh. Taken 6 times a day, the supply was to last one month. However, prior to the 30 day, the patient presented another prescription from another prescriber, D. H.. This prescription was for Oxycontin 40 mg, to be taken twice a day, as needed. It should be noted that Oxycontin is not usually prescribed on an "as needed" basis, and the patient had been previously prescribed short acting Oxycodone. Since the physicians were different, the two prescriptions could result in overdose or withdrawal. Respondent Bentow should have questioned the prescription, the patient and the prescriber, to determine whether Dr. H. knew about the prescription from Dr. S.. Further, on April 25, 2012, Oxycontin 80 mg, prescribed by Dr. Schott, was filled early. There is no documentation that respondent Bentow spoke to Dr. Sc. regarding the patient's use of Oxycontin, and the reason why she filled said prescription early. This lack of questioning and documentation show that respondent Bentow will fill any prescription presented to her, without awareness of her corresponding responsibility which amounts to gross negligence.

48. Respondent Bentow explained that RX #677592 was filled on April 25, 2012 because previous **RX #676574** was only for #30 which only lasted from April 20, 2012 to April 25, 2012 since she was taking it ten to eleven times a day. There was an increase in dosage and required a new fill. The Board's Inspector found that the patient had RX #676754 filled on April 20, 2012, prescribed by Dr. H., with directions for it to be taken once a day as needed. If the patient presented a new prescription from Dr. Sc. on April 25, 2012 (five days later) with directions for the same drug to be taken more often, Respondent Bentow should have questioned the patient, the physician, and the prescription to determine why one physician thinks that the patient needs to take it once a day, while the other physician thinks that the same patient needs to take the same medication 10-11 times a day.

49. Respondent Bentow explained that **RX #676753** was filled on April 20, 2012 because previous RX (RX #673733) for Oxycontin 40 mg was a 20 day supply. RX #673133 was for #60,

three times a day on March 28, 2012. The Board's Inspector stated that Respondent Bentow is justifying her early fills based on the time the exact same physician prescribed the same drug. However, Respondent Bentow fails to consider that the patients may be seeing multiple physicians who prescribe the same or similar drugs, and that the patient may be taking multiple other drugs prescribed at the same time. Respondent Bentow should have questioned the prescription for the stronger Oxycontin and called the physician to determine whether she knew that the patient was already being treated by Dr. H.. She should have called Dr. H. and asked if he knew the patient was being seen by Dr. S. to avoid duplicate therapy. Whenever, the patient brings in prescriptions for the same drug from two different prescribers in a short amount of time, it is a red flag to the pharmacist to question the prescription.

When reviewing the entire patient profile of Patient P.R., this patient was taking not only Oxycontin, but also this patient was taking the shorter acting Oxycodone. This shows that all Oxycodone, Roxicodone and Oxycontin prescriptions filled for this patient for one month. Patient P.R. used three different physicians and received both, short and long acting, Oxycodone. Filling a prescription early shows disregard for the directions which were given to the patient on how to take the medication. The patient has no reason to fill a prescription early when it is taken as prescribed. In a month period, Patient P.R. received over 1100 tablets of Oxycodone or Oxycontin, from eight (8) different prescriptions, each written for a month's supply. If Patient P.R. takes each prescription on top of each other, the effects could be addictive, and result in harm or death. The pharmacist has a responsibility to protect the patient and question why the patient is coming early to obtain more medications. If the pain medication is not working, the pharmacist could notify the prescriber and the patient and even recommend changing to a different medication.

50. Respondent Bentow explained that **RX #673498** was filled on March 30, 2012 because there was a large increase in dosage. The previous Rx #673134 was only for #30 and only lasted from March 28, 2012 to March 30, 2012 because they had to take it 10-11 times a day. The Board's Inspector stated that Respondent Bentow did not question why Patient P.R. filled a prescription for Roxicodone 30 mg to take once a day as needed, thereafter, two days later, the

same patient brings a prescription from a different physician (Dr. S.) instructing the patient to take Roxicodone 30 mg, 10-11 times a day. Respondent Bentow failed to document why Patient P.R. was seeing multiple doctors, or why all of a sudden this patient's prescription dosage increased from once a day to ten to eleven times a day, and why it was not a gradual increase. Respondent Bentow failed to assess that this qualifies as an early fill.

51. Respondent Bentow explained that **RX #673497** was filled on March 30, 2012 because there was an increase in dosage. The previous RX #671708 was filled on March 7, 2012 for only #60. Since she had to take 1 every 4 hours, it only lasted until March 30, 2012. The Board's Inspector stated that Respondent Bentow is comparing the Oxycontin 80 mg prescription, however, it was filled early, this should have raised red flags. Patient P.R. received a 30-day supply of Oxycontin 80 mg on March 7, 2012 from Dr. L.G., therefore, the Oxycontin prescription would have run out on April 6, 2012. However, Patient P.R. came in and filled Oxycontin 80 mg prescribed by Dr. S. early, on March 30, 2012. Patient P.R. should have had Oxycontin for approximately another additional 6 days. Further, in between the above referenced two prescriptions, Patient P.R. filled a prescription on March 28, 2012, for Oxycontin 40 mg prescribed by Dr. H.. In order to protect the safety of the patient, Respondent Bentow should have clarified with all prescribers whether they were aware each other's prescriptions, and clarified how often the patient needed to take her medications. Filling a drug early is not only about numbers, however, it is a red flag to pharmacists who should be evaluating the patient's drug profile pursuant to CCR section 1707.3. By evaluating the patient's profile, a pharmacist can determine the early fills. Further, all of the Oxycontin/Oxycodone early fills, as set forth above, should have alerted Respondent Bentow to follow up since Patient P.R. used multiple physicians, multiple prescriptions for the same drug, and Patient P.R.'s prescription dosage increased from once a day to 10-11 times a day.

52. Respondent Bentow explained that **RX #673133** was filled because Dr. L.G. passed away and the patient was looking for a new pain management physician. Prescription was for 40 mg Oxycontin which is something she didn't have before. This was a change in dose from the new physician. The Board's Inspector stated that Respondent Bentow refers to Patient P.R.'s

new physician, Dr. H.. However, Respondent Bentow filled another prescription two days later after Dr. H.'s prescription which was written by another physician. Respondent Bentow failed to follow up with the physicians and Patient P.R. about the dosage of Oxycontin to change from Oxycontin 80 mg six times a day to 40 mg Oxycontin three times a day as needed, with this new physician.

53. Respondent Bentow explained that **RX #620238** was filled on September 1, 2011, which is early by five days from previous fill date of August 7, 2011, however, insurance company allowed the refill. The Board's Inspector stated that the patient received the medication RX #620238 for a 30 day supply of Provigil on May 4, 2011 with three refills. Subsequently, it was refilled on June 1, 2011, July 5, 2011, August 7, 2011 and on September 1, 2011, which was 5 days early. There is no documentation why the refill was early. Further, the fact that the insurance company allowed a prescription to be filled early, has no relevance to the Board of Pharmacy when it comes to the corresponding responsibility.

54. Respondent Bentow explained that **RX #619348** was filled on April 21, 2011 because the dosage had increased. The previous fill was RX #616308 for #120, while the patient had to take 3 tablets every 12 hours making it a 20 day supply. The Board's Inspector stated that RX #616308 was filled on March 24, 2011 with 120 tablets, and the directions were to take one tablet every 6 hours (4 tablets per day). This prescription should have lasted 30 days, if taken as prescribed. Opana ER is taken twice a day, not every 6 hours as originally prescribed. There is no documentation that Respondent Bentow when and why the frequency was changed. Opana ER does not come in in a strength higher than 40 mg. Respondent Bentow has a corresponding responsibility to ensure the drug is being prescribed for a legitimate reason.. Respondent Bentow never explained to the Board investigator the type of problem this patient had and why this patient needed so many different pain medications.

55. Respondent Bentow explained that **RX #695750** was filled on August 28, 2012 for only a quantity of #4, not #60. Patient wanted an increase in dosage and the physician wrote a day supply until he was able to change dosage. RX #695795 shows that the dosage was changed from twice a day to three times a day, explaining the need for an early refill. The Borad's Inspector

explained that **RX #692793** was written by Dr. Si. for Oxycontin 80 mg #60, one tablet twice a day. It was filled on August 8, 2012. The prescription should have lasted for 30 days. The patient presented a new prescription to the pharmacy. Respondent Bentow stated that Respondents filled 4 tablets because the physician wrote for a day supply until the physician was able to change the dose. However, the ultimate change in dose was to three times a day, therefore, the patient only needed to take three tablets a day, only one additional tablet than the patient was already taking. Further, the patient had about 20 tablets left over as of August 28, 2012, when the physician gave a small prescription for four tablets . Subsequently, Respondent Bentow filled another prescription for a 30 day supply on August 28, 2012. However, there is no documentation explaining the changes and why the pharmacy had to fill two prescriptions on August 28, 2012 for the same medication from the same physician.

56. The need to fill another prescription for the same drug earlier than needed should be a red flag to the pharmacist, and the pharmacist should inquire. Even after conferring with the prescriber, the pharmacist is not required to fill the prescription, if not convinced.

57. Respondent Bentow explained that **RX #687861** was filled because of an increase in Oxycontin dosage. Previous medication, RX #687034, was changed from 40 mg twice a day to 80 mg twice a day. The Board's Inspector stated that this patient was seeing multiple prescribers. The prescription for Oxycontin was 80 mg, four times a day on May 1, 2012, 40 mg, four times a day on May 22, 2012, 40 mg twice a day on June 28, 2012, and 80 mg twice a day on July 5, 2012.

58. The fact that the patient comes in early for refill, is a red flag requiring the pharmacist to look at the prescription and the profile and make a proper determination. The fact that the patient is seeing multiple prescribers and has the dosage of Oxycontin changed 4 times in approximately two months, should be a concern for the pharmacist, warranting a call to the prescribers. Respondent Bentow should have also consulted with the patient to assess whether the pain is controlled.

59. Respondent Bentow informed the Board investigator that she has access to CURES data, yet, she did not use it often. This is a great concern in light of the fact that one of her

patients died from overprescribing of pain medication, where Respondents' pain medications were found in the decedent's residence.

60. Respondent Bentow explained that **RX #653019** was filled 6 days early and insurance allows early fills. The Board's Inspector stated the fact that the insurance company allows early fills is irrelevant as to the pharmacist's corresponding responsibility to ensure patient's safety.

61. Respondent Bentow explained that **RX #619611** filled five days earlier, however, the insurance allows this. The Board's Inspector explained the fact that the insurance company allows early fills is irrelevant as to the pharmacist's corresponding responsibility to ensure patient's safety.

FIRST CAUSE FOR DISCIPLINE

(Failure to Report Controlled Substance Loss Within 30 Days)

62. Respondent Pharmacy and Respondent Bentow (collectively as Respondents) are subject to disciplinary action under California Code of Regulation, title 16, section 1715.6, subdivision (b) in that Respondents failed to report to the Board in writing or otherwise of the loss of a controlled substance as required by state law. During the Board inspection of March 15, 2013, Respondent Bentow admitted to the Board inspector that Respondent Pharmacy sustained a loss of controlled substance on June 4, 2012, which was not reported to the Board.

SECOND CAUSE FOR DISCIPLINE

(Early Prescription Fills-Corresponding Responsibility)

63. Respondents are subject to disciplinary action under Health and Safety Code section 11153, subdivision (a) which provides that 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, however, a corresponding responsibility rest with the pharmacist who fills the prescription. Specifically, the following prescriptions were filled early, in violation of pharmacy law. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 30 through 61, as though set forth fully herein.

Date	RX#	Drug	Strength	Amt	Day Supply	MD	Early Refill
2/27/11	611818	Xanax	2	30		L.G.	25 days
2/20/13	724094	Oxycodone	30	60	7	S.	6 days
1/2/13	715205	Oxycodone	30	250	27	N.	25 days
1/2/13	715204	Oxycontin	80	120	20	N.	24 days
4/25/12	677593	Oxycontin	80	180	30	Sc.	25 days
4/25/12	677592	Roxicodone	30	330	30	Sc.	25 days
4/20/12	676753	Oxycontin	40	60	30	H.	10 days
3/30/12	673498	Roxicodone	30	330	30	S.	28 days
3/30/12	673497	Oxycontin	80	180	30	S.	18 days
3/28/12	673133	Oxycontin	40	60	20	H.	9 days
9/1/11	620238	Provigil	200	60	30	L.G.	5 days
4/12/11	619348	Opana ER	40	60	10	L.G.	11 days
8/28/12	695750	Oxycontin	80	60		Si.	10 days
7/5/12	687861	Oxycontin	80	60	30	O.	23 days
1/19/12	653019	Xanax	1	120	30	E.	6 days
5/9/11	619611	Xanax	1	120	30	E.	5 days

64. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 30 through 61, as though set forth fully herein.

THIRD CAUSE FOR DISCIPLINE

(Misuse of Education)

65. Respondents) are subject to disciplinary action under Business and Professions Code section 4306.5 in that Respondents committed acts or omissions that involve, in whole or in part, the inappropriate exercise of their education. Specifically, Respondents failed to document or question the following:

a. Why Patient K.D. was taking a sleep medication as well as CNS stimulant medication to stay alert or awake. Patient K.D.'s physician stated that this patient failed Morphine Sulfate Immediate Release (MSIR), however, there are no documentation substantiating that Patient K.D. ever received this drug;

b. Why Patient S.W. was on two sleep medications at the same time;

c. Patient P.R. saw multiple physicians for Oxycodone and these prescriptions were filled for them at the same time without verification or documentation of prescriber contact to verify appropriateness of duplicate therapy;

d. Why Oxycontin was prescribed for P.R. as a prn (as needed medication) against normal dosing, and Respondents failed to question the prescription and/or document their questioning of the prescription;

e. Why K.W. was dispensed medications containing Acetoaminophen over 4 mg/day for years;

f. Why K.W. had two alprazolam prescriptions filled in February 2011.

66. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 30 through 61, as though set forth fully herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Retain Controlled Substance Records)

67. Respondents are subject to disciplinary action under Business and Professions Code section 4301, subdivisions (j) and (o), in conjunction with Business and Professions Code sections 4081, 4105 and 4306.5, subdivision (d), as well as HSC section 11179 in that Respondents failed to retain prescriptions filled by the pharmacy for the following controlled substances for three (3) years from the date of filling. Specifically, Respondents failed to retain the following prescriptions:

Date	RX#	Drug	Strength	Amt	MD	Script
3/25/11	616404	Roxicodone	30	240	L.G.	No
8/28/12	695750	Oxycontin	80	60	Si.	no

68. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 30 through 61, as though set forth fully herein.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Retain Pharmacy Records for Three Years)

69. Respondents are subject to disciplinary action under Business and Professions Code section 4105, subdivision (a)(b)(c) and (e)(1), in that Respondents failed to maintain in the pharmacy three years of acquisition and disposition records in a readily retrievable form. Specifically, Respondents failed to retain the following prescriptions:

Date	RX#	Drug	Strength	Amt	MD	Script
3/25/11	616404	Roxicodone	30	240	L.G.	No
8/28/12	695750	Oxycontin	80	60	Si.	no

70. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 30 through 61, as though set forth fully herein.

SIXTH CAUSE FOR DISCIPLINE

(Unauthorized Furnishing-Dangerous Drugs)

71. Respondents are subject to disciplinary action under Business and Professions Code section 4059, subdivision (a), in that Respondents furnished a dangerous drug (RX #640641) without a prescription, in violation of Business and Professions Code section 4059, subdivision (a).

72. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 30 through 61, as though set forth fully herein.

SEVENTH CAUSE FOR DISCIPLINE

(Unauthorized Refills)

73. Respondents are subject to disciplinary action under Business and Professions Code section 4063, in that Respondents refilled several prescriptions without authorization as set forth below.

///

///

Date	RX#	Drug	Strength	Amt	Day supply	MD	Authorized
11/28/11	644383	Provigil	200	60	30	L.G.	Unauthorized

74. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 30 through 61, as though set forth fully herein.

EIGHTH CAUSE FOR DISCIPLINE

(Refill of Schedule II Prescription)

75. Respondents are subject to disciplinary action under Health and Safety Code section 11200, subdivision (c), in that Respondents filled twice prescription RX #676017 for Roxicodone on April 16, 2012, and RX #619524 was filled twice on April 13, 2011. RX #652422 filled on November 20, 2011 and RX #647987 filled on October 21, 2011 for Opana ER, were filled using the same prescription document and RX #597940 for Roxicodone was filled twice on December 10, 2010 using the same prescription blank, in violation of HSC section 11200, subdivision (c).

76. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 30 through 61, as though set forth fully herein.

NINTH CAUSE FOR DISCIPLINE

(Variation from a Prescription)

77. Respondents are subject to disciplinary action under California Code of Regulations, section 1716, in that Respondents deviated from the requirements of a prescription. Specifically, RX #644383 was written for Provigil 200 mg #30 with no refills, however, said prescription was filled for 60 tablets with two refills, and RX #620238 which was rewritten to RX #644383, was filled one too many times.

78. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 30 through 61, as though set forth fully herein.

///

///

///

TENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Medication Profile)

79. Respondents are subject to disciplinary action under California Code of Regulations, section 1707.1, in that Respondents failed to maintain medication profiles on all patients who have prescriptions filled in the pharmacy. Specifically RX #642495 for Opama ER was filled twice on September 15, 2011, using two different prescription blanks, making the patient profile incorrect, in violation of California Code of Regulations, section 1707.1.

DISCIPLINE CONSIDERATIONS

80. To determine the degree of discipline, if any, to be imposed on Respondents, Complainant alleges the following:

a. On or about November 10, 2011, the Board issued Citation No. CI 2011 50277 against Respondent Pharmacy for violation of a BPC Code sections 4081 and 4105 [failure to retain dangerous drug records] and BPC Code section 4127.1 [compounding drugs without proper licensure]. That citation is now final and is incorporated by reference as if fully set forth.

b. On or about November 10, 2011, the Board issued Citation No. CI 2011 50278 against Respondent Bentow for violation of a BPC Code sections 4081 and 4105 [failure to retain dangerous drug records] and BPC Code section 4127.1 [compounding drugs without proper licensure]. That citation is now final and is incorporated by reference as if fully set forth.

c. On or about November 14, 2008, the Board issued Citation No. CI 2007 36061 against Respondent Pharmacy for violation of a BPC Code section 4342 [dispensing expired pharmaceuticals] and BPC Code section 4076 [prescription container labeling violation]. That citation is now final and is incorporated by reference as if fully set forth.

d. On or about November 14, 2008, the Board issued Citation No. CI 2008 38037 against Respondent Bentow for violation of a BPC Code section 4342 [dispensing expired pharmaceuticals] and BPC Code section 4076 [prescription container labeling violation]. That citation is now final and is incorporated by reference as if fully set forth.

e. On or about September 25, 2008, the Board issued Citation No. CI 2007 35945 against Respondent Pharmacy for violation of a BPC Code section 4076, subdivision (a)(11)(A)

[prescription container labeling violation] and BPC Code section 4104 [procedures concerning employee drug diversion]. That citation is now final and is incorporated by reference as if fully set forth.

f. On or about September 25, 2008, the Board issued Citation No. CI 2008 37893 against Respondent Bentow for violation of a BPC Code section 4076, subdivision (a)(11)(A) [prescription container labeling violation] and BPC Code section 4104 [procedures concerning employee drug diversion]. That citation is now final and is incorporated by reference as if fully set forth.

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 Number PHY 11433, issued to West Val Pharmacy, Inc.;

2. Revoking or suspending Pharmacist License Number RPH 35541, issued to Susan Bentow;

3. Ordering West Val Pharmacy, Inc. and Susan Bentow 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;

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

DATED: 12/22/15

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

LA2013510074
51391078.doc