

**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 Nos. PHY 11433**

**STANLEY GOLDENBERG
841 Stanford Street
Santa Monica, CA 90403
Pharmacist License No. RPH 20236**

**SUSAN BENTOW
182 Dapplegray Road
Bell Canyon, CA 91307
Pharmacist License No. RPH 35541**

Respondents.

Case No. 4850

OAH No. 2016020543

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER AS TO
SUSAN BENTOW ONLY**

DECISION AND ORDER

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

This decision shall become effective on February 8, 2017.

It is so ORDERED on January 9, 2017.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA



By

Amy Gutierrez, Pharm.D.
Board President

1 KAMALA D. HARRIS
Attorney General of California
2 MARC D. GREENBAUM
Supervising Deputy Attorney General
3 MORGAN MALEK
Deputy Attorney General
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Attorneys for Complainant
7

8 **BEFORE THE**
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**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER AS TO SUSAN
BENTOW ONLY**

21
22 **IT IS HEREBY STIPULATED AND AGREED** by and between the parties to the above-
23 entitled proceedings that the following matters are true:

24 **PARTIES**

25 1. Virginia Herold (Complainant) is the Executive Officer of the Board of Pharmacy
26 (Board). She brought this action solely in her official capacity and is represented in this matter by
27 Kamala D. Harris, Attorney General of the State of California, by Morgan Malek, Deputy
28 Attorney General.

1 2. Respondent Susan Bentow (Respondent) is represented in this proceeding by attorney
2 Armond Marcarian, Esq., whose address is: 31255 Cedar Valley Drive, Suite 301
3 Westlake Village, CA 91362.

4 3. On or about August 18, 1980, the Board of Pharmacy issued Pharmacist License
5 Number RPH 35541 to the Respondent. The Pharmacist License was in full force and effect at all
6 times relevant to the charges brought herein and will expire on April 30, 2018, unless renewed.
7 Respondent is and has been the Secretary/Treasurer and 25% shareholder of West Val Pharmacy
8 Inc. since 1985.

9 **JURISDICTION**

10 4. Revised First Amended Accusation as Amended by Interlineation No. 4850 was filed
11 before the Board, and is currently pending against the respondents. The Revised First Amended
12 Accusation as Amended by Interlineation and all other statutorily required documents were
13 properly served on the Respondent on or about October 28, 2016. Respondent timely filed her
14 Notice of Defense contesting the Accusation.

15 5. A copy of Revised First Amended Accusation as Amended by Interlineation No.
16 4850 is attached as exhibit A and incorporated herein by reference.

17 **ADVISEMENT AND WAIVERS**

18 6. Respondent has carefully read, fully discussed with counsel, and understands the
19 charges and allegations in the Revised First Amended Accusation as Amended by Interlineation
20 No. 4850. Respondent has also carefully read, fully discussed with counsel, and understands the
21 effects of this Stipulated Settlement and Disciplinary Order.

22 7. Respondent is fully aware of her legal rights in this matter, including the right to a
23 hearing on the charges and allegations in the of Revised First Amended Accusation as Amended
24 by Interlineation; the right to confront and cross-examine the witnesses against her; the right to
25 present evidence and to testify on her own behalf; the right to the issuance of subpoenas to
26 compel the attendance of witnesses and the production of documents; the right to reconsideration
27 and court review of an adverse decision; and all other rights accorded by the California
28 Administrative Procedure Act and other applicable laws.

1 It supersedes any and all prior or contemporaneous agreements, understandings, discussions,
2 negotiations, and commitments (written or oral). This Stipulated Settlement and Disciplinary
3 Order may not be altered, amended, modified, supplemented, or otherwise changed except by a
4 writing executed by an authorized representative of each of the parties.

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

8 **DISCIPLINARY ORDER**

9 **IT IS HEREBY ORDERED** that Pharmacist License Number RPH 35541 issued to
10 Respondent Susan Bentow is revoked. However, the revocation is stayed and Respondent is
11 placed on probation for five (5) years on the following terms and conditions.

12 **1. Obey All Laws**

13 Respondent shall obey all state and federal laws and regulations.

14 Respondent shall report any of the following occurrences to the board, in writing, within
15 seventy-two (72) hours of such occurrence:

- 16 • an arrest or issuance of a criminal complaint for violation of any provision of the
17 Pharmacy Law, state and federal food and drug laws, or state and federal controlled
18 substances laws
- 19 • a plea of guilty or nolo contendere in any state or federal criminal proceeding to any
20 criminal complaint, information or indictment
- 21 • a conviction of any crime
- 22 • discipline, citation, or other administrative action filed by any state or federal agency
23 which involves respondent's pharmacist license or which is related to the practice of
24 pharmacy or the manufacturing, obtaining, handling, distributing, billing, or charging
25 for any drug, device or controlled substance.

26 Failure to timely report such occurrence shall be considered a violation of probation.

27 **2. Report to the Board**

1 Respondent shall report to the board quarterly, on a schedule as directed by the board or its
2 designee. The report shall be made either in person or in writing, as directed. Among other
3 requirements, respondent shall state in each report under penalty of perjury whether there has
4 been compliance with all the terms and conditions of probation. Failure to submit timely reports
5 in a form as directed shall be considered a violation of probation. Any period(s) of delinquency
6 in submission of reports as directed may be added to the total period of probation. Moreover, if
7 the final probation report is not made as directed, probation shall be automatically extended until
8 such time as the final report is made and accepted by the board.

9 **3. Interview with the Board**

10 Upon receipt of reasonable prior notice, respondent shall appear in person for interviews
11 with the board or its designee, at such intervals and locations as are determined by the board or its
12 designee. Failure to appear for any scheduled interview without prior notification to board staff,
13 or failure to appear for two (2) or more scheduled interviews with the board or its designee during
14 the period of probation, shall be considered a violation of probation.

15 **4. Cooperate with Board Staff**

16 Respondent shall cooperate with the board's inspection program and with the board's
17 monitoring and investigation of respondent's compliance with the terms and conditions of his
18 probation. Failure to cooperate shall be considered a violation of probation.

19 **5. Continuing Education**

20 Respondent shall provide evidence of efforts to maintain skill and knowledge as a
21 pharmacist as directed by the board or its designee.

22 **6. Notice to Employers**

23 During the period of probation, respondent shall notify all present and prospective
24 employers of the decision in case number 4850 and the terms, conditions and restrictions imposed
25 on respondent by the decision, as follows:

26 Within thirty (30) days of the effective date of this decision, and within fifteen (15) days of
27 respondent undertaking any new employment, respondent shall cause her direct supervisor,
28 pharmacist-in-charge (including each new pharmacist-in-charge employed during respondent's

1 tenure of employment) and owner to report to the board in writing acknowledging that the listed
2 individual(s) has/have read the decision in case number 4850, and terms and conditions imposed
3 thereby. It shall be respondent's responsibility to ensure that her employer(s) and/or supervisor(s)
4 submit timely acknowledgment(s) to the board.

5 If respondent works for or is employed by or through a pharmacy employment service,
6 respondent must notify her direct supervisor, pharmacist-in-charge, and owner at every entity
7 licensed by the board of the terms and conditions of the decision in case number 4850 in advance
8 of the respondent commencing work at each licensed entity. A record of this notification must be
9 provided to the board upon request.

10 Furthermore, within thirty (30) days of the effective date of this decision, and within fifteen
11 (15) days of respondent undertaking any new employment by or through a pharmacy employment
12 service, respondent shall cause her direct supervisor with the pharmacy employment service to
13 report to the board in writing acknowledging that she has read the decision in case number 4850
14 and the terms and conditions imposed thereby. It shall be respondent's responsibility to ensure
15 that her employer(s) and/or supervisor(s) submit timely acknowledgment(s) to the board.

16 Failure to timely notify present or prospective employer(s) or to cause that/those
17 employer(s) to submit timely acknowledgments to the board shall be considered a violation of
18 probation.

19 "Employment" within the meaning of this provision shall include any full-time,
20 part-time, temporary, relief or pharmacy management service as a pharmacist or any
21 position for which a pharmacist license is a requirement or criterion for employment,
22 whether the respondent is an employee, independent contractor or volunteer.

23 **7. No Supervision of Interns, Serving as Pharmacist-in-Charge (PIC), Serving as**
24 **Designated Representative-in-Charge, or Serving as a Consultant**

25 During the period of probation, respondent shall not supervise any intern pharmacist, be the
26 pharmacist-in-charge or designated representative-in-charge of any entity licensed by the board
27 nor serve as a consultant unless otherwise specified in this order. However, Respondent may act
28 as a pharmacist-in-charge with a consultant at West Val Pharmacy, Inc., *or the new owner of*

1 *interest to West-Val Pharmacy, Inc.* located at 5353 Balboa Blvd., Encino, CA 9316. Assumption
2 of any such unauthorized supervision responsibilities shall be considered a violation of probation.

3 **8. Reimbursement of Board Costs**

4 As a condition precedent to successful completion of probation, respondent shall pay to the
5 board its costs of investigation and prosecution in the amount of \$7,500.00. Respondent shall
6 make said payments as ordered by the Board.

7 There shall be no deviation from this schedule absent prior written approval by the board or
8 its designee. Failure to pay costs by the deadline(s) as directed shall be considered a violation of
9 probation.

10 The filing of bankruptcy by respondent shall not relieve respondent of her responsibility to
11 reimburse the board its costs of investigation and prosecution.

12 **9. Probation Monitoring Costs**

13 Respondent shall pay any costs associated with probation monitoring as determined by the
14 board each and every year of probation. Such costs shall be payable to the board on a schedule as
15 directed by the board or its designee. Failure to pay such costs by the deadline(s) as directed shall
16 be considered a violation of probation.

17 **10. Status of License**

18 Respondent shall, at all times while on probation, maintain an active, current license with
19 the board, including any period during which suspension or probation is tolled. Failure to
20 maintain an active, current license shall be considered a violation of probation.

21 If respondent's license expires or is cancelled by operation of law or otherwise at any time
22 during the period of probation, including any extensions thereof due to tolling or otherwise, upon
23 renewal or reapplication respondent's license shall be subject to all terms and conditions of this
24 probation not previously satisfied.

25 **11. License Surrender While on Probation/Suspension**

26 Following the effective date of this decision, should respondent cease practice due to
27 retirement or health, or be otherwise unable to satisfy the terms and conditions of probation,
28 respondent may tender her license to the board for surrender. The board or its designee shall have

1 the discretion whether to grant the request for surrender or take any other action it deems
2 appropriate and reasonable. Upon formal acceptance of the surrender of the license, respondent
3 will no longer be subject to the terms and conditions of probation. This surrender constitutes a
4 record of discipline and shall become a part of the respondent's license history with the board.

5 Upon acceptance of the surrender, respondent shall relinquish her pocket and wall license to
6 the board within ten (10) days of notification by the board that the surrender is accepted.

7 Respondent may not reapply for any license from the board for three (3) years from the effective
8 date of the surrender. Respondent shall meet all requirements applicable to the license sought as
9 of the date the application for that license is submitted to the board, including any outstanding
10 costs.

11 **12. Notification of a Change in Name, Residence Address, Mailing Address or**
12 **Employment**

13 Respondent shall notify the board in writing within ten (10) days of any change of
14 employment. Said notification shall include the reasons for leaving, the address of the new
15 employer, the name of the supervisor and owner, and the work schedule if known. Respondent
16 shall further notify the board in writing within ten (10) days of a change in name, residence
17 address, mailing address, or phone number.

18 Failure to timely notify the board of any change in employer(s), name(s), address(es), or
19 phone number(s) shall be considered a violation of probation.

20 **13. Tolling of Probation**

21 Except during periods of suspension, respondent shall, at all times while on probation, be
22 employed as a pharmacist in California for a minimum of 40 hours per calendar month. Any
23 month during which this minimum is not met shall toll the period of probation, i.e., the period of
24 probation shall be extended by one month for each month during which this minimum is not met.
25 During any such period of tolling of probation, respondent must nonetheless comply with all
26 terms and conditions of probation.

27 Should respondent, regardless of residency, for any reason (including vacation) cease
28 practicing as a pharmacist for a minimum of 40 hours per calendar month in California,

1 respondent must notify the board in writing within ten (10) days of the cessation of practice, and
2 must further notify the board in writing within ten (10) days of the resumption of practice. Any
3 failure to provide such notification(s) shall be considered a violation of probation.

4 It is a violation of probation for respondent's probation to remain tolled pursuant to the
5 provisions of this condition for a total period, counting consecutive and non-consecutive months,
6 exceeding thirty-six (36) months.

7 "Cessation of practice" means any calendar month during which respondent is
8 not practicing as a pharmacist for at least 40 hours, as defined by Business and
9 Professions Code section 4000 et seq . "Resumption of practice" means any calendar
10 month during which respondent is practicing as a pharmacist for at least 40 hours as a
11 pharmacist as defined by Business and Professions Code section 4000 et seq.

12 **14. Violation of Probation**

13 If a respondent has not complied with any term or condition of probation, the board shall
14 have continuing jurisdiction over respondent, and probation shall automatically be extended, until
15 all terms and conditions have been satisfied or the board has taken other action as deemed
16 appropriate to treat the failure to comply as a violation of probation, to terminate probation, and
17 to impose the penalty that was stayed.

18 If respondent violates probation in any respect, the board, after giving respondent notice
19 and an opportunity to be heard, may revoke probation and carry out the disciplinary order that
20 was stayed. Notice and opportunity to be heard are not required for those provisions stating that a
21 violation thereof may lead to automatic termination of the stay and/or revocation of the license. If
22 a petition to revoke probation or an accusation is filed against respondent during probation, the
23 board shall have continuing jurisdiction and the period of probation shall be automatically
24 extended until the petition to revoke probation or accusation is heard and decided.

25 **15. Completion of Probation**

26 Upon written notice by the board or its designee indicating successful completion of
27 probation, respondent's license will be fully restored.

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1 **16. Suspension**

2 As part of probation, respondent is suspended from the practice of pharmacy until
3 completion of 6 hours of remedial education (in person) in prescription drug abuse, corresponding
4 responsibility and pharmacy operations. These 6 hours are part of the 10 hours per year listed
5 under remedial education requirements. If the hours are completed prior to the Board's adoption
6 of the present Stipulated Settlement & Disciplinary Order as to Susan Bentow Only, there will be
7 no actual suspension when the Board's Decision becomes effective.

8 During suspension, respondent shall not enter any pharmacy area or any portion of the
9 licensed premises of a wholesaler, veterinary food-animal drug retailer or any other distributor of
10 drugs which is licensed by the board, or any manufacturer, or where dangerous drugs and devices
11 or controlled substances are maintained. Respondent shall not practice pharmacy nor do any act
12 involving drug selection, selection of stock, manufacturing, compounding, dispensing or patient
13 consultation; nor shall respondent manage, administer, or be a consultant to any licensee of the
14 board, or have access to or control the ordering, manufacturing or dispensing of dangerous drugs
15 and devices or controlled substances.

16 Respondent shall not engage in any activity that requires the professional judgment of a
17 pharmacist. Respondent shall not direct or control any aspect of the practice of pharmacy.
18 Respondent shall not perform the duties of a pharmacy technician or a designated representative
19 for any entity licensed by the board.

20 Subject to the above restrictions, respondent may continue to own or hold an interest in any
21 licensed premises in which he holds an interest at the time this decision becomes effective unless
22 otherwise specified in this order.

23 Failure to comply with this suspension shall be considered a violation of probation.

24 **17. Remedial Education**

25 Within sixty (60) days of the effective date of this decision, respondent shall submit to the
26 board or its designee, for prior approval, an appropriate program of remedial education related to
27 prescription drug abuse, corresponding responsibility, and pharmacy law. The program of
28 remedial education shall consist of at least 10 hours, which shall be completed within one year at

1 respondent's own expense. All remedial education shall be in addition to, and shall not be
2 credited toward, continuing education (CE) courses used for license renewal purposes.

3 Failure to timely submit or complete the approved remedial education shall be considered a
4 violation of probation. The period of probation will be automatically extended until such
5 remedial education is successfully completed and written proof, in a form acceptable to the board,
6 is provided to the board or its designee.

7 Following the completion of each course, the board or its designee may require the
8 respondent, at her own expense, to take an approved examination to test the respondent's
9 knowledge of the course. If the respondent does not achieve a passing score on the examination,
10 this failure shall be considered a violation of probation. Any such examination failure shall
11 require respondent to take another course approved by the board in the same subject area.

12 **18. Supervised Practice**

13 During the period of probation, respondent shall practice only under the supervision of a
14 licensed pharmacist not on probation with the board. Upon and after the effective date of this
15 decision, respondent shall not practice pharmacy and his license shall be automatically suspended
16 until a supervisor is approved by the board or its designee. The supervision shall be, as required
17 by the board or its designee, either:

18 Continuous – At least 75% of a work week

19 Substantial - At least 50% of a work week

20 Partial - At least 25% of a work week

21 Daily Review - Supervisor's review of probationer's daily activities within 24 hours

22 Within thirty (30) days of the effective date of this decision, respondent shall have her
23 supervisor submit notification to the board in writing stating that the supervisor has read the
24 decision in case number 4850 and is familiar with the required level of supervision as determined
25 by the board or its designee. It shall be the respondent's responsibility to ensure that her
26 employer(s), pharmacist-in-charge and/or supervisor(s) submit timely acknowledgement(s) to the
27 board. Failure to cause the direct supervisor and the pharmacist-in-charge to submit timely
28 acknowledgements to the board shall be considered a violation of probation.

1 If respondent changes employment, it shall be the respondent's responsibility to ensure that
2 her employer(s), pharmacist-in-charge and/or supervisor(s) submit timely acknowledgement(s) to
3 the board. Respondent shall have her new supervisor, within fifteen (15) days after employment
4 commences, submit notification to the board in writing stating the direct supervisor and
5 pharmacist-in-charge have read the decision in case number 4850 and is familiar with the level of
6 supervision as determined by the board. Respondent shall not practice pharmacy and her license
7 shall be automatically suspended until the board or its designee approves a new supervisor.
8 Failure to cause the direct supervisor and the pharmacist-in-charge to submit timely
9 acknowledgements to the board shall be considered a violation of probation.

10 Within ten (10) days of leaving employment, respondent shall notify the board in writing.

11 During suspension, respondent shall not enter any pharmacy area or any portion of the
12 licensed premises of a wholesaler, veterinary food-animal drug retailer or any other distributor of
13 drugs which is licensed by the board, or any manufacturer, or where dangerous drugs and devices
14 or controlled substances are maintained. Respondent shall not practice pharmacy nor do any act
15 involving drug selection, selection of stock, manufacturing, compounding, dispensing or patient
16 consultation; nor shall respondent manage, administer, or be a consultant to any licensee of the
17 board, or have access to or control the ordering, manufacturing or dispensing of dangerous drugs
18 and controlled substances. Respondent shall not resume practice until notified by the board.

19 During suspension, respondent shall not engage in any activity that requires the
20 professional judgment of a pharmacist. Respondent shall not direct or control any aspect of the
21 practice of pharmacy. Respondent shall not perform the duties of a pharmacy technician or a
22 designated representative for any entity licensed by the board.

23 Subject to the above restrictions, respondent may continue to own or hold an interest in any
24 licensed premises in which he holds an interest at the time this decision becomes effective unless
25 otherwise specified in this order.

26 Failure to comply with this suspension shall be considered a violation of probation.

27 **19. No New Ownership of Licensed Premises**

28 Respondent shall not acquire any new ownership, legal or beneficial interest nor serve as a

1 manager, administrator, member, officer, director, trustee, associate, or partner of any additional
2 business, firm, partnership, or corporation licensed by the board. If respondent currently owns or
3 has any legal or beneficial interest in, or serves as a manager, administrator, member, officer,
4 director, trustee, associate, or partner of any business, firm, partnership, or corporation currently
5 or hereinafter licensed by the board, respondent may continue to serve in such capacity or hold
6 that interest, but only to the extent of that position or interest as of the effective date of this
7 decision. Violation of this restriction shall be considered a violation of probation.

8 **20. Ethics Course**

9 Within sixty (60) calendar days of the effective date of this decision, respondent shall enroll
10 in a course in ethics, at respondent's expense, approved in advance by the board or its designee.
11 Failure to initiate the course during the first year of probation, and complete it within the second
12 year of probation, is a violation of probation.

13 Respondent shall submit a certificate of completion to the board or its designee within five
14 days after completing the course.

15 **21. Consultant for Owner or Pharmacist-In-Charge**

16 During the period of probation, Respondent shall retain an independent consultant at her
17 own expense, who shall be responsible for reviewing pharmacy operations on a monthly basis for
18 compliance by Respondent with state and federal laws and regulations for compliance by
19 Respondent with the obligations of a pharmacist-in-charge. The consultant shall be a pharmacist
20 licensed by and not on probation with the board and whose name shall be submitted to the board
21 or its designee, for prior approval, within thirty (30) days of the effective date of this decision.
22 Consultant for Owner or Pharmacist-In-Charge may be reduced by Board designee. During the
23 period of probation, the Board or its designee, retains the discretion to reduce the frequency of the
24 pharmacist consultant's review of Respondent West Val Pharmacy, Inc.. Failure to timely retain,
25 seek approval of, or ensure timely reporting by the consultant shall be considered a violation of
26 probation.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Armond Marcarian, Esq.. I understand the stipulation and the effect it will have on my Pharmacist License. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: _____
SUSAN BENTOW
Respondent

I have read and fully discussed with Respondent Susan Bentow the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: _____
ARMOND MARCARIAN, ESQ.
Attorney for Respondent

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Armond Marcarian, Esq.. I understand the stipulation and the effect it will have on my Pharmacist License. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: 11-16-16 Susan Bentow
SUSAN BENTOW
Respondent

I have read and fully discussed with Respondent Susan Bentow the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: Nov. 17, 2016 Armond Marcarian
ARMOND MARCARIAN, ESQ.
Attorney for Respondent

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ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Board of Pharmacy.

Dated: 11/17/16

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
MARC D. GREENBAUM
Supervising Deputy Attorney General


MORGAN MALEK
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Revised First Amended Accusation as Amended by Interlineation No. 4850

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Attorneys for Complainant
7

8 **BEFORE THE**
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9 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

10 In the Matter of the Accusation Against:
11 **WEST VAL PHARMACY, INC.**
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13 **Pharmacy Permit No. PHY 11433**

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OAH No. 2016020543

14 **STANLEY GOLDENBERG**
15 **841 Stanford Street**
Santa Monica, CA 90403
16 **Pharmacist License No. RPH 20236**

REVISED FIRST AMENDED
ACCUSATION AS AMENDED BY
INTERLINEATION

17 **SUSAN BENTOW**
18 **182 Dapplegray Road**
Bell Canyon, CA 91307
19 **Pharmacist License No. RPH 35541**

Respondents.

20 Complainant alleges:

21 **PARTIES**

22 1. Virginia Herold (Complainant) brings this Accusation solely in her official capacity
23 as the Executive Officer of the Board of Pharmacy, Department of Consumer Affairs.

24 2. On or about February 1, 1984, the Board of Pharmacy issued Pharmacy Permit
25 Number PHY 11433 to West Val Pharmacy, Inc. (Respondent Pharmacy). The Pharmacy Permit
26 was in full force and effect at all times relevant to the charges brought herein and will expire on
27 February 1, 2017, unless renewed. On or about April 20, 1957, the Board of Pharmacy issued
28

1 Pharmacist License Number RPH 20236 to Stanley Goldenberg (Respondent Goldenberg). The
2 Pharmacist License was in full force and effect at all times relevant to the charges brought herein
3 and will expire on January 31, 2017, unless renewed. Respondent Goldenberg is and has been the
4 President and 75% shareholder of Respondent Pharmacy since 1985.

5 3. On or about August 18, 1980, the Board of Pharmacy issued Pharmacist License
6 Number RPH 35541 to Susan Bentow (Respondent Bentow). The Pharmacist License was in full
7 force and effect at all times relevant to the charges brought herein and will expire on April 30,
8 2018, unless renewed. Respondent Bentow is and has been the Secretary/Treasurer and 25%
9 shareholder of Respondent Pharmacy since 1985.

10 JURISDICTION

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

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

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

16 "The expiration, cancellation, forfeiture, or suspension of a board-issued license by
17 operation of law or by order or decision of the board or a court of law, the placement of a license
18 on a retired status, or the voluntary surrender of a license by a licensee shall not deprive the board
19 of jurisdiction to commence or proceed with any investigation of, or action or disciplinary
20 proceeding against, the licensee or to render a decision suspending or revoking the license."

21 7. **Section 4302** of the Business and Professions Code states:

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

26 BUSINESS AND PROFESSIONS CODE

27 8. **Section 4059**, subdivision (a), of the Business and Professions Code states:
28

1 "A person may not furnish any dangerous drug except upon the prescription of a physician,
2 dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7. A
3 person may not furnish any dangerous device, except upon the prescription of a physician,
4 dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7."

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

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

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

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

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

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

24 "(a) All records or other documentation of the acquisition and disposition of dangerous
25 drugs and dangerous devices by any entity licensed by the board shall be retained on the licensed
26 premises in a readily retrievable form.

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

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

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

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

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

17

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

19 “The pharmacist-in-charge shall be responsible for a pharmacy's compliance with all state
20 and federal laws and regulations pertaining to the practice of pharmacy.”

21 13. **Section 4301** of the Business and Professions Code states:

22 “The board shall take action against any holder of a license who is guilty of unprofessional
23 conduct or whose license has been procured by fraud or misrepresentation or issued by mistake.
24 Unprofessional conduct shall include, but is not limited to, any of the following:

25 ...

26 “(j) The violation of any of the statutes of this state, or any other state, or of the United
27 States regulating controlled substances and dangerous drugs.

28 ...

1 (o) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the
2 violation of or conspiring to violate any provision or term of this chapter or of the applicable
3 federal and state laws and regulations governing pharmacy, including regulations established by
4 the board or by any other state or federal regulatory agency.

5

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

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

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

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

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

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

22 **HEALTH AND SAFETY CODE**

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

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

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

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

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

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

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

11 **CALIFORNIA CODE OF REGULATIONS**

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

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

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

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

21 (B) For each prescription dispensed by the pharmacy:

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

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

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

27 4. The prescription number for each prescription; and

28 5. The information required by section 1717.

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

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

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

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

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

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

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

16 **CONTROLLED SUBSTANCES AND DANGEROUS DRUGS**

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

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

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

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

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

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

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

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

13 **COST RECOVERY**

14 29. **Section 125.3** of the Business and Professions Code states, in pertinent part, that the
15 Board may request the administrative law judge to direct a licensee found to have committed a
16 violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the
17 investigation and enforcement of the case.

18 **FACTUAL BACKGROUND**

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

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

28

1 32. On March 15, 2013, a Board inspector conducted an inspection at Respondent
2 Pharmacy where she met with Respondent Bentow and her father, Respondent Goldenberg,
3 president of Respondent Pharmacy. Respondent Goldenberg notified the Board inspector that
4 Dr. L.G. committed suicide because he was being investigated by the Medical Board. In
5 preparation for the inspection, the Board inspector reviewed CURES¹ data for the pharmacy from
6 October 2008 to January 2010 and chose eleven (11) pharmacy patients, including Patient B.K., to
7 review for controlled substance dispensing.

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

11 34. During the inspection, the inspector also showed Respondent Bentow a CURES
12 report indicating that between October 2008 and January 2010, Respondent Pharmacy had filled
13 4,586 controlled substance prescriptions written by Dr. L.G., which constituted 14% of all
14 controlled substance prescriptions filled by Respondent Pharmacy during that time. The inspector
15 asked Respondent Bentow if she ever called Dr. L.G. or his office to confirm any of these
16 prescriptions, and Respondent Bentow replied that she had not.

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

21 36. At the conclusion of the on-site inspection, the inspector gave Respondent Bentow a
22 copy of the inspection report and a list of questions seeking, among other things, information on
23 each of the 11 patients she had previously identified, including all original prescriptions related to
24

25 ¹ Controlled Substance Utilization Review and Evaluation System, C.U.R.E.S, is a database that contains
26 over 100 million entries of controlled substance drugs that were dispensed in California. CURES is part of
27 a program developed by the California Department of Justice, Bureau of Narcotic Enforcement, which
28 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.

1 the patients, information on the pharmacy's relationship with Dr. L.G., information on what steps
2 taken to decide whether or not to fill a prescription, and information on the previously unreported
3 theft of drugs from the pharmacy. The Board investigator also asked for a printout for Dr. K.T., a
4 physician whose name came up while she was going through the prescriptions filled by the
5 Respondents.

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

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

28

1 L.G. had surgery on his back and ended up getting hooked on pain medications and committed
2 suicide.”

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

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

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

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

- 28 • unauthorized refills (RX #620238 on September 1, 2011;

- 1 • early prescription fills for RX# 641875, #620238, #623813 and #619348;
- 2 • evidence of two fills on the same day for the same prescription (RX #676017 on April 13,
- 3 2011;
- 4 • not all prescriptions were provided to the Board inspector (RX #662364, #662363, #650918
- 5 and # 634169);
- 6 • RX #644383 was taken as an oral prescription for Provigil 200 mg #30 with no refills,
- 7 however, it was filled for 60 tablets with 2 refills;
- 8 • In January 2012, Patient K.D. was prescribed a medication for sleep (Temazepam), but a
- 9 day later was prescribed a CNS stimulant to help the patient stay alert or awake
- 10 (Provigil). There is no documentation of why the same physician would prescribe a
- 11 medication for sleep, thereafter prescription another medication to help the patient to stay
- 12 awake. Dr. L.G. mentioned on one prescription (RX #665967 for Roxicodone) that
- 13 Patient K.D. failed on Morphine Sulfate Immediate Release (MSIR), however, there was
- 14 no record of Patient K.D. taking MSIR. There was no documentation showing whether
- 15 Respondent Pharmacy called to clarify the patient's drug history.
- 16 • Further, RX #621120 which was written by the physician to be filled on April 21, 2011, was
- 17 in fact filled on April 18, 2011, 3 days before said prescription was authorized.

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

26 (d) **Patient K.A.:** Respondent Bentow told the Board inspector that Patient K.A.
27 was “messed up.” On April 22, 2013, Respondent Bentow wrote “[P]t. has sever back pain and
28 spasms. We made sure to keep track of his refills to a minimum of 28-29 days.” Review of the

1 patient profile showed Patient K.A. received Dilaudid, Soma and MS Contin every month from
2 2009 to 2013. Every month the prescription got filled several days earlier. Although each time it
3 is not more than 4 days early, over time, filling the prescription early allows the patient to obtain
4 more medications, for example, from November 23, 2010 to April 10, 2012 (a total of 504 days)
5 Patient K.A. received about 600 day supply of medications, meaning that he had a surplus of 96
6 days of medication. Further, prescription RX #682352 which was void after May 10, 2012 was
7 filled on May 28, 2012.

8 (e) **Patient P.R.:** Respondent Bentow explained to the Board investigator that this
9 patient had surgery. On April 22, 2013, Respondent Bentow wrote “[P]t. had 2 total knee
10 replacements, back problems, and lymphedema, which causes pain in the lower extremities.
11 Further patient P.R. also had fibromyalgia and severe arthritis.” Review of the patient’s history
12 revealed that Patient P.R. used multiple physicians to obtain Oxycontin (Oxycodone). From 2012
13 to 2013, Patient P.R. saw Dr. S., Dr. N., Dr. H., Dr. Sc. and Dr. L.G.. Sometimes the physicians
14 are seen on dates close to each other, i.e., this patient was seen by Dr. H. on December 27, 2012
15 and Dr. N. on January 2, 2013. Each time a prescription was written for Oxycontin and
16 Oxycodone for 20 to 30 day supply, Respondent Pharmacy filled both prescriptions. Patient P.R.
17 received different doses of Oxycodone, i.e., on December 27, 2012, this patient received 40 mg of
18 Oxycodone and received 80 mg of Oxycodone on January 2, 2013. There is no documentation
19 showing why Patient P.R. saw a different physician and received a different strength, and why it
20 was filled even though the patient just filled a prescription days before. Further, Patient P.R. was
21 prescribed the Oxycontin against normal recommended dosing. Pursuant to its manufacturer,
22 Oxycontin should not be used as prn (as needed) analgesic. The initial dosing is 10 mg every 12
23 hours. The dose may be increased, as a guideline the total daily dose can be increased by 25% to
24 50% of the current dose. There are no well controlled studies evaluating the safety and efficacy
25 with dosing more frequently than every 12 hours. The 60 mg and 80 mg Oxycontin tablets are
26 only be used in opioid tolerant patients. The physicians prescribed Oxycontin for P.R. as a prn,
27 every 4 hour drug, which is against the recommendations. There is no documentation showing
28 why Oxycontin being given prn or as often as every 4 hours. Oxycontin is a slow release drug,

1 which is why it is dosed every 12 hours. Opana ER is also dosed at 12 hour intervals, yet, Dr.
2 L.G. prescribed it every 4 or 6 hours. There is no documentation substantiating that Respondent
3 Pharmacy spoke or clarified the dosing for this patient for Opana or Oxycontin. Further, Patient
4 P.R. received early fills for the following prescriptions: RX #724094 on February 20, 2013, RX #
5 715205 on January 2, 2013, RX #715204 on January 2, 2013, RX #677593 on April 25, 2012, RX
6 #677592 on April 25, 2012, RX #676753 on April 20, 2012, RX #673498 on March 30, 2012, RX
7 #673497 on March 30, 2012, RX #673133 on March 28, 2012.) It should be noted that the
8 respondent did not provide all prescriptions the Board inspector requested during her March 15,
9 2013 inspection.

10 (f) **Patient K.W.:** Respondent Bentow stated “[W]e made sure to keep track of her
11 refills to a minimum of 28 to 29 days.” Patient K.W. is registered nurse. She received Percocet
12 and Lortab at the same time prescribed by the same physician. These two drugs both have
13 Acetaminophen, which in large amounts over a period of time, can cause liver damage.
14 Pharmacist should know the total daily dose of Acetaminophen should not be over 3 grams per
15 day. Patient K.W. received over 4 grams per day of Acetaminophen for years. Further,
16 Respondent Bentow included a CURES printout she did for this patient in May of 2011 which
17 showed the patient used two different pharmacies in April 2011 to get Hydrocodone/apap
18 prescriptions. This should have been red flags for Respondent Bentow. Further, in February of
19 2011, Respondent Bentow filled two 30 day prescriptions for Alprazolam for this patient.
20 Respondents failed to provide all of Patient K.W.’s prescriptions to the Board’s investigator
21 during her March 15, 2013 inspection. Further, there were early fills for this patient (RX #611818
22 on February 27, 2011.)

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

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

3 (h) **Patient B.K.:** Respondent Bentow told the Board investigator that she did not
4 know about Patient B.K. Respondent Bentow wrote to the Board investigator on April 22,
5 2013 “[W]e have not serviced him since 2009 and no prescriptions were submitted to you.” The
6 Board of Pharmacy ran a CURES report on Patient B.K. from June 1, 2008 to October 11, 2011.
7 CURES report showed in 2009, Patient B.K. used the following pharmacies: 1) Kanan Pharmacy
8 & Medical; 2) West Val Pharmacy; 3) Longs Drugs; 4) Costco; 5) CVS; and 6) Rite Aid. Patient
9 B.K. saw Dr. L.G., Dr. K., Dr. M. and Dr. St. in 2009. This patient was doctor shopper and used
10 multiple pharmacies. If Respondent Pharmacy used CURES information for Patient B.K., it
11 would have shown that he was getting the same prescriptions filled for the same drug on the same
12 day at two different pharmacies, i.e., Oxycontin 80 mg #32 and Norco 10/325 #156 was filled at
13 Kanan Pharmacy on November 12, 2009, and Oxycontin 80 mg #45 and Norco 10/325 #156 was
14 filled at Respondent Pharmacy on the same day. On October 12, 2009 Respondent Pharmacy
15 filled Norco 10/325 #210 and Kanan filled Norco 10/325 #210 on October 29, 2009. On
16 November 30, 2009, Respondent Pharmacy filled Amphetamine salt combo 20 mg #60 (30 day
17 supply) and on December 7, 2009, CVS filled Amphetamine salt combo 30 mg #60 (30 day
18 supply). On December 23, 2009 Respondent Pharmacy filled Amphetamine salt combo 20 mg
19 #60 (30 day supply) and on January 6, 2010 Costco Amphetamine salt combo 30 mg #60 (30 day
20 supply. On May 29, 2013, Board investigator obtained a copy of the death certificate for Patient
21 B.K. He passed away on January 12, 2010 at the age of 26. The cause of death was listed as
22 Oxycodone intoxication. Board investigator determined that Respondent Pharmacy filled 460
23 Oxycodone containing tablets, filled over 7 months from May 6, 2009 to December 21, 2009. It
24 should be noted that Respondent Pharmacy filled the last Oxycodone prescription before Patient
25 B.K. passed away.

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

28

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

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

9 43. Respondent Bentow explained that RX #611818 was changed from **RX #610796**
10 requiring another fill for the patient since the physician ordered the wrong strength. The Board's
11 inspector found that RX #610796 was for Xanax 1 mg with a total of 2 tablets (2 mg) taken per
12 day. The prescriber wrote for a month's supply. However, five days later, the changed RX
13 #611818 is for Xanax 2 mg, #30, has no directions, however, #30 was given. Respondent Bentow
14 has no documentation showing why patient's prescription changed from Xanax 1 mg twice a day
15 to Xanax 2 mg, five days later. The prescriber, Dr. L.G. wrote both prescriptions. Respondent
16 Bentow should have followed up with Dr. L.G. and the patient.

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

25 45. Respondent Bentow explained that RX #715205 was filled because previous **RX**
26 **#714411** was for #30 and only lasted until January 2, 2013 since the patient needed to take eight
27 to nine times a day. Board's Inspector found RX #714411 was prescribed as once a day as
28 needed, therefore, it should have lasted 30 day. If the patient brought in a prescription a week

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

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

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

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

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

25 49. Respondent Bentow explained that **RX #676753** was filled on April 20, 2012 because
26 previous RX (RX #673733) for Oxycontin 40 mg was a 20 day supply. RX #673133 was for #60,
27 three times a day on March 28, 2012. The Board's Inspector stated that Respondent Bentow is
28 justifying her early fills based on the time the exact same physician prescribed the same drug.

1 However, Respondent Bentow fails to consider that the patients may be seeing multiple
2 physicians who prescribe the same or similar drugs, and that the patient may be taking multiple
3 other drugs prescribed at the same time. Respondent Bentow should have questioned the
4 prescription for the stronger Oxycontin and called the physician to determine whether she knew
5 that the patient was already being treated by Dr. H.. She should have called Dr. H. and asked if he
6 knew the patient was being seen by Dr. S. to avoid duplicate therapy. Whenever, the patient
7 brings in prescriptions for the same drug from two different prescribers in a short amount of time,
8 it is a red flag to the pharmacist to question the prescription.

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

22 50. Respondent Bentow explained that **RX #673498** was filled on March 30, 2012
23 because there was a large increase in dosage. The previous Rx #673134 was only for #30 and
24 only lasted from March 28, 2012 to March 30, 2012 because they had to take it 10-11 times a day.
25 The Board's Inspector stated that Respondent Bentow did not question why Patient P.R. filled a
26 prescription for Roxicodone 30 mg to take once a day as needed, thereafter, two days later, the
27 same patient brings a prescription from a different physician (Dr. S.) instructing the patient to take
28 Roxicodone 30 mg, 10-11 times a day. Respondent Bentow failed to document why Patient P.R.

1 was seeing multiple doctors, or why all of a sudden this patient's prescription dosage increased
2 from once a day to ten to eleven times a day, and why it was not a gradual increase. Respondent
3 Bentow failed to assess that this qualifies as an early fill.

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

23 52. Respondent Bentow explained that **RX #673133** was filled because Dr. L.G. passed
24 away and the patient was looking for a new pain management physician. Prescription was for 40
25 mg Oxycontin which is something she didn't have before. This was a change in dose from the
26 new physician. The Board's Inspector stated that Respondent Bentow refers to Patient P.R.'s
27 new physician, Dr. H.. However, Respondent Bentow filled another prescription two days later
28 after Dr. H.'s prescription which was written by another physician. Respondent Bentow failed to

1 follow up with the physicians and Patient P.R. about the dosage of Oxycontin to change from
2 Oxycontin 80 mg six times a day to 40 mg Oxycontin three times a day as needed, with this new
3 physician.

4 53. Respondent Bentow explained that **RX #620238** was filled on September 1, 2011,
5 which is early by five days from previous fill date of August 7, 2011, however, insurance
6 company allowed the refill. The Board's Inspector stated that the patient received the medication
7 **RX #620238** for a 30 day supply of Provigil on May 4, 2011 with three refills. Subsequently, it
8 was refilled on June 1, 2011, July 5, 2011, August 7, 2011 and on September 1, 2011, which was
9 5 days early. There is no documentation why the refill was early. Further, the fact that the
10 insurance company allowed a prescription to be filled early, has no relevance to the Board of
11 Pharmacy when it comes to the corresponding responsibility.

12 54. Respondent Bentow explained that **RX #619348** was filled on April 21, 2011 because
13 the dosage had increased. The previous fill was **RX #616308** for #120, while the patient had to
14 take 3 tablets every 12 hours making it a 20 day supply. The Board's Inspector stated that **RX**
15 **#616308** was filled on March 24, 2011 with 120 tablets, and the directions were to take one tablet
16 every 6 hours (4 tablets per day). This prescription should have lasted 30 days, if taken as
17 prescribed. Opana ER is taken twice a day, not every 6 hours as originally prescribed. There is
18 no documentation that Respondent Bentow when and why the frequency was changed. Opana ER
19 does not come in in a strength higher than 40 mg. Respondent Bentow has a corresponding
20 responsibility to ensure the drug is being prescribed for a legitimate reason.. Respondent Bentow
21 never explained to the Board investigator the type of problem this patient had and why this patient
22 needed so many different pain medications.

23 55. Respondent Bentow explained that **RX #695750** was filled on August 28, 2012 for
24 only a quantity of #4, not #60. Patient wanted an increase in dosage and the physician wrote a day
25 supply until he was able to change dosage. **RX #695795** shows that the dosage was changed from
26 twice a day to three times a day, explaining the need for an early refill. The Borad's Inspector
27 explained that **RX #692793** was written by Dr. Si. for Oxycontin 80 mg #60, one tablet twice a
28 day. It was filled on August 8, 2012. The prescription should have lasted for 30 days. The

1 patient presented a new prescription to the pharmacy . Respondent Bentow stated that
2 Respondents filled 4 tablets because the physician wrote for a day supply until the physician was
3 able to change the dose. However, the ultimate change in dose was to three times a day, therefore,
4 the patient only needed to take three tablets a day, only one additional tablet than the patient was
5 already taking. Further, the patient had about 20 tablets left over as of August 28, 2012, when the
6 physician gave a small prescription for four tablets . Subsequently, Respondent Bentow filled
7 another prescription for a 30 day supply on August 28, 2012. However, there is no documentation
8 explaining the changes and why the pharmacy had to fill two prescriptions on August 28, 2012 for
9 the same medication from the same physician.

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

13 57. Respondent Bentow explained that **RX #687861** was filled because of an increase in
14 Oxycontin dosage. Previous medication, RX #687034, was changed from 40 mg twice a day to
15 80 mg twice a day. The Board's Inspector stated that this patient was seeing multiple prescribers.
16 The prescription for Oxycontin was 80 mg, four times a day on May 1, 2012, 40 mg, four times a
17 day on May 22, 2012, 40 mg twice a day on June 28, 2012, and 80 mg twice a day on July 5,
18 2012.

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

25 59. Respondent Bentow informed the Board investigator that she has access to CURES
26 data, yet, she did not use it often. This is a great concern in light of the fact that one of her
27 patients died from overprescribing of pain medication, where Respondents' pain medications
28 were found in the decedent's residence.

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

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

8 **FIRST CAUSE FOR DISCIPLINE**

9 **(Failure to Report Controlled Substance Loss Within 30 Days)**

10 62. Respondent Pharmacy, Respondent Goldenberg and Respondent Bentow (collectively
11 as Respondents) are subject to disciplinary action under California Code of Regulation, title 16,
12 §1715.6(b), in conjunction with the Bus. Prof. C. §§4113, 4156, 4301, 4301(o) and 4306.5, and
13 pursuant to *Sternberg v. Board of Pharmacy* (2015) 239 Cal. App. 4th 1159 (hereinafter referred
14 as *Sternberg*), in that Respondent failed to report to the Board in writing or otherwise of the loss
15 of a controlled substance as required by state law. During the Board inspection of March 15,
16 2013, Respondent Bentow admitted to the Board inspector that Respondent Pharmacy sustained a
17 loss of controlled substance on June 4, 2012, which was not reported to the Board.

18 **SECOND CAUSE FOR DISCIPLINE**

19 **(Early Prescription Fills-Corresponding Responsibility)**

20 63. Respondents are subject to disciplinary action under Health and Safety Code section
21 11153(a), , in conjunction with the Bus. Prof. C. §§4113, 4156, 4301, 4301(d), 4301 (j), 4301(o)
22 and 4306.5, and pursuant to *Vermont & 110th Medical Arts v. Board of Pharmacy* (1981) 125
23 Cal.App.3d 19 (hereinafter referred as *Vermont*), pursuant to *Sternberg*, and pursuant to the Board
24 of Pharmacy's Precedential Decision *Board of Pharmacy v. Pacifica Pharmacy Corporation, et*
25 *al.*, (2012) Case No. 3802, OAH No. 2011010644 (hereinafter referred as *Pacifica*) in that a
26 prescription for a controlled substance shall only be issued for a legitimate medical purpose by an
27 individual practitioner acting in the usual course of his or her professional practice. The
28 responsibility for the proper prescribing and dispensing of controlled substances is upon the

1 prescribing practitioner, however, a corresponding responsibility rest with the pharmacist who
 2 fills the prescription. Specifically, the following prescriptions were filled early, in violation of
 3 pharmacy law. Complainant refers to, and by this reference incorporates, the allegations set forth
 4 above in paragraphs 30 through 61, as though set forth fully herein.

Date	RX#	Drug	Stren gth	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

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

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1 THIRD CAUSE FOR DISCIPLINE

2 (Misuse of Education)

3 65. Respondents are subject to disciplinary action under Business and Professions Code
4 §§4306.5, 4113, 4156, 4301, , 4301(o) in that Respondents committed acts or omissions that
5 involve, in whole or in part the inappropriate exercise of their education. Specifically,
6 Respondents failed to document or question the following:

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

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

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

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

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

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

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

23 FOURTH CAUSE FOR DISCIPLINE

24 (Failure to Retain Controlled Substance Records)

25 67. Respondents are subject to disciplinary action under Business and Professions Code
26 §§4081, 4105, 4306.5, 4113, 4156, and Health & Safety C. §11179, and pursuant to *Sternberg* in
27 that Respondents failed to retain prescriptions filled by the pharmacy for the following controlled
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1 substances for three (3) years from the date of filling. Specifically, Respondents failed to retain
2 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

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

9 **FIFTH CAUSE FOR DISCIPLINE**

10 **(Failure to Retain Pharmacy Records for Three Years)**

11 69. Respondents are subject to disciplinary action under Business and Professions Code
12 §§4105 (a)(b)(c) and (e)(1), and §§4113, 4156, 4301, 4301(d), 4301 (j), 4301(o), 4306.5, and
13 pursuant to *Sternberg*, in that Respondents failed to maintain in the pharmacy three years of
14 acquisition and disposition records in a readily retrievable form. Specifically, Respondents failed
15 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

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

21 **SIXTH CAUSE FOR DISCIPLINE**

22 **(Unauthorized Furnishing-Dangerous Drugs)**

23 71. Respondents are subject to disciplinary action under Business and Professions Code
24 “§§4059(a), 4113, 4156, 4301, 4301(o), 4306.5, and pursuant to *Sternberg*, in that Respondents
25 furnished a dangerous drug (RX #640641) without a prescription.

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

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1 SEVENTH CAUSE FOR DISCIPLINE

2 (Unauthorized Refills)

3 73. Respondents are subject to disciplinary action under Business and Professions Code
4 “§§4063, 4113, 4156, 4301, 4301(d), 4301 (j), 4301(o), 4306.5, and pursuant to *Sternberg*, in that
5 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

6
7
8 74. Complainant refers to, and by this reference incorporates, the allegations set forth
9 above in paragraphs 30 through 61, as though set forth fully herein.

10 EIGHTH CAUSE FOR DISCIPLINE

11 (Refill of Schedule II Prescription)

12 75. Respondents are subject to disciplinary action under Health and Safety Code section
13 11200 (c), and Bus. & Prof. C. §§4113, 4156, 4301, 4301(d), 4301 (j), 4301(o), 4306.5, and
14 pursuant to *Sternberg*, in that Respondents filled twice prescription RX #676017 for Roxicodone
15 on April 16, 2012, and RX #619524 was filled twice on April 13, 2011. RX #652422 filled on
16 November 20, 2011 and RX #647987 filled on October 21, 2011 for Opana ER, were filled using
17 the same prescription document and RX #597940 for Roxicodone was filled twice on December
18 10, 2010 using the same prescription blank, in violation of HSC section 11200, subdivision (c).

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

21 NINTH CAUSE FOR DISCIPLINE

22 (Variation from a Prescription)

23 77. Respondents are subject to disciplinary action under California Code of Regulations,
24 §1716, and Bus. & Prof. C. §§4113, 4156, 4301, 4301(o), 4306.5, and pursuant to *Sternberg*, in
25 that Respondents deviated from the requirements of a prescription. Specifically, RX #644383
26 was written for Provigil 200 mg #30 with no refills, however, said prescription was filled for 60
27 tablets with two refills, and RX #620238 which was rewritten to RX #644383, was filled one too
28 many times.

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

3 **TENTH CAUSE FOR DISCIPLINE**

4 **(Failure to Maintain Medication Profile)**

5 79. Respondents are subject to disciplinary action under California Code of Regulations,
6 §1707.1, and Bus. & Prof. C. §§4113, 4156, 4301, 4301(d), 4301(j), 4301(o), 4306.5, and
7 pursuant to Sternberg, in that Respondents failed to maintain medication profiles on all patients
8 who have prescriptions filled in the pharmacy. Specifically RX #642495 for Opama ER was
9 filled twice on September 15, 2011, using two different prescription blanks, making the patient
10 profile incorrect.

11 **DISCIPLINE CONSIDERATIONS**

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

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

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

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

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

3 e. On or about September 25, 2008, the Board issued Citation No. CI 2007 35945
4 against Respondent Pharmacy for violation of a BPC Code section 4076, subdivision (a)(11)(A)
5 [prescription container labeling violation] and BPC Code section 4104 [procedures concerning
6 employee drug diversion]. That citation is now final and is incorporated by reference as if fully
7 set forth.

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

13 **PRAYER**

14 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
15 and that following the hearing, the Board of Pharmacy issue a decision:

16 1. Revoking or suspending Pharmacy Permit Number PHY 11433, issued to West Val
17 Pharmacy, Inc.;

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

20 3. Revoking or suspending Pharmacist License Number RPH 20236, issued to Stanley
21 Goldenberg;

22 4. Ordering West Val Pharmacy, Inc., Stanley Goldenberg and Susan Bentow to pay the
23 Board of Pharmacy the reasonable costs of the investigation and enforcement of this case,
24 pursuant to Business and Professions Code section 125.3;

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5. Taking such other and further actions as deemed necessary and proper, including but not limited to 'ownership prohibition' pursuant to Bus. & Prof. C. §4307(a).

DATED: 10/27/16

mg mcdk on behalf of

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

LA2013510074