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

In the Matter of the Accusation Against: **GLESENER PHARMACY** **321 N. Citrus Street** **Covina, CA 91723** **Pharmacy License No. PHY 45665** **JOSEPH D'ANGELO** **321 N. Citrus Street** **Covina, CA 91723** **Pharmacist No. 22883** **ANTONY M. BRADLEY** **321 N. Citrus Street** **Covina, CA 91723** **Pharmacist No. 36740** **and** **DOUGLAS JAY AUSTIN** **22702 Eaglespur Road** **Diamond Bar, CA 91765** **Pharmacist No. 40244** Respondents.	Case No. 4614 **A C C U S A T I O N**

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Complainant alleges:

PARTIES

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

2. On or about July 9, 2003, the Board of Pharmacy issued Pharmacy License Number PHY 45665 to Glesener Pharmacy. The Pharmacy License was in full force and effect at all times relevant to the charges brought herein and will expire on July 1, 2014, unless renewed.

3. On or about April 8, 1963, the Board of Pharmacy issued Pharmacist Number 22883 to Joseph D'Angelo (Respondent D'Angelo). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2014, unless renewed.

4. On or about October 19, 1981, the Board of Pharmacy issued Pharmacist Number 36740 to Anthony M. Bradley (Respondent Bradley). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2015, unless renewed.

5. On or about August 21, 1986, the Board of Pharmacy issued Pharmacist Number 40244 to Douglas Jay Austin (Respondent Austin). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2014, unless renewed.

JURISDICTION

6. This Accusation is brought before the Board of Pharmacy (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

7. Section 118, subdivision (b), of the Code provides that the suspension/expiration/surrender/cancellation of a license shall not deprive the Board/Registrar/Director of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

8. Section 4300 of the Code states:

(a) Every license issued may be suspended or revoked.

(b) The board shall discipline the holder of any license issued by the board, whose default has been entered or whose case has been heard by the board and found guilty, by any of the following methods:

(1) Suspending judgment.

(2) Placing him or her upon probation.

(3) Suspending his or her right to practice for a period not exceeding on year.

(4) Revoking his or her license.

(5) Taking any other action in relation to disciplining him or her as the board in its discretion may deem proper.

. . .

(e) The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code, and the board shall have all the powers granted therein. The action shall be final, except that the propriety of the action is subject to review by the superior court pursuant to Section 1094.5 of the Code of Civil Procedure."

9. Section 4300.1 of the Code states:

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

STATUTORY AUTHORITY

10. Section 4301 of the Code states:

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

(a) Gross immorality.

(b) Incompetence.

(c) Gross negligence.

(d) The clearly excessive furnishing of controlled substances in violation of subdivision (a) of Section 11153 of the Health and Safety Code.

(e) The clearly excessive furnishing of controlled substances in violation of subdivision (a) of Section 11153.5 of the Health and Safety Code. Factors to be considered in determining whether the furnishing of controlled substances is clearly excessive shall include, but not be limited to, the amount of controlled substances furnished, the previous ordering pattern of the customer (including size and frequency of orders), the type and size of the customer, and where and to whom the customer distributes its product.

(f) The commission of any act involving moral turpitude, dishonesty, fraud, deceit, or corruption, whether the act is committed in the course of relations as a licensee or otherwise, and whether the act is a felony or misdemeanor or not.

(g) Knowingly making or signing any certificate or other document that falsely represents the existence or nonexistence of a state of facts.

. . .

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

. . .

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

(p) Actions or conduct that would have warranted denial of a license.

(q) Engaging in any conduct that subverts or attempts to subvert an investigation of the board.

. . .

11. Section 4022 of the Code states

Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

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12. Section 4051 of the Code states:

(a) Except as otherwise provided in this chapter, it is unlawful for any person to manufacture, compound, furnish, sell, or dispense any dangerous drug or dangerous device, or to dispense or compound any prescription pursuant to Section 4040 of a prescriber unless he or she is a pharmacist under this chapter.

(b) Notwithstanding any other law, a pharmacist may authorize the initiation of a prescription, pursuant to Section 4052, and otherwise provide clinical advice or information or patient consultation if all of the following conditions are met:

(1) The clinical advice or information or patient consultation is provided to a health care professional or to a patient.

(2) The pharmacist has access to prescription, patient profile, or other relevant medical information for purposes of patient and clinical consultation and advice.

(3) Access to the information described in paragraph (2) is secure from unauthorized access and use."

13. Section 4077 of the Code states, in pertinent part, that except as provided in subdivisions (b) and (c), of this section, no person shall dispense any dangerous drug upon prescription except in a container correctly labeled with the information required by Section 4076.

14. Section 4081 of the Code states:

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

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

(c) The pharmacist-in-charge or representative-in-charge shall not be criminally responsible for acts of the owner, officer, partner, or employee that violate this section and of which the pharmacist-in-charge or representative-in-charge had no knowledge, or in which he or she did not knowingly participate.

15. Code section 4126.5, subdivision (a), provides:

(a) A pharmacy may furnish dangerous drugs only to the following:

. . .

(4) Another pharmacy or wholesaler to alleviate a temporary shortage of a dangerous drug that could result in the denial of health care. A pharmacy furnishing dangerous drugs pursuant to this paragraph may only furnish a quantity sufficient to alleviate the temporary shortage.

(5) A patient or to another pharmacy pursuant to a prescription or as otherwise authorized by law.

. . .

(7) To another pharmacy under common control.

16. Section 4328 of the Code states:

Except as otherwise provided in this chapter, any person who permits the compounding or dispensing of prescriptions, or the furnishing of dangerous drugs in his or her pharmacy, except by a pharmacist, is guilty of a misdemeanor.

17. Section 4333 of the Code states, in pertinent part, that all prescriptions filled by a pharmacy and all other records required by Section 4081 shall be maintained on the premises and available for inspection by authorized officers of the law for a period of at least three years. In cases where the pharmacy discontinues business, these records shall be maintained in a board-licensed facility for at least three years.

18. Section 4105 of the Code states:

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

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

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

(d) Any records that are maintained electronically shall be maintained so that the pharmacist-in-charge, the pharmacist on duty if the pharmacist-in-charge is not on duty, or, in the case of a veterinary food-animal drug retailer or wholesaler, the designated representative on duty, shall, at all times during which the licensed

premises are open for business, be able to produce a hard copy and electronic copy of all records of acquisition or disposition or other drug or dispensing-related records maintained electronically.

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

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

STATE REGULATORY AUTHORITY

19. California Code of Regulations, title 16, section 1714, states:

(a) All pharmacies (except hospital inpatient pharmacies as defined by Business and Professions Code section 4029 which solely or predominantly furnish drugs to inpatients of the hospital) shall contain an area which is suitable for confidential patient counseling.

(b) Each pharmacy licensed by the board shall maintain its facilities, space, fixtures, and equipment so that drugs are safely and properly prepared, maintained, secured and distributed. The pharmacy shall be of sufficient size and unobstructed area to accommodate the safe practice of pharmacy.

(c) The pharmacy and fixtures and equipment shall be maintained in a clean and orderly condition. The pharmacy shall be dry, well-ventilated, free from rodents and insects, and properly lighted. The pharmacy shall be equipped with a sink with hot and cold running water for pharmaceutical purposes.

(d) Each pharmacist while on duty shall be responsible for the security of the prescription department, including provisions for effective control against theft or diversion of dangerous drugs and devices, and records for such drugs and devices. Possession of a key to the pharmacy where dangerous drugs and controlled substances are stored shall be restricted to a pharmacist.

(e) The pharmacy owner, the building owner or manager, or a family member of a pharmacist owner (but not more than one of the aforementioned) may possess a key to the pharmacy that is maintained in a tamper evident container for the purpose of 1) delivering the key to a pharmacist or 2) providing access in case of emergency. An emergency would include fire, flood or earthquake. The signature of the pharmacist-in-charge shall be present in such a way that the pharmacist may readily determine whether the key has been removed from the container.

(f) The board shall require an applicant for a licensed premise or for renewal of that license to certify that it meets the requirements of this section at the time of licensure or renewal.

(g) A pharmacy shall maintain a readily accessible restroom. The restroom shall contain a toilet and washbasin supplied with running water.

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20. California Code of Regulations, title 16, section 1718, states:

'Current Inventory' as used in Sections 4081 and 4332 of the Business and Professions Code shall be considered to include complete accountability for all dangerous drugs handled by every licensee enumerated in Sections 4081 and 4332.

The controlled substances inventories required by Title 21, CFR, Section 1304 shall be available for inspection upon request for at least 3 years after the date of the inventory.

FEDERAL REGULATORY AUTHORITY

21. Code of Federal Regulations 1311.30, subdivision (c),

(a) Only the certificate holder may access or use his or her digital certificate and private key.

(b) The certificate holder must provide FIPS-approved secure storage for the private key, as discussed by FIPS 140-2, 180-2, 186-2, and accompanying change notices and annexes, as incorporated by reference in § 1311.08.

(c) A certificate holder must ensure that no one else uses the private key. While the private key is activated, the certificate holder must prevent unauthorized use of that private key.

(d) A certificate holder must not make back-up copies of the private key.

(e) The certificate holder must report the loss, theft, or compromise of the private key or the password, via a revocation request, to the Certification Authority within 24 hours of substantiation of the loss, theft, or compromise. Upon receipt and verification of a signed revocation request, the Certification Authority will revoke the certificate. The certificate holder must apply for a new certificate under the requirements of § 1311.25.

22. Code of Federal Regulations 1311.60, subdivision (a),

(a) A supplier and purchaser must maintain records of CSOS electronic orders and any linked records for two years. Records may be maintained electronically. Records regarding controlled substances that are maintained electronically must be readily retrievable from all other records.

(b) Electronic records must be easily readable or easily rendered into a format that a person can read. They must be made available to the Administration upon request.

(c) CSOS certificate holders must maintain a copy of the subscriber agreement that the Certification Authority provides for the life of the certificate.

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COSTS

23. Section 125.3 of the Code states, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

24. Oxycontin, a brand name formation of oxycodone hydrochloride, is an opioid agonist and a Schedule II controlled substance with an abuse liability similar to morphine. OxyContin is for use in opioid tolerant patients only. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1), and a dangerous drug pursuant to Business and Professions Code section 4022.

FACTS

Respondent Glesener Pharmacy, Respondent Bradley, and Respondent D'Angelo.

25. Respondent Glesner Parmacy fills approximately 2200 prescriptions per week. In addition to filling outpatient prescriptions, the pharmacy contracts with approximately 45 board and care homes, dialysis centers and the Los Angeles County Department of Mental Health. Medications filled for the board and care homes are delivered by employees of Glesener Pharmacy.

26. Respondent Bradley and Respondent D'Angelo are each 50% owners of Respondent Glesener Pharmacy. Usually four pharmacists work Monday through Friday and one on Saturday. Each pharmacist is assigned a designated area and task within the pharmacy.

27. Respondent Bradley oversaw the sales of durable medical equipment in the front end of the pharmacy and oversaw the overall operations of the pharmacy.

28. Respondent D'Angelo oversaw the paperwork, including drug purchase and delivery, and human resources.

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Pharmacy Technicians JH, CR and XC

29. Pharmacist Technician JH[1] worked at Glesener Pharmacy from 2008 until she resigned on November 10, 2011. She worked in the dispensing area of the pharmacy where the Schedule II controlled drugs were kept.

30. Pharmacist Technician CR began working at Glesener Pharmacy in 2001 and assisted with durable equipment. CR became a licensed technician in 2010. In or about March of 2011, she began working in the dispensing area of the pharmacy where the Schedule II controlled drugs were kept.

31. Pharmacist Technician XC worked for Glesener Pharmacy for approximately 14 years and was assigned to data entry. Pharmacy Technician TH also worked for Glesener Pharmacy in 2011.

Operational Standards and Security

Respondent Austin and the CSOS System Password

32. Respondent Austin worked as a pharmacist at Glesener Pharmacy from 2005 until November 14, 2011, when he was terminated as a result of missing medication from the pharmacy. Respondent Austin was responsible for ordering Schedule II controlled drugs. He ordered drugs under the Drug Enforcement Administration's (DEA) Controlled Substance Ordering System (CSOS) program[2] through the use of his CSOS password, also known as a private key. Respondent Austin also checked in and signed the delivery of the Schedule II controlled drugs. Respondent Austin was assigned to fill and dispense outpatient prescriptions

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[1] Initials are used to protect the identity of individuals. Identities will be disclosed during discovery.

[2] This system allows for secure electronic ordering of controlled substances through a protected CSOS password. A CSOS Certificate is a digital identity issued by the DEA's CSOS Certification Authority that allows for electronic ordering for Schedule I and II (as well as III-V) controlled substances. Each CSOS certificate is issued to only one individual person. This person, called a CSOS Subscriber, is an individual who enrolled in the CSOS program with the DEA and whose name appears in the digital certificate. A digital signature using a CSOS certificate is required when submitting an electronic order for controlled substances. Only the individual subscriber whose name appears in the certificate is authorized to perform this digital signature. While the paper DEA Form-222 ordering process is still allowed, CSOS is the only method for ordering Schedule I and II controlled substances electronically.

Monday through Friday, 40 hours per week, with one hour lunch break. Respondent Austin maintained a personal monthly log that documented what Schedule II controlled drugs were dispensed. He maintained this record at home but it was not maintained accurately each month. However, he was aware that the pharmacy dispensed an average of 300 pills per month of Oxycontin 80 mg.

33. Respondent Austin's CSOS password was not secure and was located in a folder, with instructions how to order drugs, accessible to others in the pharmacy. Anyone could log into his account and electronically order Schedule II controlled drugs for the pharmacy. From May 1, 2011 to November 14, 2011, Respondent Glesener Pharmacy, Respondent Bradley and Respondent Austin failed to maintain records for the CSOS electronic orders.

34. From May 1, 2011 to November 14, 2011, Respondent Glesener Pharmacy, Respondent Bradley and Respondent Austin knowingly allowed pharmacy staff to use a CSOS password registered to Respondent Austin to order Schedule II controlled drugs, including Pharmacist Technicians XC and TH. From September 7, 2011 through September 23, 2011, Respondent Austin was on vacation and not at the pharmacy. Respondent Austin's password was used on September 15, 2011 and September 22, 2011 by staff other than Respondent Austin to order Schedule II controlled drugs. Pharmacist Technician XC placed drug orders in Respondent Austin's absence.

Acquisition, Disposition and Storage of Drugs

35. From May 1, 2011 to November 14, 2011, typically each morning, drugs were delivered to the pharmacy by AmerisourceBergen's delivery driver into the back room of the pharmacy. Respondent D'Angelo, Respondent Bradley or Respondent Austin would sign for the drug delivery and then the drugs were "stickered." Schedule II controlled drugs were placed in a locked cabinet located in the dispensing area or left on the dispensing counter. There was no log book or any record keeping of any Schedule II narcotics for receipt or dispensing. Employees worked in the backroom bubble packing 30 day dispensing cards for board and care homes. The employees would come to the dispensing counter and, without telling a pharmacist or showing

them prescription labels, would take whatever Schedule II controlled drugs they needed to bubble pack.

36. A pharmacist had a key to the locked drawer which contained Schedule II controlled drugs were kept in the locked drawer, except Percocet. However, the drawer was unlocked at the start of the day and left open until a pharmacist locked it at the end of the day. The drawer was not secure and was accessible to others in the pharmacy.

Loss of Controlled Substances

37. In early October of 2011, Respondent D'Angelo was considering changing the wholesaler from whom they purchased drugs and, therefore, examined the recent Schedule II controlled drug purchases. He noticed an escalation in purchases of Schedule II controlled drugs and advised Respondent Bradley of same.

38. Respondent Bradley then noticed a larger amount of Oxycodone was ordered by the pharmacy. He held a staff meeting and reminded staff that they should not accept any prescriptions for Oxycodone and Oxycontin from customers outside the immediate area. He also instructed staff to check to see if the prescribing physician had any disciplinary actions prior to accepting the prescription.

39. On November 7, 2011, Respondent Austin approached Respondent Bradley and stated that he ordered three bottles of Oxycontin 80 mg on November 4, 1011 and two bottles were missing. There were no prescriptions for Oxycontin 80 mg dispensed. Respondent Bradley reviewed the Schedule II controlled drug delivery receipt and noticed Respondent Austin had failed to mention he had also ordered 4 bottles of Oxycodone 10 mg and 4 bottles of Oxycodone 30 mg.

40. A review of 8 months of purchase, usage and inventory showed a loss of Schedule II controlled drugs for a six month period beginning in May 1, 2011 to November 2011. An analysis of the Schedule II controlled drug invoices revealed the pharmacy was missing tablets of Oxycodone and Oxycontin.

41. From May 1, 2011 through November 14, 2011, Respondent Austin, while working at Glesener Pharmacy, was aware that the pharmacy was ordering excessive amounts of Oxycontin 80 mg tablets without reason. Further, while he was responsible for ordering the Schedule II controlled substances, 7, 200 tablets of Oxycontin 80 mg, 3,450 tablets of Oxycontin 60 mg and 7, 520 tablets of Oxycodone 30 mg were unaccounted for and he could not provide disposition records for that medication.

42. On November 14, 2011, Respondent Austin was terminated from his employment with Respondent Glesener Pharmacy.

43. On or about the November 15, 2011, Respondent D'Angelo, as partner of Respondent Glesener Pharmacy, filed a U.S. Department of Justice Drug Enforcement Administration (DEA) Report of Theft or Loss of Controlled Substances. The report stated that Respondent Austin, using his CSOS password, purchased "all" Schedule II controlled drugs. The report stated that, Respondent Austin, when confronted by Respondent D'Angelo, admitted to purchasing several times more Oxycodone than was going to be dispensed. The report also stated that Respondent Austin's purchases included the following, for example, for Oxycontin 80 mg:

Month	Usage	Purchased
June 2011	300	800
July 2011	300	1300
August 2011	300	1600
September 2011	300	1900
November 2011	300	1600

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44. The report further stated that a loss of Schedule II controlled drugs occurred between May 2011 and November 7, 2011 as follows:

Type of Drugs Missing	Amount of Drug
Oxycodone 30 mg tablets	2806 tablets
Oxycontin 60 mg tablets	2950 tablets
Oxycontin 80 mg tablets	5766 tablets

45. The report also stated that a theft report had been made with the Covina Police Department.

46. A further review of the purchase records of AmerisourceBergen, the dispensing records, and Respondent Glesener Pharmacy's annual inventory, indicates that the actual loss of controlled substance is as follows:

Type of Drugs Missing	Amount of Drug
Oxycodone 30 mg tablets	7520 tablets
Oxycontin 60 mg tablets	3450 tablets
Oxycontin 80 mg tablets	7200 tablets

47. Respondent Glesener Pharmacy, Respondent Bradley, Respondent D'Angelo, from May 1, 2011 through November 14, 2011, did not maintain disposition records for and could not account for these missing drugs.

48. On November 23, 2011, the Board received a copy of the report filed with the DEA by Respondent D'Angelo.

49. When questioned by a Board Inspector regarding why he ordered large amounts of three different strengths of Oxycodone days apart, Respondent Austin replied "I don't know." When asked why he ordered an average of 1300 tablets of Oxycotin a month, after he confirmed that the pharmacy dispensed an average of 300 Oxycontin 80 mg tablets per month, Respondent Austin again replied "I don't know."

FIRST CAUSE FOR DISCIPLINE

Unprofessional Conduct: Lack of Operational Standards and Security- Pharmacy

(Against Respondent Glesener Pharmacy)

50. Respondent Glesener Pharmacy is subject to discipline under section 4301, subsection (o) of the Code, and/or California Code of Regulations, title 16, section 1714, subsection (b), for failure to maintain its facilities, space, fixtures, and equipment so that drugs are safely and properly prepared, maintained, secured and distributed. The circumstances are as follows:

a. From May 1, 2011 through November 14, 2011, Respondent Glesener Pharmacy could not account for the following drugs: 7, 200 tablets of Oxycontin 80 mg, 3,450 tablets of Oxycontin 60 mg and 7, 520 tablets of Oxycodone 30 mg. Complainant hereby incorporates paragraphs 32 through 49 inclusive, as though fully set forth herein.

b. From May 1, 2011 through November 14, 2011, Schedule II controlled drugs were placed in a locked cabinet located in the dispensing area or left on the dispensing counter. There was no log book or any record keeping of any Schedule II narcotics for receipt or dispensing. Employees worked in the backroom bubble packing 30 day dispensing card for board and care homes. The employees would come to the dispensing counter and, without telling a pharmacist or showing them prescription labels, would take whatever Schedule II controlled drugs they needed to bubble pack. A pharmacist had a key to the locked drawer which contained Schedule II controlled drugs, except Percocet. However, the drawer was unlocked at the start of the day and left open until a pharmacist locked it at the end of the day. The drawer was not secure and was accessible to others in the pharmacy. Complainant hereby incorporates paragraphs 35 through 36 inclusive, as though fully set forth herein.

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SECOND CAUSE FOR DISCIPLINE

Unprofessional Conduct: Lack of Operational Standards and Security- Pharmacists

(Against Respondent D'Angelo, Respondent Bradley, and Respondent Austin)

51. Respondent D' Angelo, Respondent Bradley, and Respondent Austin are each and severally subject to discipline under section 4301, subdivision (o), of the Code, and California Code of Regulations, title 16, section 1714, subdivision (d), for failure to maintain the security of the prescription department, including provisions for effective control against theft or diversion of dangerous drugs and devices, and records for such drugs and devices and to ensure that possession of a key to the pharmacy where dangerous drugs and controlled substances are stored is restricted to pharmacists. The circumstances are as follows:

a. From May 1, 2011 through November 14, 2011, Respondent D'Angelo and Respondent Bradley failed to maintain the security of the prescription department and allowed and/or were aware the pharmacy was ordering excessive amounts of Schedule II controlled drugs without reason. A total of 7,200 tablets of Oxycontin 80 mg, 3,450 tablets of Oxycontin 60 mg and 7,520 tablets of Oxycodone 30 mg were unaccounted for. Complainant hereby incorporates paragraphs 32 through 49 inclusive, as though fully set forth herein.

b. From May 1, 2011 through November 14, 2011, Respondent D'Angelo and Respondent Bradley failed to maintain the security of the prescription department and allowed Schedule II controlled drugs to be placed in a locked cabinet located in the dispensing area or left on the dispensing counter. There was no log book or any record keeping of any Schedule II narcotics for receipt or dispensing. Employees worked in the backroom bubble packing 30 day dispensing card for board and care homes. The employees would come to the dispensing counter and, without telling a pharmacist or showing them prescription labels, would take whatever Schedule II controlled drugs they needed to bubble pack. A pharmacist had a key to the locked drawer which contained all Schedule II controlled drugs, except Percocet. However, the drawer was unlocked at the start of the day and left open until a pharmacist locked it at the end of the

day. The drawer was not secure and was accessible to others in the pharmacy. Complainant hereby incorporates paragraphs 35 through 36 inclusive, as though fully set forth herein.

c. From May 1, 2011 through November 14, 2011, Respondent D'Angelo, and Respondent Bradley knowingly allowed pharmacy technicians to order Schedule II controlled drugs electronically using a CSOS password/account assigned to Respondent Austin. Complainant hereby incorporates paragraphs 32 through 34, inclusive, as though fully set forth herein.

d. From May 1, 2011 to November 14, 2011, Respondent Austin knowingly left his CSOS password to electronically order Schedule II controlled rugs available for any staff to access. Using his encrypted password, 1,200 Oxycontin 80 mg tablets were ordered by someone other than himself between September 15, 2011 and September 23, 2011 and could not be accounted for. Complainant hereby incorporates paragraphs 32 through 34, inclusive, as though fully set forth herein.

e. From May 1, 2011 through November 14, 2011 while working at Respondent Glesener Pharmacy and Respondent Austin ordered an excessive amount of Oxycontin 80 mg tablets, although he was aware the pharmacy dispensed on average 300 tablets of Oxycontin 80 mg per month, and could not explain why. 7, 200 tablets of Oxycontin 80 mg, 3,450 tablets of Oxycontin 60 mg and 7, 520 tablets of Oxycodone 30 mg were unaccounted for. Complainant hereby incorporates paragraphs 32 through 49 inclusive, as though fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

Failure to Maintain Records of Acquisition and Disposition of Dangerous Drugs (Against Respondent Glesener Pharmacy, Respondent D'Angelo and Respondent Bradley)

52. Respondent Glesener Pharmacy, Respondent D'Angelo, and Respondent Bradley, are each and severally subject to disciplinary action under section 4081, subdivision (a), and section 4105, of the Code, for failure to maintain all records of acquisition or disposition of dangerous drugs at all times open to inspection and preserved for at least three years from the date of making. The circumstances are as follows:

a. From May 1, 2011 through November 14, 2011, Glesener Pharmacy, Respondent Bradley, and Respondent D' Angelo, did not maintain disposition records for 7,200 tablets of Oxycontin 80 mg, 3,450 tablets of Oxycontin 60 mg and 7,520 tablets of Oxycodone 30 mg. Complainant hereby incorporates paragraphs 40 through 47 inclusive, as though fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

Unprofessional Conduct: Failure to Maintain Records for CSOS Electronic Orders Against Respondent Glesener Pharmacy, Respondent D'Angelo, Respondent Bradley and Respondent Austin)

53. Respondent Glesener Pharmacy, Respondent D'Angelo, Respondent Bradley, and Respondent Austin are each and severally subject to disciplinary action under section 4301, subdivision (o), of the Code and under Code of Federal Regulations section 1311.60, subdivision (a), for unprofessional conduct in that they violated or attempted to violate, directly or indirectly, any provision of the applicable federal and state laws and regulations governing pharmacy when they failed to maintain records of CSOS electronic orders and any linked orders for two years. The circumstances are as follows:

a. From May 1, 2011 through November 14, 2011, Respondent Glesener Pharmacy, Respondent D'Angelo, Respondent Bradley and Respondent Austin failed to maintain records of CSOS electronic orders as required by law. They knowingly allowed pharmacy staff to use a CSOS password registered to Respondent Austin to order Schedule II controlled drugs. The password was located in a folder accessible by all staff and was used on at least September 15, 2011 and September 22, 2011 by staff other than Respondent Austin to order Schedule II controlled drugs. Complainant hereby incorporates paragraphs 32 through 34, inclusive, as though fully set forth herein.

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FIFTH CAUSE FOR DISCIPLINE

Unprofessional Conduct: Failure to Prevent Unauthorized Use of CSOS Password (Against Respondent Glesener Pharmacy, Respondent D'Angelo, Respondent Bradley, and Respondent Austin)

54. Respondent Glesener Pharmacy, Respondent D'Angelo, Respondent Bradley, and Respondent Austin are each and severally subject to disciplinary action under section 4301, subdivision (o), of the Code, and under Code of Federal Regulations section 1311.30, subdivision (c), for unprofessional conduct in that they violated or attempted to violate, directly or indirectly, any provision of the applicable federal and state laws and regulations governing pharmacy when they failed to prevent unauthorized use of CSOS password for digitally signing orders. The circumstances are as follows:

a. From May 1, 2011 through November 14, 2011, Respondent Glesener Pharmacy, Respondent D'Angelo, and Respondent Bradley encouraged Respondent Austin to provide his CSOS password to the pharmacy staff so they could order Schedule II controlled drugs when he was not present. The private password assigned to Respondent Austin was located in a folder accessible by all staff and was used on September 15, 2011 and September 22, 2011 by staff other than Respondent Austin to order Schedule II controlled drugs. Complainant hereby incorporates paragraphs 32 through 34, inclusive, as though fully set forth herein.

b. From May 1, 2011 through November 14, 2011, Respondent Austin failed to prevent the unauthorized use of his CSOS password. He willingly left his CSOS password in a folder for any staff to access in his absence and it was used on September 15, 2011 and September 22, 2011 by someone other than himself. Complainant hereby incorporates paragraphs 32 through 34, inclusive, as though fully set forth herein.

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SIXTH CAUSE FOR DISCIPLINE

Unprofessional Conduct: Dishonesty

(Against Respondent D'Angelo, Respondent Bradley and Respondent Austin)

55. Respondent D'Angelo, Respondent Bradley, and Respondent Austin are each and severally subject to discipline under section 4301, subdivisions (f) and (p), of the Code, for unprofessional conduct in that they were dishonest and knowingly allowed pharmacy technicians to represent Respondent Austin and use a CSOS password registered to Respondent Austin to electronically order Schedule II controlled drugs from a drug wholesaler. Complainant hereby incorporates paragraphs 32 through 34, inclusive, as though fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE

Unprofessional Conduct: Falsely Representing Facts

(Against Respondent D'Angelo and Respondent Bradley)

56. Respondent D'Angelo and Respondent Bradley are each and severally subject to discipline under section 4301, subdivision (g), of the Code, for unprofessional conduct in that they knowingly made or signed a certificate or other document that falsely represented the existence of the fact that only Respondent Austin used his CSOS password to order all Schedule II controlled drugs, when they knowingly allowed pharmacy technicians to use a CSOS password registered to Respondent Austin to electronically order Schedule II controlled drugs from a drug wholesaler. Complainant hereby incorporates paragraphs 32 through 34, and 43, inclusive, as though fully set forth herein.

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EIGHTH CAUSE FOR DISCIPLINE

Unprofessional Conduct: Failure to Report Loss, Theft or Compromise of Private Key or Password to Certification Authority Within 24 Hours

(Against Respondent Austin)

57. Respondent Austin is subject to disciplinary action under section 4301, subdivision (o), of the Code, and under Code of Federal regulations 1311.30, subdivision (e), for unprofessional conduct in that he violated or attempted to violate, directly or indirectly, any provision of the applicable federal and state laws and regulations governing pharmacy when he failed to report the loss, theft or compromise of his CSOS password within 24 hours of the loss, theft or compromise to the Drug Enforcement Administration's Certification Authority[3]. From May 1, 2011 through November 14, 2011, Respondent Austin, while working at Respondent Glesener Pharmacy, knew his CSOS password had been used by staff other than himself, including on September 15, 2011 and September 22, 2011, and did not report the compromise to the Drug Enforcement Administration's Certification Authority. Complainant hereby incorporates paragraphs 32 through 34, inclusive, as though fully set forth herein.

PRAYER

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

1. Revoking or suspending Pharmacy License Number PHY 45665, issued to GLESENER PHARMACY;

2. Revoking or suspending Pharmacist Number 22883, issued to JOSEPH D'ANGELO;

3. Revoking or suspending Pharmacist Number 36740, issued to ANTONY M. BRADLEY;

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[3] As set forth above, the CSOS Certification Authority is operated by the DEA and issues CSOS Certificates for the electronic ordering of controlled substances.

4. Revoking or suspending Pharmacist Number 40244, issued to DOUGLAS JAY AUSTIN;

5. Ordering GLESENER PHARMACY, JOSEPH D'ANGELO, ANTONY M. BRADLEY and DOUGLAS JAY AUSTIN to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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

DATED: 9/7/13

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

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