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

In the Matter of the Accusation Against: **DEAL ENTERPRISES, INC. DBA TAPO PHARMACY; ALAN N. SIEGEL, President; DEE M. SIEGEL, Secretary** 2950 N. Sycamore Dr. Simi Valley, CA 93065 **Pharmacy Permit No. PHY 32351** and **ALAN N. SIEGEL** Tapo Pharmacy 2950 N. Sycamore Dr. Simi Valley, CA 93065 **Pharmacist License No. RPH 21740** Respondents.	Case No. 5222 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On September 16, 1985, the Board issued pharmacy permit number PHY 32351 to Deal Enterprises, Inc. dba Tapo Pharmacy (Respondent Tapo or Tapo Pharmacy), with Alan N.

Siegel, RPH 21740, as President, and Dee M. Siegel as Secretary. Pharmacy permit number was in full force and effect at all times relevant to the charges brought herein and will expire on September 1, 2016, unless renewed.

3. On July 22, 1960, the Board issued pharmacist license number RPH 21740 to Alan N. Siegel (Respondent A. Siegel). Pharmacist license number RPH 21740 was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2017, unless renewed.

4. Respondent A. Siegel has been the pharmacist-in-charge (PIC) of Tapo Pharmacy since April 14, 1996.

JURISDICTION

5. This Accusation is brought before the Board, under the authority of the following laws.

6. Business and Professions Code section 118, subdivision (b),[1] provides in pertinent part that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued, or reinstated.

7. Section 4300, subdivision (a), provides that every license issued by the Board may be suspended or revoked.

8. Section 4300.1 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.

9. Section 4011 provides that the Board shall administer and enforce both the Pharmacy Law (Bus. & Prof. Code, § 4000 et seq.) and the Uniform Controlled Substances Act (Health & Saf. Code, § 11000 et seq.).

[1] All further statutory references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

10. Section 4301 states in pertinent part:

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:

. . .

(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.

. . .

(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.

11. Section 4306.5 states:

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

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

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

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

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

12. Section 4307 states:

(a) Any person who has been denied a license or whose license has been revoked or is under suspension, or who has failed to renew his or her license while it was under suspension, or who has been a manager, administrator, owner, member, officer, director, associate, or partner of any partnership, corporation, firm, or association whose application for a license has been denied or revoked, is under suspension or has been placed on probation, and while acting as the manager, administrator, owner, member, officer, director, associate, or partner had knowledge of or knowingly participated in any conduct for which the license was denied, revoked, suspended, or placed on probation, shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee as follows:

(1) Where a probationary license is issued or where an existing license is placed on probation, this prohibition shall remain in effect for a period not to exceed five years.

(2) Where the license is denied or revoked, the prohibition shall continue until the license is issued or reinstated.

(b) Manager, administrator, owner, member, officer, director, associate, or partner, as used in this section and Section 4308, may refer to a pharmacist or to any other person who serves in that capacity in or for a licensee.

(c) The provisions of subdivision (a) may be alleged in any pleading filed pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code. However, no order may be issued in that case except as to a person who is named in the caption, as to whom the pleading alleges the applicability of this section, and where the person has been given notice of the proceeding as required by Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code. The authority to proceed as provided by this subdivision shall be in addition to the board's authority to proceed under Section 4339 or any other provision of law.

13. Section 4113, subdivision (c), states, "The pharmacist-in-charge shall be responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy."

14. Health and Safety Code section 11153, subdivision (a), states, in pertinent part:

A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription.

REGULATORY PROVISIONS

15. California Code of Regulations, title 16, section 1707.3, states:

Prior to consultation as set forth in section 1707.2, a pharmacist shall

review a patient's drug therapy and medication record before each prescription drug is delivered. The review shall include screening for severe potential drug therapy problems.

16. California Code of Regulations, title 16, section 1761, states:

(a) No pharmacist shall compound or dispense any prescription which contains any significant error, omission, irregularity, uncertainty, ambiguity or alteration. Upon receipt of any such prescription, the pharmacist shall contact the prescriber to obtain the information needed to validate the prescription.

(b) Even after conferring with the prescriber, a pharmacist shall not compound or dispense a controlled substance prescription where the pharmacist knows or has objective reason to know that said prescription was not issued for a legitimate medical purpose.

17. California Code of Regulations, title 16, section 1716, states, in pertinent part, "Pharmacists shall not deviate from the requirements of a prescription except upon the prior consent of the prescriber . . ."

CONTROLLED SUBSTANCES AND DANGEROUS DRUGS

18. Section 4021 provides that, "'[c]ontrolled substance' means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code."

19. Section 4022 states in pertinent part:

"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.

. . .

(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.

20. Alprazolam is a Schedule IV controlled substance as designated by section 4021 and Health and Safety Code section 11057, subdivision (d)(1). It is also a dangerous drug as defined by section 4022.

21. Oxycontin is the brand name for oxycodone, which is a Schedule II controlled substance as designated by section 4021 and Health and Safety Code section 11055, subdivision (b)(1)(M). It is also a dangerous drug as defined by section 4022 and is prescribed to treat pain.

22. Diazepam is a Schedule IV controlled substance as designated by section 4021 and Health and Safety Code section 11057, subdivision (d)(9). Valium is a brand name for diazepam. It is also a dangerous drug as defined by section 4022.

23. Norco is a Schedule III controlled substance as designated by section 4021 and Health and Safety Code section 11056, subdivision (e)(4). Norco is a brand name for hydrocodone with acetaminophen. It is also a dangerous drug as defined by section 4022.

24. Roxicodone is a brand name for oxycodone, which Schedule II controlled substance as designated by section 4021 and Health and Safety Code section 11055, subdivision (b)(1)(M). It is also a dangerous drug as defined by section 4022 and is prescribed to treat pain.

25. Xanax is the brand name for alprazolam.

26. Suboxone is a brand name for buprenorphine and naloxone, commonly used to treat drug addiction and withdrawal.

COST RECOVERY

27. Section 125.3 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.

FACTS

28. On or about July 1, 2013, the Board received a complaint from A.S.[2] stating that his daughter J.S. was addicted to prescription drugs because of prescriptions written by Dr. D.G., and that the prescriptions were dispensed by Respondent Tapo. J.S. was treated by Dr. D.G. from January 2011 to September 2011. A.S. alleged that Respondent Tapo collaborated with Dr. D.G. to dispense prescriptions for controlled substances such as alprazolam, oxycodone, amphetamine, diazepam, and carisoprodol for J.S. without paying attention to the number of tablets dispensed each week or bi-weekly and ahead of schedule. He claimed that Respondents Siegel and Tapo failed to exercise their corresponding responsibility and that many of J.S.'s friends were also

[2] All complainants, patients, and doctors associated with this case are referred to by their initials to maintain their confidentiality.

getting prescriptions for controlled substances dispensed by Respondent Tapo. A.S. feared the loss of his daughter to addiction to controlled substances.

29. As of March 27, 2014, Dr. D.G.'s license was revoked by the Medical Board of California (Medical Board) for negligently prescribing painkillers to patients with addictions. Dr. D.G. treated patients with addictive drugs such as Oxycontin and Norco knowing they were fighting drug dependency problems. According to the Medical Board's records, two patients died of drug overdose. The Medical Board Accusation against Dr. D.G. showed negligence pertaining to seven of Dr. D.G.'s patients.

30. On or about October 25, 2013, Board Inspector Sejal Desai inspected Tapo Pharmacy while Respondent A. Siegel was on duty. Respondent A. Siegel stated that Dr. D.G. was a psychiatrist and pain management prescriber. When Inspector Desai questioned Respondent A. Siegel about corresponding responsibility, Respondent A. Siegel stated that the pharmacy verified prescriptions with the prescribing doctor, and that if the doctor stated that the prescription was "okay," the pharmacy would fill the prescription. Respondent A. Siegel stated that he does not dispense prescriptions if the patient looked "weird" or was from out of the area, but that there was no geographical boundaries for dispensing prescriptions. Respondent A. Siegel stated that he signed up with the prescription drug monitoring program (PDMP) but that he lost his ID and password. He stated that he evaluated patients by calling Kramer Pharmacy in Agoura Hills to get the Controlled Substance Utilization Review and Evaluation System patient activity report (CURES PAR).[3]

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[3] The Controlled Substance Utilization Review and Evaluation System or CURES is a database maintained by the California Department of Justice, Bureau of Narcotic Enforcement. The program began in 1998 and required mandatory monthly pharmacy reporting of dispensed Schedule II controlled substances. The CURES program was amended in January 2005 to include mandatory weekly reporting of Schedule II-IV controlled substances. The data is sent to a data collection company, who sends the pharmacy confirmation that the data was received and informs the pharmacy if the data was rejected. The data is collected statewide and can be used by health care professionals to evaluate and determine whether their patients are utilizing controlled substances correctly.

Dr. D.G.'s Dispensing History at Tapo Pharmacy

31. Inspector Desai reviewed CURES PAR for Tapo Pharmacy from January 1, 2010 to September 18, 2013. Of the 1,949 prescriptions for controlled substances from Dr. D.G., the top three controlled substances dispensed below accounted for 44.23% of the controlled substances dispensed:

Drug	Number of Prescriptions	Total Quantity
Oxycodone 30 mg	440	52,111
Alprazolam 2 mg	343	21,142
Diazepam 10mg	79	5,032

Price of Oxycodone Charged by Tapo Pharmacy

32. Inspector Desai compared what Respondent Tapo paid for oxycodone 30mg with the price they charged the patient and found the following:

Drug	Tapo Purchase Price	Tapo Cost Per Tablet
Oxycodone 30mg	$21.36–$35 for 100ct	$0.21–$0.35 (avg. $0.28)

33. The following table shows the percent mark-up by Tapo Pharmacy:

Drug/Qty/Avg Cost	Tapo Pharmacy's Price	$ Mark-Up	% Mark-Up
Oxycodone 30 mg #150 ($0.28 X 150 = $42.00)	$98.50	$56.50	135.5%
Oxycodone #120 ($0.28 X 120 = $33.60)	$109.20	$75.60	225%

Distance Traveled to Tapo Pharmacy (Dr. D.G.'s Patients)

34. The range of distance traveled for the selected patients was between 1.32 miles and 62.56 miles. The average distance was 9.71 miles.

35. Due to the number of readily accessible pharmacies throughout California, the common trading area is considered to be five miles.

36. Multiple patients share the same address.

37. The total distance some of the patients traveled to obtain controlled substances could be excessive.

Questionnaires and Surveys

38. Inspector Desai provided Respondent A. Siegel with pharmacy patient questionnaires to determine what Respondent A. Siegel knew about the patient, prescriber, the diagnosis, and overall patient's pain management.

39. Upon review of the patient questionnaires completed by Respondent A. Siegel, Inspector Desai noted the following: most of the patients had the same or similar diagnoses; some of the patients' profiles showed the patient received other drugs for the underlying condition causing the pain; the pharmacy did not keep notes or files on any patients' drug therapy; despite what the prescription hard copy said, the Medical Board's website showed Dr. D.G. had no areas of practice identified nor any board certifications identified, which indicated that Respondent A. Siegel lacked the knowledge of the prescribers' scope of practice; all questionnaires said the therapy prescribed was valid for the diagnosis; according to Respondent A. Siegel, Dr. D.G. claimed that he was a psychiatrist, but most of the drugs prescribed for the patients reviewed were for pain rather than to treat psychiatric conditions.

40. Inspector Desai provided Respondent A. Siegel with a pharmacy survey for Tapo Pharmacy. In this survey, Respondent A. Siegel admitted that the pharmacy did not have access to PDMP.

Comparison of Controlled Substances Dispensing Records with Neighboring Pharmacies

41. Inspector Desai reviewed CURES PAR to compare the amount of controlled substances dispensed by Tapo Pharmacy to the amount of controlled substances dispensed by neighboring pharmacies including CVS, Walgreens, and Golden Life Pharmacy. Her review of this data revealed that Tapo Pharmacy dispensed 22.58% of oxycodone 30mg prescriptions for Dr. D.G. In contrast, the neighboring pharmacies dispensed 0.47%, 1.43%, and 0.47%.

Payment Methods

42. Inspector Desai evaluated the payment methods for Dr. D.G.'s prescriptions for Tapo Pharmacy and the neighboring pharmacies. Inspector Desai found that Tapo Pharmacy had 41.66% of its patients pay cash for Dr. D.G.'s controlled substances prescriptions, while the neighboring pharmacies had 10.06%, 7.84%, and 0.94% of their patients pay cash.

CURES PAR (January 10, 2010 to September 18, 2013)

43. Inspector Desai reviewed the data from the CURES PAR from January 10, 2010 to September 18, 2013 to determine whether any of the patients who obtained controlled substances from Respondent Tapo were using multiple pharmacies and prescribers to obtain controlled substance prescriptions. In her review of 11 patients' CURES PAR, Inspector Desai found the following:

Patient	Dates	# of PHY	# of Prescribers
D.B.	1/4/10 to 9/18/13	11	5
J.K.	1/12/10 to 8/29/13	19	38
T.L.	5/4/10 to 9/18/13	8	10
D.M.	2/3/10 to 7/9/13	8	5
N.N.	1/10/10 to 9/17/13	23	65
D.N.	6/3/10 to 9/6/13	9	9
M.P.	5/3/10 to 3/4/12	5	8
J.S.	1/4/10 to 6/25/13	10	12
R.S.	1/7/10 to 9/17/13	9	11
S.S.	1/4/10 to 2/15/13	4	5
R.U.	1/4/10 to 9/17/13	12	16

44. Inspector Desai found that all of the above-listed patients, except M.P., were going to multiple pharmacies and prescribers while going to Tapo Pharmacy. If Tapo Pharmacy had requested a CURES PAR, they would have been able to determine the multiple pharmacies and prescribers that their patients were going to.

Controlled Substances Dispensed from November 25, 2010 to November 25, 2013 versus Non-Controlled Substances for the 11-patient sample of Dr. D.G.

45. Inspector Desai evaluated the patient profiles and prescriptions to compare the percentage of controlled substances dispensed by Respondent Tapo for each of 11 patients for the

time period of November 25, 2010 to November 25, 2013, to the total number of prescriptions dispensed by Respondent Tapo for each patient for the same time period.

46. Inspector Desai found that the percentage of controlled substances dispensed ranged from 67.39% to 100%.

Review of Prescriptions for 11 of Dr. D.G. Patients

47. Inspector Desai reviewed a sample of patient prescriptions written by Dr. D.G. and dispensed by Respondent Tapo and found the following:

48. Patient D.B.: For patient D.B., Dr. D.G. prescribed over 500 oxycodone 30mg per month on numerous occasions, which were dispensed by Respondent Tapo. Twelve prescriptions contained incorrect directions dispensed on the prescriptions. Several prescriptions written by Dr. D.G. for D.B. had two or three oxycodone 30mg with different directions. The CURES PAR revealed that D.B. was getting oxycodone, which was prescribed by Dr. D.G., dispensed at multiple pharmacies, including Tapo Pharmacy, at the same time.

49. Patient J.K.: Patient J.K. was getting prescriptions written by Dr. D.G. dispensed at multiple pharmacies, and some of the prescriptions were dispensed on or around the same days. J.K. was also getting prescriptions for similar or the same medication written by different doctors. J.K.'s practice of using multiple pharmacies and prescribers occurred on numerous occasions between 2010 and 2013. If Respondents Siegel or Tapo had checked the CURES PAR, they would have seen this.

50. Patient T.L.: Prior to going to Tapo Pharmacy, patient T.L. was placed on Suboxone, which is commonly used for narcotic addiction. Respondent Tapo dispensed amphetamine to T.L. If Respondent A. Siegel or Respondent Tapo had checked CURES PAR, they would have been able to determine the unusual prescribing pattern of Dr. D.G.

51. Patient D.M.: Per the CURES PAR, patient D.M. had no significant pain or anxiety history before obtaining prescriptions from Dr. D.G. D.M. was placed on Suboxone after seeing Dr. D.G. CURES PAR showed he was on Suboxone prior to going to Dr. D.G. In addition, for one prescription, the date was not written in the prescriber's handwriting.

52. Patient N.N.: CURES PAR revealed that patient N.N. went to numerous pharmacies and prescribers while going to Tapo Pharmacy and Dr. D.G. N.N. had controlled substances from various prescribers dispensed by Respondent Tapo. CURES PAR also showed that N.N. received numerous hydrocodone products from various prescribers dispensed at multiple pharmacies.

53. Patient D.N.: Dr. D.G. prescribed Suboxone to D.N., which was dispensed by Tapo Pharmacy, yet D.N. was getting oxycodone prescribed from multiple prescribers dispensed at multiple pharmacies. Per CURES PAR, D.N. had no significant pain history prior to going to Dr. D.G. Also, the prescription for Oxycontin 80mg, dispensed by Respondent Tapo, was above the recommended dosing interval of twice daily.

54. Patient M.P.: Patient M.P. obtained alprazolam 2mg and oxycodone 30mg from Respondent Tapo.

55. Patient J.S.: A prescription written on August 11, 2011 had two prescriptions for Roxicodone 30mg written on the same prescription. One was for a quantity of 90 and the other was for 150. An August 11, 2011, a prescription for alprazolam 2mg and diazepam 5mg written by Dr. D.G. was dispensed by Respondent Tapo. This is therapy duplication as they are both in the same class of drugs. On August 22, 2011, J.S. was given another prescription for 150 count of Roxicodone by Dr. D.G. CURES PAR revealed J.S. had no significant pain history prior to going to Dr. D.G. It also showed that while going to Tapo Pharmacy and Dr. D.G., J.S. was getting other narcotic pain drugs from other prescribers and pharmacies. CURES PAR showed that J.S. received Suboxone after getting prescriptions from Dr. D.G.

56. Patient R.S.: One of R.S.'s prescriptions for oxycodone was given above the recommended interval of twice daily. While going to Tapo Pharmacy and Dr. D.G., R.S. went to other prescribers to get controlled substance prescriptions which were also dispensed at Tapo Pharmacy. CURES PAR for R.S. revealed he had various controlled substances dispensed from multiple prescribers at multiple pharmacies. R.S. also had multiple prescriptions for oxycodone 30mg prescribed by Dr. D.G., which were dispensed at multiple pharmacies. R.S. was prescribed 950 tablets of oxycodone 30mg by Dr. D.G. in June 2013. Also, a prescription that was dispensed on December 12, 2011 had a written date of December 13, 2011.

57. Patient S.S.: While going to Tapo Pharmacy, S.S. had prescriptions written by Dr. D.G. dispensed at multiple pharmacies, some of which were on or around the same date. The practice of S.S. receiving oxycodone 30mg from various pharmacies occurred many times between 2010 and 2013. S.S. received two prescriptions for oxycodone 30mg by Dr. D.G. on six different dates. This information was revealed in the CURES PAR.

58. Patient R.U.: R.U. was given a prescription for 42 counts of oxycodone 30mg and 112 counts of Oxycontin 40mg on the same day, which Respondent Tapo placed on file. R.U. received Oxycontin 80mg above recommended dosing interval of twice daily. CURES PAR revealed that R.U. was getting oxycodone prescribed from multiple prescribers and dispensed at multiple pharmacies.

Early Refills for 11 of Dr. D.G. Patients

59. The range of early refills dispensed by Respondent Tapo of Dr. D.G.'s sampling of 11 patients was 4 days to 41 days. Inspector Desai only included the early refills for 2011 for patients D.B. and R.S., but she found that the same dispensing pattern for early refills for these patients continued in 2012 and 2013.

FIRST CAUSE FOR DISCIPLINE

(Failure to Exercise Professional Judgment or Corresponding Responsibility)

60. Respondents Tapo and Siegel (collectively, Respondents) are subject to disciplinary action under sections 4301 and 4306.5, in conjunction with California Code of Regulations, title 16, sections 1707.3 and 1761, in that Respondents committed one or more acts of unprofessional conduct when they failed to exercise or implement their best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances or dangerous drugs. Specifically, on or about November 25, 2010 to November 25, 2013, while Respondent A. Siegel was the PIC of Tapo Pharmacy, Respondents failed to exercise their best professional judgment while dispensing controlled substance prescriptions prescribed by Dr. D.G. Additionally, Respondents did not assume their corresponding responsibility when they failed to appropriately scrutinize patients' drug therapy with readily available tools such as CURES

reports and Respondents' own pharmacy records. Complainant refers to, and by this reference incorporates, the allegations in paragraphs 28–59, above, as though set forth fully herein.

SECOND CAUSE FOR DISCIPLINE

(Excessive Furnishing of Controlled Substances)

61. Respondents are subject to disciplinary action under sections 4301, subdivisions (d) or (j), and 4306.5, in conjunction with California Code of Regulations, title 16, section 1761, in that Respondents committed one or more acts of unprofessional conduct when they excessively furnished controlled substances in violation of Health and Safety Code section 11153, subdivision (a). Complainant refers to, and by this reference incorporates, the allegations in paragraph 28–59, above, as though set forth fully herein.

THIRD CAUSE FOR DISCIPLINE

(Violation of Laws and Regulations Governing Pharmacy)

62. Respondents are subject to disciplinary action under section 4301, subdivision (o), in that Respondents committed one or more acts of unprofessional conduct when they violated or attempted to violate, directly or indirectly, or assisted in or abetted the violation of laws and regulations governing pharmacy. Respondents were not in compliance with California Code of Regulations, title 16, section 1716, when they deviated from the requirements of a prescription without prior consent of the prescriber. Specifically, between November 25, 2010 and November 25, 2013, Tapo Pharmacy dispensed 12 prescriptions with incorrect directions on the prescription labels. Additionally, Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 28–61, above, as though set forth fully herein.

OTHER MATTERS

63. Pursuant to section 4307, if discipline is imposed on permit number PHY 32351 issued to Respondent Tapo, Respondent Tapo shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if pharmacy permit number PHY 32351 is placed on probation or until pharmacy permit number PHY 32351 is reinstated if it is revoked.

64. Pursuant to section 4307, if discipline is imposed on pharmacy permit number PHY 32351 issued to Respondent Tapo while Alan N. Siegel and/or Dee M. Siegel has been an officer and had knowledge of or knowingly participated in any conduct for which the licensee was disciplined, Respondent A. Siegel and Dee M. Siegel shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if pharmacy permit number PHY 32351 is placed on probation or until pharmacy permit number PHY 32351 is reinstated if it is revoked.

DISCIPLINARY CONSIDERATIONS

65. To determine the degree of discipline, if any, to be imposed on Respondent Tapo, Complainant alleges that on October 30, 2013, in a prior action, the Board issued citation number CI 2012 56451 to Respondent Tapo and ordered Respondent Tapo to pay $500 for violations of California Code of Regulations, title 16, sections 1716 and 1711, subdivisions (a) and (c)(1). Specifically, on or about March 25, 2013, while Pharmacist Deborah A. Yee (RPH 44765) and Respondent and PIC Seigel were working at Tapo Pharmacy, they incorrectly verified the prescription for Ms. H. Pharmacist Yee incorrectly verified the prescription for prescription number 1079328. Said prescription was written for requip 0.5mg and was misfilled with another medication, possibly risperidone. The medication was then dispensed incorrectly on or about March 25, 2013. Respondent A. Siegel incorrectly verified prescription number 1084666, which was prescribed for protonix 40mg and was misfiled with plavix 75mg and the medication was dispensed incorrectly on or about April 5, 2013. Additionally, although Respondent A. Siegel was aware of the March 25, 2013 incident, a quality assurance review was neither preformed nor available during an inspection of June 13, 2013. Citation number CI 2012 56451 is now final and is incorporated by reference as if set forth fully herein.

66. To determine the degree of discipline, if any, to be imposed on Respondent A. Siegel, Complainant alleges that on October 30, 2013, in a prior action, the Board issued citation number CI 2013 58438 to Respondent A. Siegel and ordered Respondent A. Siegel to pay $500 for violations of California Code of Regulations, title 16, sections 1716 and 1711, subdivisions (a) and (c)(1). Specifically, on or about April 4, 2013, Respondent A. Siegel while working at Tapo

Pharmacy as a PIC, incorrectly verified the medication for Ms. H. Prescription numbers 1084666 and 1084666 were prescribed for Protonix 40mg but were incorrectly filled with Plavix 75mg, and the medication was dispensed incorrectly on or about April 5, 2013. Additionally, although Respondent A. Siegel was aware of a March 25, 2013 incident where pharmacist Yee misfiled a prescription, a quality assurance review was neither preformed nor available during an inspection of June 13, 2013. Citation number CI 2013 58438 is now final and is incorporated by reference as if set forth fully herein.

67. To determine the degree of discipline, if any, to be imposed on Respondents Tapo and Siegel, Complainant alleges that on November 27, 2002, in a prior action, the Board issued a Decision and Order *In the Matter of the Accusation Against: Tapo Pharmacy and Alan N. Siegel*, Board of Pharmacy case no. 2399, adopting Stipulated Settlement for Public Letter of Reproval re: Tapo Pharmacy and Alan N. Siegel for case no. 2399. Said Decision and Order is incorporated by reference herein.

PRAYER

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

1. Revoking or suspending pharmacy permit number PHY 32351, issued to Deal Enterprises, Inc. dba Tapo Pharmacy;

2. Revoking or suspending pharmacist license number RPH 21740, issued to Alan N. Siegel;

3. Prohibiting Alan N. Siegel from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if pharmacy permit number PHY 32351 is placed on probation or until pharmacy permit number PHY 32351 is reinstated if pharmacy permit number PHY 32351 issued to Deal Enterprises, Inc. dba Tapo Pharmacy is revoked.

4. Prohibiting Dee M. Siegel from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if pharmacy permit number PHY 32351 is placed on probation or until pharmacy permit number PHY 32351 is reinstated if

pharmacy permit number PHY 32351 issued to Deal Enterprises, Inc. dba Tapo Pharmacy is revoked.

5. Ordering Respondents Deal Enterprises, Inc. dba Tapo Pharmacy and Alan N. Siegel to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to section 125.3;

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

DATED: 5/25/16

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