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8 **BEFORE THE**
9 **BOARD OF PHARMACY**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the First Amended Accusation Against:

Case No. 5525

13 **DAVISON DRUG & STATIONERY**
14 **FRANKLIN P. DAVISON,**
15 **aka FRANKLIN PETESCH DAVISON, Owner**
16 **JAMES A. DAVISON,**
17 **aka JAMES ARCH DAVISON, Pharmacist-in-Charge**
18 **640 Market Street**
19 **Colusa, CA 95932**

**FIRST AMENDED
ACCUSATION**

20 **Original Pharmacy Permit No. PHY 47044,**

21 **and**

22 **FRANKLIN PETESCH DAVISON**
23 **1114 Carson Street**
24 **Colusa, CA 95923**

25 **Original Pharmacist License No. RPH 42614,**

26 **and**

27 **JAMES ARCH DAVISON**
28 **640 Market Street**
Colusa, CA 95932

Original Pharmacist License No. RPH 20987

Respondents.

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1 Complainant alleges:

2 **PARTIES**

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

5 2. On or about March 2, 2005, the Board issued Original Pharmacy Permit Number
6 PHY 47044 to Franklin P. Davison, also known as Franklin Petesch Davison (“Respondent
7 Franklin Davison”), owner of Davison Drug & Stationery, with James A. Davison, also known as
8 James Arch Davison (“Respondent James Davison”), as pharmacist-in-charge (“PIC”). The
9 original pharmacy permit was in full force and effect at all times relevant to the charges brought
10 herein and will expire on March 1, 2017, unless renewed.

11 3. On or about August 3, 1989, the Board issued Original Pharmacist License Number
12 RPH 42614 to Respondent Franklin Davison. The original pharmacist license was in full force
13 and effect at all times relevant to the charges brought herein and will expire on July 31, 2017,
14 unless renewed.

15 4. On or about November 1, 1958, the Board issued Original Pharmacist License
16 Number RPH 20987 to Respondent James Davison. The original pharmacist license was in full
17 force and effect at all times relevant to the charges brought herein and will expire on July 31,
18 2017, unless renewed.

19 **JURISDICTION**

20 5. This Accusation is brought before the Board under the authority of the following
21 laws. All section references are to the Business and Professions Code (Code) unless otherwise
22 indicated.

23 6. Code section 4300 states, in pertinent part:

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

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

27 (1) Suspending judgment.

28 (2) Placing him or her upon probation.

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

7. Code 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.

8. Section 4307(a) of the Code states that:

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 manger, administrator, owner, member, officer, director, associate, or partner had knowledge 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 manger, 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.

....

STATUTORY AND REGULATORY PROVISIONS

9. Code 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:

...

(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 . . .

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

6 10 Code section 4113, subdivision (c), states that “[t]he pharmacist-in-charge shall be
7 responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining
8 to the practice of pharmacy.”

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

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

15 12. Health and Safety Code section 11200 states, in pertinent part:

16 (a) No person shall dispense or refill a controlled substance prescription
17 more than six months after the date thereof.

18 (b) No prescription for a Schedule III or IV substance may be refilled
19 more than five times and in an amount, for all refills of that prescription taken
20 together, exceeding a 120-day supply

21 13. California Code of Regulations, title 16, section 1709.1, subdivision (a), states that
22 “[t]he pharmacist-in-charge of a pharmacy shall be employed at that location and shall have
23 responsibility for the daily operation of the pharmacy.”

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

25 (a) No pharmacist shall compound or dispense any prescription which
26 contains any significant error, omission, irregularity, uncertainty, ambiguity or
27 alteration. Upon receipt of any such prescription, the pharmacist shall contact the
28 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.

COST RECOVERY

15. Code section 125.3 provides, in pertinent part, that a Board may request the
administrative law judge to direct a licentiate found to have committed a violation or violations of

1 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
2 enforcement of the case.

3 **CONTROLLED SUBSTANCES**

4 16. "Methadone" is a Schedule II controlled substance as designated by Health and
5 Safety Code section 11055, subdivision (c)(14).

6 17. "Morphine Sulfate IR (immediate release)" is a Schedule II controlled substance as
7 designated by Health and Safety Code section 11055, subdivision (b)(1)(L).

8 18. "Morphine Sulfate ER (extended release)" is a Schedule II controlled substance as
9 designated by Health and Safety Code section 11055, subdivision (b)(1)(L).

10 19. "Oxycodone" is a Schedule II controlled substance as designated by Health and
11 Safety Code section 11055, subdivision (b)(1)(M).

12 20. "Hydromorphone" is a Schedule II controlled substance as designated by Health and
13 Safety Code section 11055, subdivision (b)(1)(J).

14 21. "Fentanyl" is a Schedule II controlled substance as designated by Health and Safety
15 Code section 11055, subdivision (c)(8).

16 22. "Norco" is a compound consisting of 10 mg hydrocodone bitartrate, also known as
17 dihydrocodeinone, and 325 mg acetaminophen per tablet. At the time of the incidents described
18 below, Norco was classified as a Schedule III controlled substance pursuant to Health and Safety
19 Code section 11056, subdivision (e)(4).¹

20 23. "Vicodin" is a compound consisting of 5 mg hydrocodone bitartrate, also known as
21 dihydrocodeinone, and 500 mg acetaminophen per tablet. At the time of the incidents described
22 below, Vicodin was classified as a Schedule III controlled substance pursuant to Health and
23 Safety Code section 11056, subdivision (e)(4).

24 24. "Diazepam" is a Schedule IV controlled substance as designated by Health and Safety
25 Code section 11057, subdivision (d)(9).

26 ///

27 ¹ Hydrocodone has been rescheduled from a Schedule III to Schedule II controlled
28 substance via the Controlled Substances Act (21 CFR Part 1308 § 1308.12; 21 U.S.C. 812 (c)).

1 25. "Klonopin," a brand of clonazepam, is a Schedule IV controlled substance as
2 designated by Health and Safety Code section 11057, subdivision (d)(7).

3 26. "Temazepam" is a Schedule IV controlled substance as designated by Health and
4 Safety Code section 11057, subdivision (d)(29).

5 27. "Lorazepam" is a Schedule IV controlled substance as designated by Health and
6 Safety Code section 11057, subdivision (d)(16).

7 **STATEMENT OF FACTS**

8 28. On or about November 15, 2013, the Medical Board of California revoked Dr. A. L.'s
9 physician's and surgeon's certificate. The revocation was stayed and Dr. A. L. was placed on
10 probation. Dr. A. L. was also suspended from the practice of medicine for 30 days. Dr. A. L.
11 was charged in the disciplinary proceeding with prescribing excessive amounts and high doses of
12 controlled substances.

13 29. The Drug Enforcement Administration had commenced an investigation of Dr. A. L.
14 and the pharmacies that filled prescriptions for his patients (the investigation was subsequently
15 halted due to the death of Dr. A. L. in December 2013).

16 30. A Board analyst ran CURES² reports showing Dr. A. L.'s prescribing habits.
17 Davison Drug & Stationery was identified as one of the two pharmacies dispensing the most
18 prescriptions for Dr. A. L.'s patients. Dr. A. L.'s practice was located in Colusa, California,
19 approximately three blocks from Davison Drug & Stationery.

20 31. On or about September 2, 2014, Board Inspector J. H. obtained CURES information
21 from September 1, 2011 to September 8, 2014, for Davison Drug & Stationery and three other
22 pharmacies located in close proximity to Davison Drug & Stationery, CURES reports that had
23 previously been requested by Board Inspector J. W., and CURES reports for six patients, TB, DJ,
24 RV, TS, SC, and SH, from January 1, 2009 to January 15, 2014. Inspector J. H. also requested
25 additional CURES reports for these patients from January 16 to September 8, 2014. Inspector J.

26
27 ² CURES is a database containing information on Schedule II through IV controlled
28 substances dispensed in California. It is a valuable investigative, preventive, and educational tool
for the healthcare community, regulatory boards, and law enforcement.

1 H. chose an additional nineteen patients to review, who had received prescriptions from Dr. A. L.,
2 patients EBW, MC, PC, JD, KL, GR, DV, DW, BP, TN1, RP, MP, JW, TW, JT, LT, KE, VM and
3 TN, a total of twenty-five patients. Inspector J. H. requested CURES information for each patient
4 from September 1, 2011 to September 8, 2014.

5 32. On or about September 17, 2014, Inspectors J. H. and J. W. conducted an inspection
6 of Davison Drug & Stationery. Respondent James Davison ("PIC Davison") was not present at
7 the pharmacy; however, owner and staff pharmacist, Respondent Franklin Davison ("RPH
8 Davison"), assisted with the inspection. RPH Davison stated that their normal service area was
9 fifty to sixty miles. During the inspection, Inspector J. H. collected several hardcopy
10 prescriptions for the twenty-five patients and had RPH Davison print the patient profiles for each
11 patient from September 1, 2011 to September 17, 2014.

12 33. On or about January 26, 2015, Inspector J. H. requested more hardcopy prescriptions
13 for the twenty-five patients.

14 34. Inspector J. H. reviewed the CURES reports for Davison Drug & Stationery and the
15 three other pharmacies, and compared the total number of controlled substances dispensed by the
16 pharmacies with the total number of controlled substances written by Dr. A. L. for the period
17 from September 1, 2011 to September 8, 2014. Inspector J. H. found that Davison Drug &
18 Stationery dispensed more controlled substances written by Dr. A. L. than any of the other
19 pharmacies. Inspector J. H. created a chart showing the roundtrip distance from the twenty-five
20 patients' homes to Dr. A. L.'s office in Colusa, to Davison Drug & Stationery, and back home.
21 Only eight of the patients lived in the pharmacy's trade area, defined by RPH Davison as fifty to
22 sixty miles from the pharmacy. Thirteen of the patients traveled more than one-hundred miles
23 one way to see Dr. A. L., six of the patients traveled more than five-hundred miles one way to Dr.
24 A. L., and five of the patients traveled more than two-thousand miles one way to see Dr. A. L.

25 35. Inspector J. H. created a chart based on the hardcopy prescriptions showing the
26 patient's initials, date of the prescription, prescription number, drug name, strength and quantity,
27 directions, diagnosis code, duration of the patient's treatment, and any abnormalities or unusual
28 findings. Inspector J. H. determined that there were a total of approximately 295 prescriptions

1 filled for the patients, approximately seventy-five of which were filled by PIC Davison and
2 approximately 218 of which were filled by RPH Davison. Inspector J. H. found that Dr. A. L.'s
3 prescribing practices showed duplication in therapy, and the same combinations of drugs were
4 prescribed for multiple patients, including fentanyl 100 mcg/h, morphine ER 100 mg or 200 mg,
5 methadone 10 mg, oxycodone 30 mg, hydromorphone 8 mg, morphine IR 30 mg, and
6 hydrocodone-APAP 10/325 mg. Dr. A. L. also prescribed more than one long acting opioid for
7 certain patients, short acting opioids together, and the highest strength available for certain drugs.
8 Further, Dr. A. L. prescribed unusually large quantities and doses of the controlled substances.

9 36. Inspector J. H. also found in reviewing the CURES information that Davison Drug &
10 Stationery had filled several prescriptions for controlled substances, including Klonopin,
11 clonazepam, temazepam, lorazepam, and Vicodin, for different patients over the amount of five
12 refills or the 120-day supply allowed by law. Inspector J. H. found five patients who had
13 prescriptions filled a total of seven times, including the original fill. This meant that the
14 prescriptions were refilled six times, which was over the maximum of five refills; most of them,
15 taken together, exceeded the maximum 120-day supply. Inspector J. H. requested the hardcopy
16 prescriptions for each patient and the refill approvals for each prescription.

17 FIRST CAUSE FOR DISCIPLINE

18 (Failure to Exercise Corresponding Responsibility for the 19 Proper Prescribing and Dispensing of Controlled Substances)

20 37. Respondent Franklin Davison's original pharmacy permit and original pharmacist
21 license are subject to disciplinary action pursuant to Code section 4301, subdivision (o), for
22 unprofessional conduct, in that Respondent violated or attempted to violate, directly or indirectly,
23 assisted in or abetted the violation of, or conspired to violate state laws and regulations governing
24 pharmacy, as follows: On and between January 1, 2009 and September 8, 2014, Respondent, as a
25 licensed pharmacist and owner and operator of Davison Drug & Stationery, failed to exercise his
26 corresponding responsibility for the proper prescribing and dispensing of controlled substances.
27 Specifically, Respondent dispensed numerous prescriptions for controlled substances to the
28 twenty-five patients, identified above, all of which had been issued by Dr. A. L., when

1 Respondent knew, or had objective reason to know, that the prescriptions were not issued for a
2 legitimate medical purpose as evidenced by several “red flags” or factors, including the
3 prescribing of large or excessive quantities and doses of highly abused controlled substances,
4 duplication of therapies for individual patients, multiple patients receiving the same drugs or
5 combinations of drugs, and the distances traveled by the patients to Dr. A. L.’s office and to
6 Davison Drug & Stationery, in violation of Health and Safety Code section 11153, subdivision
7 (a), and California Code of Regulations, title 16, section 1761, subdivision (b).

8 **SECOND CAUSE FOR DISCIPLINE**

9 **(Violations of State Laws Regulating Controlled Substances)**

10 38. Respondent Franklin Davison’s original pharmacy permit and original pharmacist
11 license are subject to disciplinary action pursuant to Code section 4301, subdivision (j), for
12 unprofessional conduct, in that Respondent violated Health and Safety Code section 11200, as
13 follows: Respondent refilled multiple prescriptions for Schedule III and/or IV controlled
14 substances totaling more than a 120-day supply or more than five refills, as set forth in paragraph
15 36 above.

16 **THIRD CAUSE FOR DISCIPLINE**

17 **(Failure to Exercise Corresponding Responsibility for the**
18 **Proper Prescribing and Dispensing of Controlled Substances)**

19 39. Respondent James Davison’s original pharmacist license is subject to disciplinary
20 action pursuant to Code section 4301, subdivision (o), for unprofessional conduct, in that
21 Respondent violated or attempted to violate, directly or indirectly, assisted in or abetted the
22 violation of, or conspired to violate state laws and regulations governing pharmacy, as follows:
23 On and between January 1, 2009 and September 8, 2014, Respondent, as a licensed pharmacist
24 and pharmacist-in-charge of Davison Drug & Stationery, failed to exercise his corresponding
25 responsibility for the proper prescribing and dispensing of controlled substances. Specifically,
26 Respondent dispensed numerous prescriptions for controlled substances to the twenty-five
27 patients, identified above, all of which had been issued by Dr. A. L., when Respondent knew, or
28 had objective reason to know, that the prescriptions were not issued for a legitimate medical

1 purpose as evidenced by several "red flags" or factors, including the prescribing of large or
2 excessive quantities and doses of highly abused controlled substances, duplication of therapies for
3 individual patients, multiple patients receiving the same drugs or combinations of drugs, and the
4 distances traveled by the patients to Dr. A. L.'s office and to Davison Drug & Stationery, in
5 violation of Health and Safety Code section 11153, subdivision (a), and California Code of
6 Regulations, title 16, section 1761, subdivision (b).

7 **FOURTH CAUSE FOR DISCIPLINE**

8 **(Violations of State Laws Regulating Controlled Substances)**

9 40. Respondent James Davison's original pharmacist license is subject to disciplinary
10 action pursuant to Code section 4301, subdivision (j), for unprofessional conduct, in that
11 Respondent violated Health and Safety Code section 11200, as follows: Respondent refilled
12 multiple prescriptions for Schedule III and/or IV controlled substances totaling more than a 120-
13 day supply or more than five refills, as set forth in paragraph 35 above.

14 **OTHER MATTERS**

15 41. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number
16 PHY 47044 issued to Davison Drug & Stationery, Franklin P. Davison, aka Franklin Petesch
17 Davison, owner, Franklin P. Davison, aka Franklin Petesch Davison, shall be prohibited from
18 serving as a manager, administrator, owner, member, officer, director, associate, or partner of a
19 licensee for five years if Pharmacy Permit Number PHY 47044 is placed on probation or until
20 Pharmacy Permit Number PHY 47044 is reinstated if it is revoked.

21 **MATTERS IN AGGRAVATION**

22 42. To determine the degree of discipline to be assessed against Respondent James
23 Davison, if any, Complainant alleges as follows: On or about February 11, 2013, the Board
24 issued Citation and Fine No. CI 2012 54841 against Respondent James Davison for violating
25 Code section 4301, subdivision (g) (unprofessional conduct: knowingly making or signing any
26 certificate or other document that falsely represents the existence or nonexistence of a state of
27 facts), and Code section 4231, subdivision (d), in conjunction with California Code of
28 Regulations, title 16, section 1732.5 (failure to provide documentation substantiating completion

1 of continuing education/renewal requirements for pharmacist). The Board ordered Davison to
2 pay fines totaling \$400 by March 13, 2013. Davison paid the citation on or about March 1, 2013.

3 43. On or about October 30, 2015, the Board issued Citation and Fine Nos. CI 2014
4 64027 and CI 2015 67732 against Respondents for violating: (1) California Code of Regulations,
5 title 16, section 1716 (variation from prescription); (2) California Code of Regulations, title 16,
6 section 1707.3 (duty to review drug therapy); (3) Code section 4081(b), in conjunction with
7 California Code of Regulations, title 16, section 1717(b)(1) (records of dangerous drugs and
8 devices kept open for inspection; maintenance of records, current inventory; Pharmacist in charge
9 responsible for maintaining records/information shall be maintained for each prescription on file
10 and readily retrievable: date dispensed, name or initials of dispensing pharmacist. . .); and (4)
11 Code section 4125, in conjunction with California Code of Regulations, title 16, section
12 1711(e)(4) (Pharmacy Quality Assurance Program Required/Quality assurance program shall
13 advance error prevention. . .). The Board ordered Respondent James Davison to pay fines
14 totaling \$1,250 by November 29, 2015.

15 **PRAYER**

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

18 1. Revoking or suspending Original Pharmacy Permit Number PHY 47044, issued to
19 Franklin P. Davison, also known as Franklin Petesch Davison, owner of Davison Drug &
20 Stationery;

21 2. Revoking or suspending Original Pharmacist License Number RPH 42614, issued to
22 Franklin P. Davison, also known as Franklin Petesch Davison;

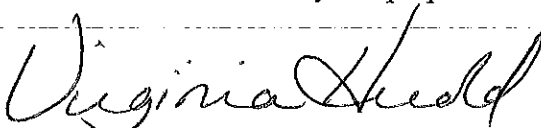
23 3. Revoking or suspending Original Pharmacist License Number RPH 20987, issued to
24 James A. Davison, also known as James Arch Davison;

25 4. Prohibiting Franklin P. Davison from serving as a manager, administrator, owner,
26 member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit
27 Number PHY 47044 is placed on probation or until Pharmacy Permit Number PHY 47044 is
28 reinstated if Pharmacy Permit Number 47044 issued to Davison Drug & Stationery is revoked;

1 5. Ordering Franklin P. Davison, also known as Franklin Petesch Davison, individually,
2 and as the owner of Davison Drug & Stationery, and James A. Davison, also known as James
3 Arch Davison, individually, and as pharmacist-in-charge of Davison Drug & Stationery, to pay
4 the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case,
5 pursuant to Business and Professions Code section 125.3; and

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

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8 DATED: 2/2/17



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

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15 SA2015104281

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A C C U S A T I O N

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1 Complainant alleges:

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10 herein and will expire on March 1, 2016, unless renewed.

11 3. On or about August 3, 1989, the Board issued Original Pharmacist License Number
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13 and effect at all times relevant to the charges brought herein and will expire on July 31, 2017,
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26 board, whose default has been entered or whose case has been heard by the board and
found guilty, by any of the following methods:

27 (1) Suspending judgment.

28 (2) Placing him or her upon probation.

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

2 (4) Revoking his or her license.

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

5 7. Code section 4300.1 states:

6 The expiration, cancellation, forfeiture, or suspension of a board-issued
7 license by operation of law or by order or decision of the board or a court of law, the
8 placement of a license on a retired status, or the voluntary surrender of a license by a
9 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.

10 **STATUTORY AND REGULATORY PROVISIONS**

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13 of unprofessional conduct or whose license has been procured by fraud or
14 misrepresentation or issued by mistake. Unprofessional conduct shall include, but is
not limited to, any of the following:

15 . . .

16 (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 . . .

17 (o) Violating or attempting to violate, directly or indirectly, or assisting in
18 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
19 pharmacy, including regulations established by the board or by any other state or
federal regulatory agency

20 9. Code section 4113, subdivision (c), states that “[t]he pharmacist-in-charge shall be
21 responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining
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11. Health and Safety Code section 11200 states, in pertinent part:

(a) No person shall dispense or refill a controlled substance prescription more than six months after the date thereof.

(b) No prescription for a Schedule III or IV substance may be refilled more than five times and in an amount, for all refills of that prescription taken together, exceeding a 120-day supply

12. California Code of Regulations, title 16, section 1709.1, subdivision (a), states that “[t]he pharmacist-in-charge of a pharmacy shall be employed at that location and shall have responsibility for the daily operation of the pharmacy.”

13. 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.

COST RECOVERY

14. Code section 125.3 provides, in pertinent part, that a 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.

CONTROLLED SUBSTANCES

15. “Methadone” is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(14).

16. “Morphine Sulfate IR (immediate release)” is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(L).

17. “Morphine Sulfate ER (extended release)” is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(L).

18. “Oxycodone” is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M).

1 19. "Hydromorphone" is a Schedule II controlled substance as designated by Health and
2 Safety Code section 11055, subdivision (b)(1)(J).

3 20. "Fentanyl" is a Schedule II controlled substance as designated by Health and Safety
4 Code section 11055, subdivision (c)(8).

5 21. "Norco" is a compound consisting of 10 mg hydrocodone bitartrate, also known as
6 dihydrocodeinone, and 325 mg acetaminophen per tablet. At the time of the incidents described
7 below, Norco was classified as a Schedule III controlled substance pursuant to Health and Safety
8 Code section 11056, subdivision (e)(4).¹

9 22. "Vicodin" is a compound consisting of 5 mg hydrocodone bitartrate, also known as
10 dihydrocodeinone, and 500 mg acetaminophen per tablet. At the time of the incidents described
11 below, Vicodin was classified as a Schedule III controlled substance pursuant to Health and
12 Safety Code section 11056, subdivision (e)(4).

13 23. "Diazepam" is a Schedule IV controlled substance as designated by Health and Safety
14 Code section 11057, subdivision (d)(9).

15 24. "Klonopin," a brand of clonazepam, is a Schedule IV controlled substance as
16 designated by Health and Safety Code section 11057, subdivision (d)(7).

17 25. "Temazepam" is a Schedule IV controlled substance as designated by Health and
18 Safety Code section 11057, subdivision (d)(29).

19 26. "Lorazepam" is a Schedule IV controlled substance as designated by Health and
20 Safety Code section 11057, subdivision (d)(16).

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27 ¹ Hydrocodone has been rescheduled from a Schedule III to Schedule II controlled
28 substance via the Controlled Substances Act (21 CFR Part 1308 § 1308.12; 21 U.S.C. 812 (c)).

STATEMENT OF FACTS

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2 27. On or about November 15, 2013, the Medical Board of California revoked Dr. A. L.'s
3 physician's and surgeon's certificate. The revocation was stayed and Dr. A. L. was placed on
4 probation. Dr. A. L. was also suspended from the practice of medicine for 30 days. Dr. A. L.
5 was charged in the disciplinary proceeding with prescribing excessive amounts and high doses of
6 controlled substances.

7 28. The Drug Enforcement Administration had commenced an investigation of Dr. A. L.
8 and the pharmacies that filled prescriptions for his patients (the investigation was subsequently
9 halted due to the death of Dr. A. L. in December 2013).

10 29. A Board analyst ran CURES² reports showing Dr. A. L.'s prescribing habits.
11 Davison Drug & Stationery was identified as one of the two pharmacies dispensing the most
12 prescriptions for Dr. A. L.'s patients. Dr. A. L.'s practice was located in Colusa, California,
13 approximately three blocks from Davison Drug & Stationery.

14 30. On or about September 2, 2014, Board Inspector J. H. obtained CURES information
15 from September 1, 2011 to September 8, 2014, for Davison Drug & Stationery and three other
16 pharmacies located in close proximity to Davison Drug & Stationery, CURES reports that had
17 previously been requested by Board Inspector J. W., and CURES reports for six patients, TB, DJ,
18 RV, TS, SC, and SH, from January 1, 2009 to January 15, 2014. Inspector J. H. also requested
19 additional CURES reports for these patients from January 16 to September 8, 2014. Inspector J.
20 H. chose an additional nineteen patients to review, who had received prescriptions from Dr. A. L.,
21 patients EBW, MC, PC, JD, KL, GR, DV, DW, BP, TN1, RP, MP, JW, TW, JT, LT, KE, VM and
22 TN, a total of twenty-five patients. Inspector J. H. requested CURES information for each patient
23 from September 1, 2011 to September 8, 2014.

24 31. On or about September 17, 2014, Inspectors J. H. and J. W. conducted an inspection
25 of Davison Drug & Stationery. Respondent James Davison ("PIC Davison") was not present at

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27 ² CURES is a database containing information on Schedule II through IV controlled
28 substances dispensed in California. It is a valuable investigative, preventive, and educational tool
for the healthcare community, regulatory boards, and law enforcement.

1 the pharmacy; however, owner and staff pharmacist, Respondent Franklin Davison ("RPH
2 Davison"), assisted with the inspection. RPH Davison stated that their normal service area was
3 fifty to sixty miles. During the inspection, Inspector J. H. collected several hardcopy
4 prescriptions for the twenty-five patients and had RPH Davison print the patient profiles for each
5 patient from September 1, 2011 to September 17, 2014.

6 32. On or about January 26, 2015, Inspector J. H. requested more hardcopy prescriptions
7 for the twenty-five patients.

8 33. Inspector J. H. reviewed the CURES reports for Davison Drug & Stationery and the
9 three other pharmacies, and compared the total number of controlled substances dispensed by the
10 pharmacies with the total number of controlled substances written by Dr. A. L. for the period
11 from September 1, 2011 to September 8, 2014. Inspector J. H. found that Davison Drug &
12 Stationery dispensed more controlled substances written by Dr. A. L. than any of the other
13 pharmacies. Inspector J. H. created a chart showing the roundtrip distance from the twenty-five
14 patients' homes to Dr. A. L.'s office in Colusa, to Davison Drug & Stationery, and back home.
15 Only eight of the patients lived in the pharmacy's trade area, defined by RPH Davison as fifty to
16 sixty miles from the pharmacy. Thirteen of the patients traveled more than one-hundred miles
17 one way to see Dr. A. L., six of the patients traveled more than five-hundred miles one way to Dr.
18 A. L., and five of the patients traveled more than two-thousand miles one way to see Dr. A. L.

19 34. Inspector J. H. created a chart based on the hardcopy prescriptions showing the
20 patient's initials, date of the prescription, prescription number, drug name, strength and quantity,
21 directions, diagnosis code, duration of the patient's treatment, and any abnormalities or unusual
22 findings. Inspector J. H. determined that there were a total of approximately 295 prescriptions
23 filled for the patients, approximately seventy-five of which were filled by PIC Davison and
24 approximately 218 of which were filled by RPH Davison. Inspector J. H. found that Dr. A. L.'s
25 prescribing practices showed duplication in therapy, and the same combinations of drugs were
26 prescribed for multiple patients, including fentanyl 100 mcg/h, morphine ER 100 mg or 200 mg,
27 methadone 10 mg, oxycodone 30 mg, hydromorphone 8 mg, morphine IR 30 mg, and
28 hydrocodone-APAP 10/325 mg. Dr. A. L. also prescribed more than one long acting opioid for

1 certain patients, short acting opioids together, and the highest strength available for certain drugs.
2 Further, Dr. A. L. prescribed unusually large quantities and doses of the controlled substances.

3 35. Inspector J. H. also found in reviewing the CURES information that Davison Drug &
4 Stationery had filled several prescriptions for controlled substances, including Klonopin,
5 clonazepam, temazepam, lorazepam, and Vicodin, for different patients over the amount of five
6 refills or the 120-day supply allowed by law. Inspector J. H. found five patients who had
7 prescriptions filled a total of seven times, including the original fill. This meant that the
8 prescriptions were refilled six times, which was over the maximum of five refills; most of them,
9 taken together, exceeded the maximum 120-day supply. Inspector J. H. requested the hardcopy
10 prescriptions for each patient and the refill approvals for each prescription.

11 **FIRST CAUSE FOR DISCIPLINE**

12 **(Failure to Exercise Corresponding Responsibility for the**
13 **Proper Prescribing and Dispensing of Controlled Substances)**

14 36. Respondent Franklin Davison's original pharmacy permit and original pharmacist
15 license are subject to disciplinary action pursuant to Code section 4301, subdivision (o), for
16 unprofessional conduct, in that Respondent violated or attempted to violate, directly or indirectly,
17 assisted in or abetted the violation of, or conspired to violate state laws and regulations governing
18 pharmacy, as follows: On and between January 1, 2009 and September 8, 2014, Respondent, as a
19 licensed pharmacist and owner and operator of Davison Drug & Stationery, failed to exercise his
20 corresponding responsibility for the proper prescribing and dispensing of controlled substances.
21 Specifically, Respondent dispensed numerous prescriptions for controlled substances to the
22 twenty-five patients, identified above, all of which had been issued by Dr. A. L., when
23 Respondent knew, or had objective reason to know, that the prescriptions were not issued for a
24 legitimate medical purpose as evidenced by several "red flags" or factors, including the
25 prescribing of large or excessive quantities and doses of highly abused controlled substances,
26 duplication of therapies for individual patients, multiple patients receiving the same drugs or
27 combinations of drugs, and the distances traveled by the patients to Dr. A. L.'s office and to

1 Davison Drug & Stationery, in violation of Health and Safety Code section 11153, subdivision
2 (a), and California Code of Regulations, title 16, section 1761, subdivision (b).

3 **SECOND CAUSE FOR DISCIPLINE**

4 **(Violations of State Laws Regulating Controlled Substances)**

5 37. Respondent Franklin Davison's original pharmacy permit and original pharmacist
6 license are subject to disciplinary action pursuant to Code section 4301, subdivision (j), for
7 unprofessional conduct, in that Respondent violated Health and Safety Code section 11200, as
8 follows: Respondent refilled multiple prescriptions for Schedule III and/or IV controlled
9 substances totaling more than a 120-day supply or more than five refills, as set forth in paragraph
10 35 above.

11 **THIRD CAUSE FOR DISCIPLINE**

12 **(Failure to Exercise Corresponding Responsibility for the**
13 **Proper Prescribing and Dispensing of Controlled Substances)**

14 38. Respondent James Davison's original pharmacist license is subject to disciplinary
15 action pursuant to Code section 4301, subdivision (o), for unprofessional conduct, in that
16 Respondent violated or attempted to violate, directly or indirectly, assisted in or abetted the
17 violation of, or conspired to violate state laws and regulations governing pharmacy, as follows:
18 On and between January 1, 2009 and September 8, 2014, Respondent, as a licensed pharmacist
19 and pharmacist-in-charge of Davison Drug & Stationery, failed to exercise his corresponding
20 responsibility for the proper prescribing and dispensing of controlled substances. Specifically,
21 Respondent dispensed numerous prescriptions for controlled substances to the twenty-five
22 patients, identified above, all of which had been issued by Dr. A. L., when Respondent knew, or
23 had objective reason to know, that the prescriptions were not issued for a legitimate medical
24 purpose as evidenced by several "red flags" or factors, including the prescribing of large or
25 excessive quantities and doses of highly abused controlled substances, duplication of therapies for
26 individual patients, multiple patients receiving the same drugs or combinations of drugs, and the
27 distances traveled by the patients to Dr. A. L.'s office and to Davison Drug & Stationery, in

1 violation of Health and Safety Code section 11153, subdivision (a), and California Code of
2 Regulations, title 16, section 1761, subdivision (b).

3 **FOURTH CAUSE FOR DISCIPLINE**

4 **(Violations of State Laws Regulating Controlled Substances)**

5 39. Respondent James Davison's original pharmacist license is subject to disciplinary
6 action pursuant to Code section 4301, subdivision (j), for unprofessional conduct, in that
7 Respondent violated Health and Safety Code section 11200, as follows: Respondent refilled
8 multiple prescriptions for Schedule III and/or IV controlled substances totaling more than a 120-
9 day supply or more than five refills, as set forth in paragraph 35 above.

10 **MATTERS IN AGGRAVATION**

11 40. To determine the degree of discipline to be assessed against Respondent James
12 Davison, if any, Complainant alleges as follows: On or about February 11, 2013, the Board
13 issued Citation and Fine No. CI 2012 54841 against Respondent James Davison for violating
14 Code section 4301, subdivision (g) (unprofessional conduct: knowingly making or signing any
15 certificate or other document that falsely represents the existence or nonexistence of a state of
16 facts), and Code section 4231, subdivision (d), in conjunction with California Code of
17 Regulations, title 16, section 1732.5 (failure to provide documentation substantiating completion
18 of continuing education/renewal requirements for pharmacist). The Board ordered Davison to
19 pay fines totaling \$400 by March 13, 2013. Davison paid the citation on or about March 1, 2013.

20 41. On or about October 30, 2015, the Board issued Citation and Fine Nos. CI 2014
21 64027 and CI 2015 67732 against Respondents for violating: (1) California Code of Regulations,
22 title 16, section 1716 (variation from prescription); (2) California Code of Regulations, title 16,
23 section 1707.3 (duty to review drug therapy); (3) Code section 4081(b), in conjunction with
24 California Code of Regulations, title 16, section 1717(b)(1) (records of dangerous drugs and
25 devices kept open for inspection; maintenance of records, current inventory; Pharmacist in charge
26 responsible for maintaining records/information shall be maintained for each prescription on file
27 and readily retrievable: date dispensed, name or initials of dispensing pharmacist. . .); and (4)
28 Code section 4125, in conjunction with California Code of Regulations, title 16, section

1 1711(e)(4) (Pharmacy Quality Assurance Program Required/Quality assurance program shall
2 advance error prevention. . .). The Board ordered Respondent James Davison to pay fines
3 totaling \$1,250 by November 29, 2015.

4 PRAYER

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

7 1. Revoking or suspending Original Pharmacy Permit Number PHY 47044, issued to
8 Franklin P. Davison, also known as Franklin Petesch Davison, owner of Davison Drug &
9 Stationery;

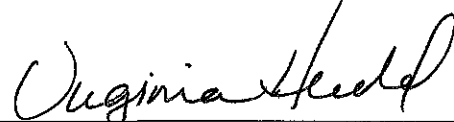
10 2. Revoking or suspending Original Pharmacist License Number RPH 42614, issued to
11 Franklin P. Davison, also known as Franklin Petesch Davison;

12 3. Revoking or suspending Original Pharmacist License Number RPH 20987, issued to
13 James A. Davison, also known as James Arch Davison;

14 4. Ordering Franklin P. Davison, also known as Franklin Petesch Davison, individually,
15 and as the owner of Davison Drug & Stationery, and James A. Davison, also known as James
16 Arch Davison, individually, and as pharmacist-in-charge of Davison Drug & Stationery, to pay
17 the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case,
18 pursuant to Business and Professions Code section 125.3; and

19 5. Taking such other and further action as deemed necessary and proper.

20
21 DATED: 3/18/16



22 VIRGINIA HEROLD
23 Executive Officer
24 Board of Pharmacy
25 Department of Consumer Affairs
26 State of California
27 Complainant

28 SA2015104281