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

In the Matter of the First Amended Accusation Against: **LIVE OAK PHARMACY** **RANJIT SINGH, Owner/Pharmacist-In-Charge** **9970 Live Oak Blvd.** **Live Oak, CA 95953** **Original Pharmacy Permit No. PHY 45317** **and** **RANJIT SINGH** **3215 Pennington Road** **Live Oak, CA 95953** **Original Pharmacist License No. RPH 46870** Respondents.	Case No. 5527 **FIRST AMENDED ACCUSATION**

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 or about April 12, 2001, the Board issued Original Pharmacy Permit Number PHY 45317 to Ranjit Singh ("Respondent"), owner and pharmacist-in-charge of Live Oak Pharmacy. The original pharmacy permit was in full force and effect at all times relevant to the

charges brought herein, and was canceled on January 3, 2017.

3. On or about March 7, 1994, the Board issued Original Pharmacist License Number RPH 46870 to Respondent. The original pharmacist license was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2018, unless renewed.

JURISDICTION

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

5. Code section 4300 states, in pertinent part:

> (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 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 . . . .

6. 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.

7. 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

8. 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:

. . .

(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 . . . .

9. Code section 4113, subdivision (c), states that, "[t]he 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."

10. 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 . . . .

11. 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."

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12. 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

13. 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

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

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

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

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

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

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

20. "Norco" is a compound consisting of 10 mg hydrocodone bitartrate, also known as dihydrocodeinone, and 325 mg acetaminophen per tablet. At the time of the incidents described below, Norco was classified as a Schedule III controlled substance pursuant to Health and Safety

Code section 11056, subdivision (e)(4).[1]

STATEMENT OF FACTS

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

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

23. A Board analyst ran CURES[2] reports showing Dr. A. L.'s prescribing habits. Live Oak Pharmacy was identified as one of two pharmacies dispensing the most prescriptions for Dr. A. L.'s patients. Dr. A. L.'s practice was located in Colusa, California, approximately 32.9 miles from Live Oak Pharmacy.

24. On or about September 1, 2014, a Board Inspector obtained CURES information from September 1, 2011 to September 5, 2014, for Live Oak Pharmacy and three other pharmacies located in close proximately to Live Oak Pharmacy. The inspector selected certain patients, identified in the CURES report for Live Oak Pharmacy to review based on the distance the patients lived from the pharmacy, the quantities of controlled substances prescribed, the combinations of controlled substances prescribed, and whether the individuals were patients of Dr. A. L. The inspector also requested CURES data from September 1, 2011 to September 5, 2014, for each patient selected, including the following fourteen patients: TB, PM, JB, DS, MH, RB, BN, KS, DM, CF, DB, JY, TF1, and TF2.

///

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

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

25. On or about September 3, 2014, the inspector and another representative of the Board conducted an inspection of Live Oak Pharmacy during which they were assisted by Respondent. The inspector requested patient profiles for the above fourteen patients, and found in reviewing the profiles that nine of the fourteen patients were from out of the area, including Shasta Lake, California (113 miles away) and Granite Bay, California (fifty-six miles away). The inspector obtained several hardcopy prescriptions for thirteen of the fourteen patients and requested drug utilization reports (DUR's) for Dr. A. L. from January 1, 2012 to September 3, 2014. On or about September 24, 2014, the inspector received the DUR's from Respondent.

26. The inspector reviewed the CURES reports for Live Oak Pharmacy and the three other pharmacies located in close proximity to Live Oak Pharmacy, and created spreadsheets based on the data. The inspector compared the total number of controlled substances dispensed by the pharmacies with the total number of controlled substances written by Dr. A. L. for the period from September 1, 2011 to September 5, 2014, and found that Live Oak Pharmacy dispensed more of Dr. A. L.'s prescriptions than any of the other pharmacies.

27. The inspector created a chart showing the round trip distance from the fourteen patients' homes to Dr. A. L.'s office in Colusa and Live Oak Pharmacy. Only five of the fourteen patients lived in Live Oak Pharmacy's trade area, defined by Respondent as Yuba City, Gridley, and Live Oak. The shortest distance traveled for the fourteen patients was 64.7 miles round trip; the longest distance traveled was 257.9 miles round trip.

28. The inspector also created a chart based on the hardcopy prescriptions showing the date the prescriptions were written, drug name, strength and quantity, directions, diagnosis code, and duration of the patient's treatment. The inspector determined in reviewing the prescriptions, CURES information, and patient profiles that Dr. A. L.'s prescribing practices showed duplication in therapy, and the same combinations of drugs were prescribed for multiple patients, including fentanyl 100 mcg/h, morphine ER 100 mg or 200 mg, methadone 10 mg, oxycodone 30 mg, hydromorphone 8 mg, and morphine IR 30 mg. On several occasions, Dr. A. L. prescribed more than one long acting opioid or short acting opioid for the patient and would prescribe short

acting opioids together. Dr. A. L. also prescribed the highest strength or dose a drug was available in and prescribed large or excessive quantities of the above controlled substances.

FIRST CAUSE FOR DISCIPLINE

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

29. Respondent's original pharmacy permit and original pharmacist license are subject to disciplinary action pursuant to Code section 4301, subdivision (o), California Health and Safety Code section 11153, and California Code of Regulations, title 16, section 1761, for unprofessional conduct, in that Respondent violated or attempted to violate, directly or indirectly, assisted in or abetted the violation of, or conspired to violate state laws and regulations governing pharmacy, as follows: On and between September 1, 2011 and September 5, 2014, Respondent, as a licensed pharmacist and as the owner, operator, and pharmacist-in-charge of Live Oak Pharmacy, failed to exercise his corresponding responsibility for the proper prescribing and dispensing of controlled substances. Specifically, Respondent dispensed, or authorized or permitted the dispensing of, numerous prescriptions for controlled substances to at least fourteen different patients, all of which had been issued by Dr. A. L., when Respondent knew, or had objective reason to know, that the prescriptions were not issued for a legitimate medical purpose as evidenced by several "red flags" or factors, including the prescribing of large or excessive quantities and doses of highly abused controlled substances, duplication of therapies for individual patients, multiple patients receiving the same drugs or combinations of drugs, and the distances traveled by the patients to Dr. A. L.'s office and to Live Oak Pharmacy, in violation of Health and Safety Code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, subdivision (b).

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SECOND CAUSE FOR DISCIPLINE

(Failure by Pharmacist-in-Charge to Ensure Pharmacy's Compliance With All State and Federal Laws and Regulations Pertaining to the Practice of Pharmacy)

30. Respondent's original pharmacist license is subject to disciplinary action pursuant to Code section 4113, subdivision (c), and California Code of Regulations, title 16, section 1709.1, subdivision (b), in that on and between September 1, 2011 and September 5, 2014, Respondent, as the pharmacist-in-charge of Live Oak Pharmacy, failed to ensure Live Oak Pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy. The facts and circumstances are described with more particularity in paragraph 29, above.

MATTERS IN AGGRAVATION

31. On or about September 30, 2015, Respondent was issued a citation for: (1) failing to comply with California Code of Regulations, title 16, section 1716, which prohibits a pharmacist from deviating from the requirements of a prescription except upon prior consent of the prescriber; and (2) failing to comply with California Code of Regulations, title 16, section 1711(f), which requires all pharmacies to participate in an established quality assurance program which documents and assesses medication errors to determine cause and an appropriate response, and to keep a record of quality assurance review for at least one year from the date the record was created.

32. On or about September 30, 2015, Registered Pharmacist Harinder S. Rai, while employed as a pharmacist by Respondent, was issued two citations for: (1) failing to comply with California Code of Regulations, title 16, section 1716, which prohibits a pharmacist from deviating from the requirements of a prescription except upon prior consent of the prescriber; and (2) failing to comply with California Code of Regulations, title 16, section 1711(f), which requires all pharmacies to participate in an established quality assurance program which documents and assesses medication errors to determine cause and an appropriate response, and to keep a record of quality assurance review for at least one year from the date the record was created.

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OTHER MATTERS

33. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 45317 issued to Live Oak Pharmacy, Ranjit Singh Owner/Pharmacist-In-Charge, Ranjit Singh 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 45317 is placed on probation or until Pharmacy Permit Number PHY 45317 is reinstated if it is revoked.

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 Original Pharmacy Permit Number PHY 45317, issued to Ranjit Singh, owner and pharmacist-in-charge of Live Oak Pharmacy;

2. Revoking or suspending Original Pharmacist License Number RPH 46870, issued to Ranjit Singh;

3. Prohibiting Ranjit Singh from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 45317 is placed on probation or until Pharmacy Permit Number PHY 45317 is reinstated if Pharmacy Permit Number 45317 issued to Live Oak Pharmacy is revoked;

4. Ordering Ranjit Singh, individually, and as the owner and pharmacist-in-charge of Live Oak Pharmacy, 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; and

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

DATED: 2/2/17

Virginia Herold

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

SA2015104280

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

In the Matter of the Accusation Against: **LIVE OAK PHARMACY** **RANJIT SINGH, Owner/Pharmacist-In-Charge** **9970 Live Oak Blvd.** **Live Oak, CA 95953** **Original Pharmacy Permit No. PHY 45317** **and** **RANJIT SINGH** **3215 Pennington Road** **Live Oak, CA 95953** **Original Pharmacist License No. RPH 46870** Respondents.	Case No. 5527 **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 or about April 12, 2001, the Board issued Original Pharmacy Permit Number PHY 45317 to Ranjit Singh ("Respondent"), owner and pharmacist-in-charge of Live Oak Pharmacy. The original pharmacy permit was in full force and effect at all times relevant to the charges brought herein and will expire on April 1, 2016, unless renewed.

3. On or about March 7, 1994, the Board issued Original Pharmacist License Number RPH 46870 to Respondent. The original pharmacist license was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2016, unless renewed.

JURISDICTION

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

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COST RECOVERY

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CONTROLLED SUBSTANCES

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STATEMENT OF FACTS

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

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

22. A Board analyst ran CURES[2] reports showing Dr. A. L.'s prescribing habits. Live

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

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Oak Pharmacy was identified as one of two pharmacies dispensing the most prescriptions for Dr. A. L.'s patients. Dr. A. L.'s practice was located in Colusa, California, approximately 32.9 miles from Live Oak Pharmacy.

23. On or about September 1, 2014, a Board Inspector obtained CURES information from September 1, 2011 to September 5, 2014, for Live Oak Pharmacy and three other pharmacies located in close proximately to Live Oak Pharmacy. The inspector selected certain patients, identified in the CURES report for Live Oak Pharmacy to review based on the distance the patients lived from the pharmacy, the quantities of controlled substances prescribed, the combinations of controlled substances prescribed, and whether the individuals were patients of Dr. A. L. The inspector also requested CURES data from September 1, 2011 to September 5, 2014, for each patient selected, including the following fourteen patients: TB, PM, JB, DS, MH, RB, BN, KS, DM, CF, DB, JY, TF1, and TF2.

24. On or about September 3, 2014, the inspector and another representative of the Board conducted an inspection of Live Oak Pharmacy during which they were assisted by Respondent. The inspector requested patient profiles for the above fourteen patients, and found in reviewing the profiles that nine of the fourteen patients were from out of the area, including Shasta Lake, California (113 miles away) and Granite Bay, California (fifty-six miles away). The inspector obtained several hardcopy prescriptions for thirteen of the fourteen patients and requested drug utilization reports (DUR's) for Dr. A. L. from January 1, 2012 to September 3, 2014. On or about September 24, 2014, the inspector received the DUR's from Respondent.

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26. The inspector created a chart showing the round trip distance from the fourteen patients' homes to Dr. A. L.'s office in Colusa and Live Oak Pharmacy. Only five of the fourteen

patients lived in Live Oak Pharmacy's trade area, defined by Respondent as Yuba City, Gridley, and Live Oak. The shortest distance traveled for the fourteen patients was 64.7 miles round trip; the longest distance traveled was 257.9 miles round trip.

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FIRST CAUSE FOR DISCIPLINE

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

28. Respondent's original pharmacy permit and original pharmacist license are subject to disciplinary action pursuant to Code section 4301, subdivision (o), California Health and Safety Code section 11153, and California Code of Regulations, title 16, section 1761, for unprofessional conduct, in that Respondent violated or attempted to violate, directly or indirectly, assisted in or abetted the violation of, or conspired to violate state laws and regulations governing pharmacy, as follows: On and between September 1, 2011 and September 5, 2014, Respondent, as a licensed pharmacist and as the owner, operator, and pharmacist-in-charge of Live Oak Pharmacy, failed to exercise his corresponding responsibility for the proper prescribing and dispensing of controlled substances. Specifically, Respondent dispensed, or authorized or permitted the dispensing of, numerous prescriptions for controlled substances to at least fourteen different patients, all of which had been issued by Dr. A. L., when Respondent knew, or had objective reason to know, that the prescriptions were not issued for a legitimate medical purpose

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

SECOND CAUSE FOR DISCIPLINE

(Failure by Pharmacist-in-Charge to Ensure Pharmacy's Compliance With All State and Federal Laws and Regulations Pertaining to the Practice of Pharmacy)

29. Respondent's original pharmacist license is subject to disciplinary action pursuant to Code section 4113, subdivision (c), and California Code of Regulations, title 16, section 1709.1, subdivision (b), in that on and between September 1, 2011 and September 5, 2014, Respondent, as the pharmacist-in-charge of Live Oak Pharmacy, failed to ensure Live Oak Pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy. The facts and circumstances are described with more particularity in paragraph 28, above.

MATTERS IN AGGRAVATION

30. On or about September 30, 2015, Respondent was issued a citation for: (1) failing to comply with California Code of Regulations, title 16, section 1716, which prohibits a pharmacist from deviating from the requirements of a prescription except upon prior consent of the prescriber; and (2) failing to comply with California Code of Regulations, title 16, section 1711(f), which requires all pharmacies to participate in an established quality assurance program which documents and assesses medication errors to determine cause and an appropriate response, and to keep a record of quality assurance review for at least one year from the date the record was created.

31. On or about September 30, 2015, Registered Pharmacist Harinder S. Rai, while employed as a pharmacist by Respondent, was issued two citations for: (1) failing to comply with California Code of Regulations, title 16, section 1716, which prohibits a pharmacist from deviating from the requirements of a prescription except upon prior consent of the prescriber; and

(2) failing to comply with California Code of Regulations, title 16, section 1711(f), which requires all pharmacies to participate in an established quality assurance program which documents and assesses medication errors to determine cause and an appropriate response, and to keep a record of quality assurance review for at least one year from the date the record was created.

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 Original Pharmacy Permit Number PHY 45317, issued to Ranjit Singh, owner and pharmacist-in-charge of Live Oak Pharmacy;

2. Revoking or suspending Original Pharmacist License Number RPH 46870, issued to Ranjit Singh;

3. Ordering Ranjit Singh, individually, and as the owner and pharmacist-in-charge of Live Oak Pharmacy, 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; and

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

DATED: 3/25/16

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

SA2015104280