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

In the Matter of the Statement of Issues Against: **ALBERT FARAH DAHER** **Pharmacy Technician Registration Applicant** Respondent.	Case No. 5585 **STATEMENT OF ISSUES**

Complainant alleges:

PARTIES

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

2. On or about March 9, 2015, the Board of Pharmacy, Department of Consumer Affairs received an application for a Pharmacy Technician Registration from Albert Farah Daher (Respondent). On or about February 23, 2015, Albert Farah Daher certified under penalty of perjury to the truthfulness of all statements, answers, and representations in the application. The Board denied the application on July 9, 2015.

3. On or about March 12, 1985, the Board of Pharmacy issued Pharmacist License Number RPH 39189 to Albert Farah Daher (Respondent Daher). The Pharmacist License was revoked effective January 27, 2014, as set forth in paragraph 5 below.

4. On or about June 27, 1995, the Board of Pharmacy issued Retail Pharmacy License Number PHY 40912 to Jay Scott Drugs (Respondent), located at 220 North Glenoaks, Burbank, California. Albert Farah Daher was the sole owner of Jay Scott Drugs and was the Pharmacist-in-Charge of Jay Scott Drugs from 1998 to January 27, 2014. The Retail Pharmacy License was revoked effective January 27, 2014, as set forth in paragraph 5 below.

DISCIPLINARY HISTORY

5. On December 27, 2013, pursuant to the Decision in the disciplinary action titled *In the Matter of the Accusation Against: Jay Scott Drugs, Albert Farah Daher, et al.*, Case No. 3482, the Board revoked Respondent's Pharmacist License Number RPH 39189 and Jay Scott Drugs' Retail Pharmacy License Number PHY 40912, with Respondent as sole owner and Pharmacist-in-Charge, effective January 27, 2014, for Respondent's violations of the following:

a. Business and Professions Code Sections 4301, subdivision (o), and 4063 (Unprofessional Conduct - Refill of Prescriptions without Prescriber's Authorization);

b. Business and Professions Code Sections 4301, subdivision (o), and 4306.5, subdivision (c), and California Code of Regulations, title 16, sections 1707.3 or 1761 (Unprofessional Conduct - Failure to Review Drug Therapy and Patient Medication Record);

c. Business and Professions Code Section 4301, subdivisions (d), (j) and (o), Health and Safety Code section 11153, and California Code of Regulations, title 16, section 1761, subdivision (b) (Unprofessional Conduct - Failure to Exercise Professional Judgment/Corresponding Responsibility);

d. Business and Professions Code Section 4301 (Unprofessional Conduct).

A true and correct copy of the Decision is attached hereto as Exhibit A.

JURISDICTION

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

STATUTORY PROVISIONS

7. Section 480 of the Code states, in part:

"(a) A board may deny a license regulated by this code on the grounds that the applicant has one of the following:

. . .

"(3) (A) Done any act that if done by a licentiate of the business or profession in question, would be grounds for suspension or revocation of license.

"(B) The board may deny a license pursuant to this subdivision only if the crime or act is substantially related to the qualifications, functions, or duties of the business or profession for which application is made."

8. Section 4300 provides in pertinent part, that every license issued by the Board is subject to discipline, including suspension or revocation.

9. Section 4301 states, in 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:

. . . .

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

10. Section 4313 of the Code states:

"In determining whether to grant an application for licensure or whether to discipline or reinstate a license, the board shall give consideration to evidence of rehabilitation. However, public protection shall take priority over rehabilitation and, where evidence of rehabilitation and public protection are in conflict, public protection shall take precedence."

REGULATORY PROVISIONS

11. California Code of Regulations, title 16, section 1770, states:

"For the purpose of denial, suspension, or revocation of a personal or facility license pursuant to Division 1.5 (commencing with Section 475) of the Business and Professions Code, a crime or act shall be considered substantially related to the qualifications, functions or duties of a

licensee or registrant if to a substantial degree it evidences present or potential unfitness of a licensee or registrant to perform the functions authorized by his license or registration in a manner consistent with the public health, safety, or welfare."

CAUSE FOR DENIAL

(Acts Warranting Revocation of Licensure: Accusation No. 3482)

11. Respondent's application is subject to denial pursuant to sections 4301, subdivision (p), and 480, subdivisions (a)(3)(A) and (a)(3)(B), in conjunction with California Code of Regulations, title 16, section 1770, in that he committed acts while holding Pharmacist License Number RPH 39189 and Jay Scott Drugs' Retail Pharmacy License Number PHY 40912, as sole owner and Pharmacist-in-Charge, which were grounds for revocation of the licenses, as set forth in paragraph 5 above.

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. Denying the application of Albert Farah Daher for a Pharmacy Technician Registration;

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

DATED: 11/23/15

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

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EXHIBIT A

Decision in *In the Matter of the Accusation Against: Jay Scott Drugs, Albert Farah Daher, et al.*, Case No. 3482

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

In the Matter of the First Amended Accusation Against: **JAY SCOTT DRUGS,** **P.I.C. ALBERT DAHER,** Retail Pharmacy Permit No. PHY 40912 **ALBERT FARAH DAHER** Pharmacist License No. RPH 39189 **AHMAD SHATI NABHAN** Pharmacist License No. RPH 41754 and **JUN YAMASAKI** Pharmacist License No. RPH 19983 Respondents.	Agency Case No. 3482 OAH Case No. 2011020500

DECISION AFTER NONADOPTION

Daniel Juárez, Administrative Law Judge, Office of Administrative Hearings, heard this matter on October 30 and 31, and November 1, 5-7, and 13-16, 2012, and May 23 and 24, and June 4-7, 2013, in Los Angeles, California.

Nancy A. Kaiser, Deputy Attorney General, represented Virginia K. Herold (Complainant), Executive Officer of the Board of Pharmacy (Board).

Gregory P. Matzen, Esq., and Friedenthal, Heffernan & Klein, and Daniel R. Friedenthal, Esq., represented Jay Scott Drugs (Respondent JSD), Albert Farah Daher (Respondent Daher), Ahmad Shati Nabhan (Respondent Nabhan), and Jun Yamasaki

(Respondent Yamasaki). Respondents were each present on the first day of hearing. During the hearing, Respondents Nabhan and Yamasaki requested leave to attend to their employment duties, while having Respondent Daher present on every day of hearing. Respondents Nabhan and Yamasaki made themselves available for examination as needed by both parties. The Administrative Law Judge (ALJ) made no negative findings against Respondents from the requested and permitted absences of Respondents Nabhan and Yamasaki.

The ALJ left the record open to allow the parties to file closing briefs by July 12, 2013. The parties filed closing briefs timely.

The parties submitted the matter for decision by the ALJ on July 12, 2013.

The proposed decision of the ALJ was submitted to the Board of Pharmacy on August 14, 2013. After due consideration thereof, the Board of Pharmacy declined to adopt said proposed decision and thereafter on September 25, 2013 issued an Order of Non-adoption. On September 25, 2013, the Board also issued an Order Fixing Date for Submission of Written Arguments. Thereafter, Respondents requested additional time to submit written arguments. On October 15, 2013, an Order Extending Time for Providing Written Argument was issued granting the parties until November 8, 2013 to submit written arguments.

Written argument having been received from Complainant and Respondents, the time for filing written argument in this matter having expired, and the entire record, including the transcript of said hearing having been read and considered, the Board of Pharmacy pursuant to Section 11517 of the Government Code hereby makes the following decision:

STATEMENT OF THE CASE

Complainant alleges that Respondents excessively dispensed controlled substances to numerous patients, resulting in violations of pharmacy law, and in some cases, patient deaths or the exacerbation of drug addictions. Reference to the patients is limited to initials to preserve their privacy. The patients are: A.S., J.S., N.V., S.R., G.C. III, D.L., D.K., B.G., D.S., L.G., A.W., C.G., T.P., K.P., S.P., G.C. Jr., N.C., F.R., J.C., and A.C. The alleged causes for discipline are: 1) refilling prescriptions without prescriber authorization; 2) failing to review drug therapies and patient medication records; 3) failing to exercise professional judgment; 4) failing to review patient profiles prior to dispensing prescriptions; and, 5) unprofessional conduct. Complainant seeks the revocation of each Respondent's Board-issued license and the costs of investigation and prosecution.

Respondents deny the allegations, asserting that they considered each patient's prescription before dispensing and exercised their professional judgment accordingly. Respondents seek the dismissal of the Accusation.

FACTUAL FINDINGS

Jurisdiction

1. Complainant filed the First Amended Accusation on February 24, 2012. The original Accusation was filed on August 4, 2010. Respondents Nabhan and Yamasaki filed Notices of Defense on August 21, 2010, and August 23, 2010, respectively. Respondents JSD and Daher filed a Notice of Defense on August 30, 2010 (Respondents' counsel filed this Notice of Defense on all Respondents' behalf).

License Certification

2. On June 27, 1995, the Board issued original permit number PHY 40912 to Respondent JSD, authorizing Respondent Daher to do business as "Jay Scott Drugs." Respondent Daher has been the pharmacist-in-charge (P.I.C.) at Jay Scott Drugs since June 1, 1998. At hearing, evidence of licensure established that Respondent JSD's permit expired on June 1, 2013. Subsequently, Respondent JSD renewed its permit and it is currently set to expire on June 1, 2014. Even if Respondent JSD had not renewed its permit, however, the Board retains jurisdiction over all of Respondents' licenses for purposes of this action, pursuant to Business and Professions Code section 4300.1.

3. On March 12, 1985, the Board issued original pharmacist license number RPH 39189 to Respondent Daher; it expires on January 31, 2015, unless renewed.

4. On April 20, 1988, the Board issued original pharmacist license number RPH 41754 to Respondent Nabhan; it expires on May 31, 2015, unless renewed.

5. On July 28, 1956, the Board issued original pharmacist license number RPH 19983 to Respondent Yamasaki; it expires on March 31, 2014, unless renewed.

The Board's Inspection—Overall Findings

6. Board Inspector Sarah Bayley (Bayley) inspected Respondent JSD on various occasions between 2008 and 2011 and determined that Respondents violated pharmacy laws and regulations involving the filling and dispensing of controlled substances that Respondents knew or should have known were for illegitimate purposes.

7. She received a Doctor of Pharmacy degree from the University of Southern California in 1994. From 1994 to 2000, Bayley was a Staff Pharmacist/Diabetes Care Pharmacist at Sav-On Pharmacy in Hawaiian Gardens, California. Bayley has been a Board Inspector since 2000. During her time as an inspector for the Board, Bayley has performed approximately six hundred (600) investigations; thirty (30) of those cases involved allegations of a pharmacist failing to

properly exercise his or her corresponding responsibility in dispensing controlled substances.

8. During Bayley's reviews, she found recurring issues with a number of patients who received controlled substances. The characteristics included, among other things, repeated, consistent prescriptions for controlled substances for the same combination of drugs in the same dosage, same quantity, and with the same directions to a large number of generally younger patients and to many types of patients regardless of age or gender. The drugs are described in detail later. According to Bayley and as alleged by Complainant, these drugs, in combination, were a popular combination sought by drug addicts. Bayley also found that the patients at issue paid in cash exclusively, or almost exclusively, and traveled significant distances from their homes to obtain the medications, which should have raised "flags" for Respondents.

9. Bayley opined that a prudent pharmacist would question Dr. Bass' prescribing pattern of issuing prescriptions for the same dosage, quantity and drug combinations over a long period of time for different types of patients. This was particularly true for those combinations that should be closely monitored; specifically, those drug combinations that include sedatives. In her view, Respondents had many chances over a long period of time to re-evaluate, communicate with the prescriber, talk to the patients about their drug therapies, and document the communications for best patient care. However, she found no evidence that Respondents had done this. Similarly, Bayley found no documentation of any communications between Respondents and Dr. Bamdad about any patient. After Bayley began her investigation, Respondent Daher indicated that he had stopped dispensing prescriptions for the types of pain medications that Dr. Bass had prescribed. However, on April 16, 2008, Respondent Daher wrote Bayley a letter indicating that he was experiencing a "slow down of our business" and he was "having to choose how many and which employees to lay off because of the slow down of our business..." (State's Ex. 13).

Bernard N. Bass, M.D. and Massoud Bamdad, M.D.

10. Complainant focused her case on the prescriptions issued by two physicians, Bernard N. Bass, M.D. (Bass), and, to a lesser extent, Massoud Bamdad, M.D. (Bamdad). Bass treated the vast majority of the patients at issue here and issued the majority of their prescriptions. Unrelated to the instant disciplinary matter, and at different times, each physician admitted to improperly prescribing controlled substances. Each physician faced medical license disciplinary action and criminal prosecution for his prescribing practices, among other things. Those actions are noted herein to establish that the prescribing practices of Bass and Bamdad were below the standard of care for physicians. However, the license discipline and criminal actions against Bass and Bamdad are not dispositive of whether Respondents violated the standard of care for pharmacists. The Board did not find or conclude that Respondents violated any pharmacy law or regulation based on Bass' or Bamdad's Medical Board discipline or criminal prosecutions. The prescriptions at issue were

analyzed independent of Bass' and Bamdad's misconduct as physicians and viewed from the perspective of a reasonable and prudent pharmacist.

11. In March and April 2008, seven patients of Bass died due to drug overdoses. Respondent JSD dispensed prescriptions from Bass to five of the seven deceased patients: A.S., L.G., A.W., D.L., and D.K. Bass suffered criminal prosecution and license discipline with regard to his prescription activity.

12. On July 8, 2008, the Ventura County Superior Court ordered Bass to cease and desist from the practice of medicine as a condition of bail or as a condition of release on his own recognizance during the pendency of the criminal action against him. The court further ordered Bass to surrender all controlled substance prescription forms by July 11, 2008, to the court clerk (*The People of the State of California v. Bernard N. Bass*, case no. 20080206956).

13. Effective February 20, 2009, the California Medical Board revoked Bass's medical license, stayed the revocation, and placed Bass's medical license on seven years' probation with various terms and conditions. The terms and conditions of probation included a 90-day actual suspension, Bass' surrendering of his Drug Enforcement Administration permit and prescription forms, abstaining from the use or possession of controlled substances, taking a prescribing practices course, a medical record keeping course, an ethics course, a clinical training program, and submitting to a practice and billing monitor. The Board also prohibited Bass from engaging in the solo practice of medicine (*In the Matter of the Accusation Against Bernard N. Bass, M.D.*, agency case no. 05-2005-167939).

14. On May 29, 2009, following a guilty plea in case number 2008026956, the Ventura County Superior Court convicted Bass of violating Penal Code section 182, subdivision (a)(1) (conspiracy to commit a crime: the fraudulent prescription of controlled substances), a felony. The evidence was inconclusive regarding the court's sentence; it appeared that the court sentenced Bass to two years of probation.

15. Bass died on a date unspecified by the evidence, but before the instant hearing.

16. At the time of the hearing, the Medical Board's website showed that Bass had a primary general medicine practice and a secondary practice area of "pain medicine." The Medical Board's website did not further explain or describe his pain medicine practice. There was no evidence of what the Medical Board's website contained in 2006, 2007 and 2008.

17. Bamdad was prosecuted in federal court and is currently serving prison time. On July 29, 2010, the Central District of the United States District Court, in case number CR 08-506-GW, following a not guilty plea, convicted Bamdad of violating 21 U.S.C. section 841, subdivisions (a)(1), (b)(1), and (c) (distribution and dispensing of a controlled substance, and distribution and dispensing of a controlled substance to

persons under 21 years of age). On August 2, 2010, the court sentenced Bamdad to 300 months in prison, barred him from licensed employment, and ordered him to pay fines and fees totaling more than $1,000,000.

The Medications at Issue

18. The medications at issue here include Norco, Xanax, Valium, Vicodin, and Soma. These medications are referred to herein occasionally by their brand name, although the record refers to some by their generic name.

19. Norco is the drug's brand name and hydrocodone/APAP (acetaminophen) is the drug's generic name. Norco is a schedule III controlled substance used for pain.

20. Xanax is the drug's brand name and alprazolam is the drug's generic name. Xanax is a schedule IV controlled substance used for anxiety, and it is a non-barbiturate, benzodiazepine sedative hypnotic.

21. Valium is the drug's brand name and diazepam is the drug's generic name. Valium is a schedule IV controlled substance used for anxiety, and it is a non-barbiturate benzodiazepine sedative hypnotic.

22. Soma is the drug's brand name and carisoprodol is the drug's generic name. Soma became a schedule IV controlled substance in 2012. Before 2012, Soma was unscheduled; it is a muscle relaxant. The time at issue here involves the time Soma was an unscheduled substance.

23. Other drugs noted herein include:

Ambien (brand name)/zolpidem (generic name), schedule IV controlled substance, used for insomnia;

Oxycontin (brand name)/oxycodone (generic name), schedule II controlled substance, used for pain;

Subutex (brand name) or Suboxone (brand name)/buprenorphine (generic name), schedule III controlled substance, commonly used to treat narcotic addiction and less commonly used to treat pain;

Adipex (brand name)/phentermine HCL (generic name), schedule IV controlled substance, used for weight loss;

Bontril—slow release (brand name)/phendimetrizine (generic name), schedule IV controlled substance, used for weight loss.

24. All of the drugs noted in Factual Findings 18-23 are dangerous drugs as

defined in Business and Professions Code section 4022.

The Generalized Prescription Quantity and Dosage Analyses

25. While there was some variation in the prescriptions assessed herein, generally, the vast majority of Bass' prescriptions to his patients were as follows: 125 tablets of 10/325 mg. Norco (1 to 2 tablets every 4 hours), a 10-day supply; 60 tablets of 2 mg. Xanax (1 tablet every 6 hours), a 15-day supply; 15, 20, 50, or 60 tablets of 350 mg. Soma (1 tablet every 6 hours), a 3-day, 5-day, 12-day, or 15-day supply, respectively; and 60 tablets of 10 mg. Valium (1 tablet every 6 hours), a 15-day supply.

26. The quantity and dosage of the medications Bass prescribed to each patient are generally referred to here by their day's supply.

27. Unless otherwise indicated within each patient description, that follows, Bass issued prescriptions for each patient approximately every 12 to 15 days throughout the indicated periods of treatment, and Respondents filled and dispensed the prescribed medications to each patient every 12 to 15 days. Unless otherwise indicated herein, generally, each patient or a person authorized by the patient, consistently purchased and obtained the prescribed medications without interruption of the 12-15 day interval. Where the prescription time interval was other than 12 to 15 days, or where the dispensing and purchasing time was other than 12 to 15 days and where no other time interval is noted, the time interval was given no weight in resolving the allegations set forth in this case.

Specific Patient Facts

A.S.

28. In 2008, A.S. was approximately 22 years old. Between January 5, 2007, and March 18, 2008, Bass treated A.S. and issued him prescriptions for 10/325 mg. Norco, 2 mg. Xanax, and 350 mg. Soma. A.S. purchased the prescribed medications from Respondent JSD as well as other pharmacies, in Fountain Valley, California, and Thousand Oaks, California. Respondents filled and dispensed approximately 90 Bass-issued prescriptions to A.S. on and between January 5, 2007, and March 18, 2008. During this time period, Respondents dispensed 3,875 tablets of Hydrocodone/APAP 10/325 mg. (generic for Norco), 1,860 tablets of Alprazolam 2 mg (generic for Xanax), and 405 tablets of Carisoprodol (generic for Soma) to A.S.. Of these prescriptions, Respondent Daher dispensed 79 prescriptions, Respondent Yamasaki dispensed 9 prescriptions, and Respondent Nabhan dispensed 2 prescriptions for this patient.

29. On January 19, 2007, pursuant to a Bass-issued prescription, Respondent Daher dispensed a 10-day supply of the generic for Norco (Hydrocodone/APAP 10/325 mg, 125 tablets – Prescription No. 182811). This original prescription did not authorize any refills. Nevertheless, on January 22, 2007,

Respondent Daher dispensed another 10-day supply of Hydrocodone/APAP. Respondent Daher did not document a reason why he dispensed Hydrocodone/APAP seven days early, but he testified that he accepted Bass' prescription as legitimate. However, that prescription was not authorized to be filled on January 22, 2007. On January 22, 2007, Respondent Daher's dispensed more Hydrocodone/APAP (10/325 mg, 125 tablets) under Prescription No. 183159 and without prescriber authorization. This prescription was dated January 30, 2007. However, the dispensing sticker on the original prescription shows that the prescription was dispensed on January 22, 2007. According to the evidence and the law applicable in this case, such a post-dated prescription is not a legal prescription. Therefore, the dispensing of this prescription is considered an unauthorized refill of the January 19, 2007 prescription.

30. For A.S., the evidence showed that over a four-day period from January 19-22, 2007, Respondent Daher deviated from the prescribers' directions by providing A.S. with 250 tablets of Hydrocodone/APAP (10/325 mg), 120 tablets of Alprazolam (2 mg), and 30 Carisoprodol (350 mg) tablets. This was enough Hydrocodone/APAP to take 62 tablets per day, more than 4 times the 12 tablets as directed by Dr. Bass, enough Alprazolam to take 30 tablets per day, which is 7 times as much as the maximum amount of 4 tablets per day as directed by Dr. Bass, and enough Carisoprodol to take 7 tablets per day instead of 1 per day as directed.

31. At all times relevant to this matter, A.S. lived in Thousand Oaks, approximately 43 miles from Respondent JSD and approximately 40 miles from Bass's office. Respondent JSD is five miles from Bass' office.

32. In 2007, A.S. was being treated with Subutex by a physician other than Bass. He received prescriptions for Subutex from Jonathan Reitman, M.D. on October 26, 2007, and November 5, 2007. The evidence did not establish whether Respondents were aware that A.S. had been prescribed Subutex.

33. On March 20, 2008, A.S. died, at the age of 22, from hydrocodone intoxication. The evidence did not establish how many Hydrocodone/APAP tablets A.S. consumed the day he died in his bed. However, empty prescription bottles for Hydrocodone and Alprazolam, which were prescribed by Dr. Bass and dispensed by Respondent Daher on March 18, 2008, were found on the night stand next to his bed.

34. On June 3, 2008, A.S.'s parents filed a complaint with the Board alleging that Respondents improperly dispensed controlled substances to A.S.

35. K.S., A.S.'s mother, testified. K.S. explained that A.S. had a serious drug problem. As a child, A.S. had attention deficit disorder and was in special education. He also contracted spinal meningitis on an unspecified date. By the seventh grade, A.S. was using cigarettes, beer, other alcohol, and marijuana. K.S. conceded that as an adult, A.S. was addicted to drugs, including prescription drugs. She believes Bass' prescriptions and Respondent's dispensing of medications furthered A.S.'s drug addiction. K.S. believed A.S. had health insurance that covered prescription

medication in some manner, but she understood that A.S. would obtain Bass' prescribed drugs by paying cash. The evidence confirmed that A.S. purchased his Bass-prescribed medications with cash. K.S. does not believe A.S was in chronic pain when Bass prescribed his medications and when Respondents filled and dispensed them. The evidence did not establish whether A.S. had chronic pain, but it did establish that A.S. was addicted to pain medications. On May 11, 2009, Respondent Daher wrote to the Board regarding the complaint, stating:

> "I did not sell [A.S.] his medication in a dark alley, he walked into my store. We regret his death but ultimately he is responsible for his own actions...Were his parents aware of his drug addiction? Did they do anything about it?" (State's Ex. 18.)

36. Complainant argued that Respondents failed to evaluate A.S.'s needs to assure that Bass' prescriptions were for a legitimate medical need. Complainant further argued that had Respondents requested a CURES report for this patient after December 1, 2007, they would have seen A.S.' prescriptions for Subutex, and understood that A.S. was being treated for opiate addiction.[1] As such, it would have further caused Respondents to question the propriety of Bass' prescriptions for Norco and Xanax.

37. a. Respondents argued that they evaluated A.S. generally and found no reason to refuse to dispense Bass' prescriptions. They further argued that accessing CURES data was difficult and not practical in 2007 and 2008. The parties did not dispute that online, "real time" access to CURES was unavailable in 2007 and 2008, and instead, pharmacists would have to make requests for CURES data by facsimile or regular mail. Such requests would require several weeks before pharmacists would receive responsive data. While Respondents and their experts tended to tout or emphasize Respondents' excellent recordkeeping practices, Respondents also argued that the early refills, as described in Factual Finding 29[2], were the result of Respondent JSD's transition to a new computer system and was a record keeping error.

b. However, Inspector Bayley testified that when she started to investigate these allegations, although Respondents told her about recent computer changes, Respondents never claimed a data error was responsible for causing the unauthorized refills. In addition, Respondents failed to persuasively explain how the transition to the new computer system would result in such a record keeping error or why, if the error did indeed occur, they would not have corrected their records upon discovery of the error. Additionally, the evidence failed to establish that the computer transition indeed

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[1] CURES is the Controlled Substance Utilization Review Evaluation System. It is a database maintained by the California Department of Justice's Bureau of Narcotic Enforcement containing schedule II through IV prescription data.

[2] Similar arguments were made for the unauthorized dispensing of J.S.'s medications discussed at Factual Finding 91.

caused a record keeping error in this circumstance. In light of the foregoing, Respondents' explanation was not credible.

L.G.

38. In 2008, L.G. was approximately 21 years old. Bass treated L.G. with 10/325 mg. Norco, 2 mg. Xanax, and 350 mg. Soma. Respondents filled and dispensed L.G.'s approximately 105 Bass-issued prescriptions to L.G. from September 20, 2006, to March 28, 2008. During this time period, Respondents dispensed 4,625 tablets of Hydrocodone/APAP 10/325 mg. (generic for Norco), 2,160 tablets of Alprazolam 2 mg (generic for Xanax), and 2,200 tablets of Carisoprodol (generic for Soma) to L.G. Of these prescriptions, Respondent Daher dispensed 75 prescriptions, Respondent Yamasaki dispensed 18 prescriptions, and Respondent Nabhan dispensed 12 prescriptions for this patient.

39. On June 21, 2007, Respondents dispensed a 10-day supply of Norco and a 15-day supply of Xanax. On June 28, 2007, Respondents dispensed the same medications in the same quantity again, both based on Bass' prescriptions. Respondents did not document a reason why they dispensed the Norco three days early. Respondents explained that they trusted L.G. and accepted Bass' prescription as legitimate.

40. L.G. purchased his Bass-prescribed medications with cash.

41. At all times relevant to this matter, L.G. lived in Simi Valley, California, approximately 27 miles from Respondent JSD and approximately 31 miles from Bass' office.

42. L.G. died on April 13, 2008, from oxycodone and methamphetamine intoxication; however, Respondents never dispensed oxycodone or methamphetamine to L.G.

43. Complainant argued that even if Respondents did not dispense the drugs that caused L.G.'s death, Respondents still had a corresponding responsibility to assure that they dispensed prescriptions that were for a legitimate medical purpose, and by dispensing the large quantities of controlled substances prescribed by Bass, Respondents furthered each patient's drug addiction.[3] Complainant argued that Bass' prescriptions for A.S., L.G., and all of the patients discussed herein were not for a legitimate medical purpose because each patient was addicted to pain medications and sought the prescribed medications to feed his or her addiction or for recreational purposes.

[3] A pharmacist shares a corresponding responsibility, or liability, with the physician prescriber to ensure the prescription is, among other things, legitimate.

A.W.

44. In 2008, A.W. was approximately 31 years old. Bass treated her with 10/325 mg. Norco, 10 mg. Valium, and 350 mg. Soma. Respondent filled and dispensed approximately 12 Bass-issued prescriptions to A.W. from February 6, 2008, to March 25, 2008. During this 48-day period, Respondents dispensed 500 tablets of Hydrocodone/APAP 10/325 mg. (generic for Norco), 300 tablets of Diazepam (Valium), 10 mg., and 240 tablets of Carisoprodol 350 mg. (generic for Soma) to A.W.. Of these prescriptions, Respondent Daher dispensed 9 prescriptions, and Respondent Yamasaki dispensed 3 prescriptions for this patient.

45. At all times relevant to this matter, A.W. lived in Simi Valley, California, approximately 28 miles from Respondent JSD and approximately 31 miles from Bass' office.

46. A.W. died at the age of 31 on April 11, 2008, due to morphine, hydrocodone, and diazepam intoxication.

47. According to the Ventura County Coroner's death report, A.W. had attempted suicide by drug overdose three times before her death.

48. Respondents never dispensed morphine to A.W..

49. The evidence did not establish how many Norco and Valium tablets A.W. consumed the day of her death. However, on March 25, 2008, A.W.'s last prescriptions filled by Respondent Yamasaki included Hydrocodone/APAP and Diazepam.

D.L.

50. In 2008, D.L. was approximately 25 years old. Bass treated him with 10/325 mg. Norco, 10 mg. Valium, 10 mg. Ambien, and 350 mg. Soma. Respondents filled and dispensed approximately 30 prescriptions to D.L. from May 2, 2007, to March 24, 2008. During this time period, Respondents dispensed 2,375 tablets of Hydrocodone/APAP 10/325 mg. (generic for Norco), 120 tablets of Valium 10 mg., 520 tablets of Carisoprodol (generic for Soma), and 90 tablets of Ambien to D.L. Of these prescriptions, Respondent Daher dispensed 23 prescriptions, Respondent Yamasaki dispensed 4 prescriptions, and Respondent Nabhan dispensed 3 prescriptions to this patient.

51. In September and October 2007, D.L. was also prescribed Suboxone by another physician in San Fernando, California. Suboxone is an opioid antagonist that is commonly used to treat opiate addicts. Taking Suboxone and an opioid at the same time usually causes a negative effect in most individuals. However, Suboxone is also used as a pain medication, although its use for pain is not common. Respondents did

not document knowledge of D.L.'s Suboxone prescription history. Respondents did not take any action to discuss D.L.'s Suboxone prescription history with Bass or D.L.

52. At all times relevant to this matter, D.L. lived in Newbury Park, California, approximately 47 miles from Respondent JSD and approximately 40 miles from Bass' office.

53. D.L. died at the age of 25 on April 10, 2008. The cause of death was cocaine, Valium, Ambien, and Soma toxicity.

54. The evidence did not establish how many Valium, Ambien, or Soma tablets D.L. consumed the day of his death. However, D.L.'s last prescription filled by Respondent Daher on March 24, 2008 included 80 tablets of Carisoprodol 350 mg (generic for Soma), 30 tablets of Ambien 10 mg, and 60 tablets of Valium 10 mg..

55. Complainant argued that had Respondents reviewed D.L.'s medical and prescription history, they would have uncovered the fact that D.L. had been prescribed Suboxone in the past. Complainant explained that a prudent pharmacist would have uncovered D.L.'s Suboxone prescription history and Respondents would have concluded or at least suspected that D.L. was an opiate addict and then questioned Bass' prescriptions. Complainant argued that Respondents should have contacted Bass to express such a concern and perhaps refused to dispense Bass' prescriptions until receiving more information from Bass, at the least.

56. Through their expert witnesses, discussed hereafter, Respondents argued that occasionally, physicians prescribe Suboxone as a pain medication. Respondents argued that had they had knowledge of a Suboxone prescription history, and given the drug's use for pain, it would not have been appropriate for them to presume the patient was being treated for opiate addiction. Furthermore, it is within the discretion of the prescriber to dispense the combination of medications he or she deems medically appropriate.

57. The evidence established that Suboxone can be used as a pain medication. The evidence further established that its use for pain is uncommon and that a prudent pharmacist who was aware of Suboxone or Subutex prescriptions would, at the least, suspect that the patient had an opiate addiction issue and confirm the patient's treatment history with the prescribing physician.

58. Respondents did not document any knowledge that D.L. was prescribed Suboxone. They did not contact Bass or any other of D.L.'s physicians.

D.K.

59. In 2008, D.K. was approximately 32 years old. Bass treated him with 10/325 mg. Norco, 10 mg. Valium, 2 mg. Xanax, and 350 mg. Soma. Respondents filled and dispensed 61 prescriptions to D.K. . between December 7, 2006, and March

11, 2008; 47 of those prescriptions were for the generic drugs for Norco, Xanax and Soma . During this time period, Respondents dispensed 3,000 tablets of Hydrocodone/APAP 10/325 mg. (generic for Norco), 1,200 tablets of Alprazolam 2 mg (generic for Xanax), and 90 tablets of Carisoprodol (generic for Soma) to D.K.. Of these prescriptions, Respondent Daher dispensed 33 prescriptions, Respondent Yamasaki dispensed 6 prescriptions, and Respondent Nabhan dispensed 8 prescriptions for this patient.

60. D.K. lived in Newbury Park, approximately 42 miles from Respondent JSD and approximately 37 miles from Bass' office.

61. D.K. died, at the age of 32, on March 14, 2008. The cause of death was Lobar Pneumonia.

62. D.K. had asthma. There was no evidence that Respondents questioned whether Dr. Bass' prescribed drug combination, which the experts testified was known to cause respiratory depression, was safe for someone with D.K.'s respiratory condition.

B.G.

63. In 2008, B.G. was approximately 27 years old. Bass treated him with 10/325 mg. Norco, 10 mg. Valium, 2 mg. Xanax, and 350 mg. Soma. Respondents filled and dispensed 103 Bass-issued prescriptions (generic versions) to B.G. on and between October 30, 2006, and March 31, 2008. Of these prescriptions, Respondent Daher dispensed 82 prescriptions, Respondent Yamasaki dispensed 15 prescriptions, and Respondent Nabhan dispensed 6 prescriptions to this patient.

64. B.G. lived in Thousand Oaks, 41 miles from Respondent JSD.

65. B.G. was addicted to hydrocodone.

66. On January 10, 2008, B.G.'s mother called Respondents and told them to stop filling Bass' prescriptions. She alleged that Bass "owned" Respondent JSD. Respondent Daher told B.G.'s mother that he could not discuss B.G.'s prescriptions with her because B.G. was an adult. On that same day, Respondent Daher noted in Respondent JSD's records that Respondents would no longer fill B.G.'s prescriptions.

67. However, on January 18, 2008, B.G.'s mother wrote a note to Respondents stating that B.G. could be treated and medicated by Bass, as Bass "sees fit." Respondents kept this note with a copy of B.G.'s driver license in their records.

68. Respondents Daher explained that he complied with B.G.'s mother's requests because he presumed she had her son's best interests at heart and he did not want to cause B.G. any problems.

69. Respondent Nabhan asserted that B.G.'s mother's communications with Respondents did not raise a "red flag" in his assessment of B.G. as a pharmacy patient. As opined by Complainant's experts, discussed later, those communications should have reasonably raised a significant concern regarding the propriety of B.G.'s prescriptions and the strong suspicion that B.G. suffered from drug addiction.

C.G.

70. In 2008, C.G. was approximately 25 years old. Bass treated her with 10/325 mg. Norco, 10 mg. Valium, and 2 mg. Xanax. Respondents filled and dispensed 72 Bass-issued prescriptions to C.G. from October 30, 2006 to April 9, 2008, all for Hydrocodone/APAP (generic for Norco) and Alprazolam (generic for Xanax). Of these prescriptions, Respondent Daher dispensed 52 prescriptions and Respondent Yamasaki dispensed 20 prescriptions to this patient.

71. C.G. and B.G., discussed in Factual Findings 63-69, are siblings.

72. The Norco and Xanax prescriptions for C.G. and B.G. were identical. On seven different occasions, C.G.'s and B.G.'s prescriptions were presented together at Respondent JSD and Respondents dispensed the prescriptions for both at the same time. The seven occasions were: October 30, 2006, November 27, 2006, December 11, 2006, January 23, 2007, February 8, 2007, February 21, 2007, and March 5, 2007. Respondents saw no problem with two siblings presenting similar prescriptions at the same time from the same prescriber. C.G.'s and B.G.'s tandem prescriptions should have reasonably raised a significant concern regarding the propriety of B.G.'s and C.G.'s prescriptions and the strong suspicion that B.G. and C.G. were seeking prescriptions for an illegitimate purpose.

73. C.G. and B.G. always paid cash for all of their Bass-issued prescriptions at Respondent JSD.

74. C.G. lived in Thousand Oaks, 40 miles from Bass' office and 41 miles from Respondent JSD.

T.P.

75. In 2008, T.P. was approximately 40 years old. T.P. was Bass' secretary. T.P. was married to K.P., discussed in Factual Findings 79-80. Respondents filled and dispensed prescriptions to T.P., K.P, and S.P., the adult daughter of T.P. and K.P. From November 1, 2006 through April 2008, Respondents dispensed approximately 9,000 Norco or Hydrocodone/APAP, 1,960 OxyContin, 1,230 Alprazolam, 480 diazepam, and 2,765 Carisoprodol to this family. Bass treated T.P. with 10/325 mg. Norco and Soma. From November 1, 2006, to April 7, 2008, Respondents filled and dispensed 84 prescriptions to T.P.; 77 of those prescriptions were for Hydrocodone/APAP (generic for Norco), Norco and Carisoprodol (generic for Soma).

Of these prescriptions, Respondent Daher dispensed 65 prescriptions and Respondent Yamasaki dispensed 12 prescriptions to this patient.

76. According to Respondents, T.P. and K.P. were divorced, did not live together, and paid separately for their respective prescriptions. The evidence did not establish these facts.

77. Complainant alleged that, in Bass' office, T.P. would accept cash payments from patients in exchange for a prescription for controlled substances without Bass' examination. The evidence did not establish this fact.

78. T.P. lived in Sunland, California, nine miles from Respondent JSD.

K.P.

79. In 2008, K.P. was approximately 45 years old. K.P. was married to T. P., discussed in Factual Findings 75-78, Bass treated him with 80 mg. Oxycontin, 10/325 mg. Norco, 2 mg. Xanax, 10 mg. Valium, and 350 mg. Soma. From November 3, 2006, through April 1, 2008, Respondents filled and dispensed 134 prescriptions to K.P.; 106 of those were Bass-issued prescriptions for Hydrocodone/APAP, Alprazolam, Carisoprodol, Diazepam and OxyContin. Of these prescriptions, Respondent Daher dispensed 76 prescriptions, Respondent Yamasaki dispensed 24 prescriptions, and Respondent Nabhan dispensed 6 to this patient.

80. K.P. lived in Los Angeles, 13 miles from Respondent JSD.

S.P.

81. In 2008, S.P. was approximately 20 years old. S.P. is the daughter of K.P. and T.P. (Factual Findings 75-80.) Bass treated S.P. with 10/325 mg. Norco and 350 mg. Soma. From March 22, 2007 through April 7, 2008, Respondents filled and dispensed 53 prescriptions to S.P; 25 of those prescriptions dispensed were for Hydrocodone/APAP (generic for Norco), Diazepam (generic for Xanax) and Carisoprodol (generic for Soma). Of these prescriptions, Respondent Daher dispensed 22 prescriptions and Respondent Nabhan dispensed 3 prescriptions to this patient.

82. Complainant argued that Respondents failed to review the T.P., K.P., and S.P. family drug history and failed to verify the legitimacy of the prescriptions, taking into consideration that T.P., K.P., and S.P. were related, had similar prescriptions of dangerous controlled substances, and were all prescribed by Bass.

83. Respondents argued that they deferred to Bass' discretion and did not presume the familial relationship was evidence that the prescriptions were illegitimate. Respondent's position was not credible. Three family members seeking similar prescriptions, while not definitive of illegitimate prescriptions, should have caused

Respondents concern and raised their suspicions that the prescriptions were not for proper medical purposes for all three patients.

N.V.

84. In 2008, N.V. was approximately 36 years old. Bass treated her with 10/325 mg. Hydrocodone/APAP. From January 18, 2007, through April 4, 2008, Respondents filled and dispensed 38 Bass-issued prescriptions to N.V.

85. N.V. lived in Tujunga, California, nine miles from Respondent JSD.

86. Respondents filled and dispensed a 10-day supply of Hydrocodone/APAP (generic for Norco) to N.V. on the following dates: March 21, and 29, 2007, two days early; May 22, and May 29, 2007 (Respondent Nabhan), three days early; June 21, and June 26, 2007 (Respondent Yamasaki), five days early; February 4, and 12, 2008, two days early (Respondent Daher); March 4, and 13, 2008 (Respondent Daher), one day early; and March 27, and April 4, 2008 (Respondent Daher), two days early. Respondents did not document the reasons why they dispensed the generic for Norco to N.V. early. Complainant further alleged that had Respondents Yamasaki and Nabhan consulted patient profiles prior to dispensing Hydrocodone/APAP on May 29, 2007 and June 26, 2007, then the early refills would not have occurred. At hearing, neither Respondent Yamasaki nor Nabhan could recall this patient or these prescriptions. Though they asserted that they generally did nothing wrong in their dispensing practices, there was no credible evidence presented that Respondents Yamasaki and Nabhan consulted patient profiles on these occasions prior to dispensing.

87. Complainant calculated a 14-day supply of Norco for N.V. on the dates noted in Factual Finding 86; and alleged that those same early refills were six, seven, nine, three, six, and five days early, respectively. Complainant's 14-day supply calculations were inaccurate. As noted previously, they were 10-day supplies.

88. Complainant also alleged that Respondents' filling and dispensing of Norco to N.V. on October 15, 2007, constituted a three-day early refill. It was a 10-day supply. Respondents filled and dispensed the same prescription to N.V. on October 4, 2007. Therefore, the October 15, 2007 dispensing was not early.

89. On various occasions, N.V. confirmed in writing to Respondents that she required early refills for apparently legitimate reasons. On those occasions, on August 10, 2007, November 17, 2007, and September 13, 2009, Respondents filled Bass' prescriptions for N.V. early, based on her written reasons that Respondents accepted as true. Given Respondents' documentation of N.V.'s reasons for needing the early refills, these three early refills were appropriate.

J.S.

90. In 2008, J.S. was approximately 23 years old. Bass treated him with 10/325 mg. Norco, 2 mg. Xanax, and 350 mg. Soma. Respondents dispensed 36 Bass-issued prescriptions to J.S. from October 31, 2006 through April 5, 2007. During this time, Respondents dispensed 1,875 tablets of Hydrocodone/APAP (including one incident of Hydrocodone/APAP 10/500 mg.), 800 tablets of Alprazolam (generic for Xanax) 2 mg., and a 110 tablets of Carisoprodol (generic for Soma) to J.S. Of these prescriptions, Respondent Daher dispensed 22 prescriptions and Respondent Yamasaki dispensed 14 prescriptions to this patient.

91. Respondent Yamasaki dispensed a 10-day supply of Norco to J.S. on January 15, 2007. Respondent Daher dispensed 10-day supplies of Norco to J.S. on January 19 and 22, 2007. The evidence contained only one written prescription from Bass for the January 19, 2007 dispensing. Having received a 10-day supply of Norco on January 15, 2007, the January 19, 2007 dispensing constituted an early refill by six days. The dispensing on January 22, 2007 constituted an early refill by seven days. Because there was no evidence of Bass' prescriptions for the January 19 and 22, 2007 filling and dispensing of Norco to J.S., Respondent Daher's dispensing constituted the dispensing of controlled substances without physician authorization.

92. Respondent Daher filled and dispensed a 15-day supply of Xanax to J.S. on January 19, and 24, 2007. Thus, Respondents filled and dispensed Xanax to J.S. 10 days early on January 24, 2007. Respondent Daher did not document a reason for the early refills; he argued that he deferred to Bass' discretion.

93. According to Respondents, J.S. attempted to improperly obtain early refills after January 2007, and on April 5, 2007, Respondent Daher refused to serve J.S. further.

94. Complainant alleged that Respondents had filled a Norco prescription six days early, on January 30, 2007, without consulting Bass. However, the evidence did not establish that Respondents dispensed any Norco to J.S. on January 24, or 30, 2007.

95. J.S. would alternate between paying cash and using his insurance. J.S. paid cash for Norco on five occasions on January 19 and 24, 2007, and February 12, 2007, and he paid cash for Xanax on February 16 and 20, 2007. Complainant argued that Respondents should have determined that J.S.' use of cash was due to J.S.' health insurance refusing to cover the prescriptions due to the amount of drugs and the frequency of the prescriptions. Nothing in the evidence, however, established that J.S.' health insurance had rejected coverage as Complainant alleged.

96. J.S. lived in Thousand Oaks, 39 miles from Respondent JSD and 35 miles from Bass' office.

A.C.

97. In 2008, A.C. was approximately 23 years old. Bamdad treated him with 40 mg. Oxycontin and 2 mg. Xanax; he prescribed an approximately 30-day supply of both medications. Respondents filled and dispensed eight Bamdad-issued medications to A.C. from December 11, 2007, to April 10, 2008. During this period, Respondent Daher dispensed 270 tablets of Oxycodone and 240 tablets of Xanax 2 mg. to this patient.

98. A.C. paid cash for all of his Bamdad-issued prescriptions from Respondent JSD. The evidence showed that Bamdad was a family medicine doctor. There was no evidence that Bamdad had any declared specialty in pain management.

99. A.C. would present and purchase his Bamdad-issued prescriptions at Respondent JSD on an approximately monthly basis.

100. Respondents did not maintain any written records supporting consultations with Bamdad regarding A.C.'s diagnoses. Respondents argued that nothing in Bamdad's prescribing pattern for A.C. required any such consultations.

101. A.C. lived in Thousand Oaks, 43 miles from Respondent JSD and 36 miles from Bamdad's office. The evidence showed that A.C. would buy OxyContin one day and return the next day to pick up the Xanax portion of his prescription from Jay Scott Drugs. This was an approximate 86-mile round trip.

102. A.C. died on April 13, 2008, in an in-patient rehabilitation center in Pasadena, California, where he had been admitted for opiate addiction. A.C. died from multiple drug effects, including significantly high Oxycodone levels.

103. Complainant argued that Bamdad's Oxycontin and Xanax prescriptions contributed to A.C.'s death. The evidence did not establish how many Oxycontin or Xanax tablets A.C. consumed the day of his death. However, A.C's last prescription dispensed by Respondent Daher on April 10, 2008 included 90 tablets of Oxycodone 30 mg.

104. A.C.'s father, R.C. testified. R.C. filed a complaint with the Board. R.C. asserted that A.C. had no major sports injuries. (See also Factual Finding 136.) R.C. became aware of A.C.'s drug use in 2006, while A.C. was a college student. R.C. described A.C. as addicted to drugs.

S.R. and F.R.

105. In 2008, S.R. was approximately 31 years old. Bass treated him with 10/650 mg. Lorcet (Hydrocodone Bitartrate and Acetaminophen), Soma 350 mg. and 2 mg. Xanax .

106. Complainant alleged that Respondents dispensed 125 tablets of Lorcet and 60 tablets of Xanax, six days early on four occasions: October 10, and 24, 2007, November 7, 2007, and December 19, 2007 (Respondents dispensed Lorcet and Xanax on November 21, 2007 also). However, this allegation presumed that the quantity and dosage instructions on each medication equated to a 20-day supply, that is, 1 tablet every 4 hours for Lorcet, and 1 tablet every 6 hours for Xanax. Only the October 24, 2007 written prescription was in evidence and that prescription showed a dosage that equated to a 20-day supply. With no other Bass-issued prescription in evidence, and given that, from January through April 2008, Bass had directed the dosage of Lorcet for S.R. to be 1-2 tablets every four hours (a 10-day supply), the evidence could not establish that the remaining prescriptions were a 20-day supply. Further, the CURES report for S.R., on each of the dates in question, including October 24, 2007, described the quantities prescribed as 14-day supplies. Thus, the evidence was insufficient to establish early refills for any day other than October 24, 2007.

107. From October 10, 2007 to April 9, 2008, S.R. and F.R., who shared the same last name, paid cash for their Bass-issued prescriptions. During this time period, Respondents dispensed a total of 78 prescriptions for Hydrocodone/APAP 125 tablets, Alprazolam 2 mg 60 tablets, and Carisoprodol 350 mg 60 tablets for both S.R. and F.R. (39 prescriptions each). Of these prescriptions, Respondent Daher dispensed 66 prescriptions and Respondent Yamasaki dispensed 12 prescriptions to these patients. S.R. and F.R. would frequently present their prescriptions for controlled substances together at Respondent JSD, even though they lived in different cities. There was no evidence of their relationship, if any. As opined by Complainant's expert, discussed later, Respondents should have questioned Bass about why S.R. and F.R. were getting prescriptions together with the same doses and directions. There was no evidence that Respondents discussed medical conditions or the drug therapy for these two patients with Dr. Bass prior to dispensing.

108. S.R. lived in Ventura, California, 62 miles from Respondent JSD.

G.C. III

109. In 2008, G.C. III was approximately 32 years old. Bass treated him with 10/325 mg. Norco, 2 mg. Xanax, and 350 mg. Soma.. Respondents dispensed 39 Bass-prescribed generic drugs for these medications to G.C. III from October 10, 2007 to April 9, 2008. Of these medications, Respondent Daher dispensed 33 prescriptions and Respondent Yamasaki dispensed 6 prescriptions to this patient.

110. Respondent Daher filled and dispensed 150 tablets of Alprazolam (generic for Xanax) to G.C. III on November 21, 2007, a 37-day supply, and 28 days later, Respondents filled and dispensed 75 tablets of the same drug on December 19, 2007. The refill was nine days early. On each of 11 dates between October 24, 2007, and March 26, 2008, Respondent Daher dispensed Alprazolam to G.C. III four days early. Respondent did not document the reasons for these early refills.

111. G.C. III was the son of G.C. Jr. (father) and N.C.(mother). Between October 25, 2006, and April 7, 2008, Bass also treated G.C. Jr., a 61-year-old-man, with Norco, Valium, Adipex, Bontril, and Soma and N.C. with Vicodin ES, Valium, Adipex, and Bontril. Respondents dispensed prescriptions to G.C. and N.C. from October 10, 2007 to April 7, 2008. During that time, Respondents filled prescriptions for G.C. that included Bontril 105 mg 30 capsules, Hydrocodone/APAP 10/650 125 tablets, Carisoprodol 350 mg 30 tablets, and Diazepam 10 mg 50 tablets. Of these prescriptions, Respondent Daher dispensed 30 prescriptions and Respondent Yamasaki dispensed 7 prescriptions to G.C. During that time, Respondents also filled prescriptions for N.C. for, among others, Hydrocodone/APAP (7.5/750) 125 tablets, and Bontril 105 mg 30 capsules, Phendimetrazine 375 mg 60 tablets, and Diazepam 10 mg 50 tablets. Of these prescriptions, Respondent Daher dispensed 20 prescriptions to N.C. and Respondent Yamasaki dispensed 5 prescriptions to N.C.

112. G.C. Jr. and N.C. had the same address listed in their patient profiles. They would come into Respondent JSD together to purchase their Bass-issued prescriptions. Complainant argued that this fact was another red flag that should have raised Respondents' suspicions. Through their expert opinions, discussed later, Respondents argued that it was logical for the married couple to present themselves together at Respondent JSD. Respondents' argument was unpersuasive. G.C. Jr. and N.C.'s presentations should have, at the very least, raised Respondents' suspicions that the patients' prescriptions had to be verified by Bass.

113. G.C. III lived in Ventura, 62 miles from Respondent JSD.

J.C.

114. In 2008, J.C. was 24 years old. Bass treated J.C. with 10/325 mg. Norco between October 30, 2006, and October 9, 2007, and with 2 mg. Xanax between January 23, 2007, to October 9, 2007. The distance between Dr. Bass' office and Jay Scott Drugs was approximately 17 miles.

115. During the time J.C. was purchasing his prescription medication from Respondents, J.C. was using three different physicians and three different pharmacies for prescription medication. Complainant argued that Respondents would have uncovered such facts had they accessed a CURES report for J.C.

116. Respondents argued that accessing CURES would not have given them timely evidence of the multiple doctors and pharmacies, and that even with that information, such information would not mean that the prescriptions were for an illegitimate purpose. Respondents further argued that while physician shopping is a red flag for abuse and diversion, it is also a common circumstance for patients dealing with the under-treatment of pain. There was no evidence that J.C. had pain that was being inadequately treated.

Other Patient Issues

117. J.C., S.R., G.C.III, and G.C. Jr. were all members of the Hells Angels motorcycle gang. Complainant implicitly argued that this information should have raised Respondents' suspicions about the legitimacy of each of these patients' prescriptions. However, there was no evidence to establish that membership in the motorcycle gang, in and of itself, would warrant such a presumption. To begin to identify those types of factors as reasons to suspect illegitimate prescriptions would lead to improper and inaccurate presumptions.

118. Complainant argued that the following patients had illogical drug combinations of non-barbiturate sedative hypnotics, benzodiazepines, and nonbenzodiazepines. Valium, Xanax, and Halcion are benzodiazepines. Ambien is a non-barbiturate sedative hypnotic.

D.L: Ambien and Valium

D.K.: Xanax, Ambien, and Valium

K.P.: Xanax and Valium

B.G.: Xanax and Valium

D.S.: Xanax, Ambien, and Valium

L.G.: Xanax and Valium

Complainant failed to sufficiently explain why a reasonably prudent pharmacist would find these drug combinations "illogical." Complainant alleged that the combinations were duplicative in the First Amended Accusation, but failed to put on evidence as to why such combinations were sufficient to raise inquiry to the prescriber by Respondents. Consequently, this allegation was not supported by the evidence.

<u>Respondents</u>

Respondent Daher

119. Respondent Daher came to the United States from Lebanon in 1978. He attended the Oregon State University (OSU), School of Pharmacy and graduated in 1983. He worked as a pharmacist for Kaiser Permanente and CVS before opening his first pharmacy in Glendale in 1987. Respondent Daher purchased Respondent JSD in 1995; he was and is the P.I.C. Respondent Nabhan started with Respondent JSD in 1987 and Yamasaki, in 1991. Respondent Daher is married and has four children. He keeps close ties with OSU. He has set up a family scholarship foundation at the OSU pharmacy program, providing internship opportunities for its students. Respondent Daher has acted as preceptor for students for the last five years.

120. Respondent Daher explained that one reason Respondents got so much pain medication business was their prices. He stated that he sells 125 tablets of 10/325 mg. Norco for approximately $40, while large chain pharmacies, like CVS, charge more than $90 for the same medication. The evidence was unclear whether these prices were the prices when Respondent JSD first opened or currently. Respondent JSD was a larger, independent pharmacy with a great volume of business for medications and durable medical equipment.

121. In his deposition in another case, dated May 5, 2011, Respondent Daher agreed Respondent JSD had 600 patients[4] from Bass and approximately 90 of those patients resided in Ventura County. He disputed that most of the patients were young, asserting that from his accounting of the 90 patients from Ventura County, 30 patients were under 26 years of age, 30 patients were between 26 and 30 years old, and 30 patients were over 30 years old. There was no independent evidence to establish Respondent Daher's age descriptions, but there was also insufficient evidence to conclude that any sizeable population of Respondent JSD was under 30. While the evidence established that some of the patients at issue in this matter were under 30 years of age, of the 17 patients discussed herein (with the exception of N.C., who was likely well over 30), nine patients were under 30 years of age.

122. Respondent Daher did not feel that the patients exhibited evidence of being drug addicts improperly seeking pain medications. Respondent Daher did not agree that the fact that several patients were members of a motorcycle gang should have prompted concern in and of itself. He believed that those paying cash were simply part of the many individuals in the community who are uninsured.

123. According to Respondent Daher, Respondents were conscious that the patient demand increased in 2007 and 2008 and developed policies to ensure they practiced pharmacy within the law and did not contribute to medication abuse. Complainant argued that Respondents developed these policies after the Board began to investigate the instant matter. The evidence did not establish when Respondents developed the policies or when they came into effect.

124. Respondents' undated, written policy for filling pain management prescriptions was signed by each Respondent, but undated. The policy included the following requirements, among others: 1) check prescriptions with physicians; 2) check physician licenses; 3) patients must be present and must sign for their own prescriptions unless they sign a release in the presence of the patient and authorized person; 4) educate patients on the dangers of medications; 4) require patients to read and sign the auxiliary warning labels; 5) use professional judgment when patients use multiple pain doctors and call each doctor and disclose that fact; 6) no early refills unless the patient is going to surgery, leaving town (documented); and 7) prescriptions must be filled in order and recorded daily into a book, and numbered for retrieval.

[4] Respondent Daher agreed that this amounted to an estimated $1.7 million dollars that Respondent JSD filled for Dr. Bass' patients over a two-year period.

125. Respondents had additional policies. They kept Pain Management Prescriptions Policy and Procedures guidelines for receiving schedule II drugs, schedule III-IV drugs, recording of receivables, inventory, prescription filling, prescription pick-up, and early refills. With regard to prescription filling, the policy had various requirements, including that: 1) Respondents should ask all out-of-area patients why they are filling their prescriptions at Respondent JSD; 2) Respondents should check patient identification with their fraud detection unit;[5] 3) Respondents should contact the physician office on all schedule II through V prescriptions; 4) If the dose is out of the ordinary, contact the physician and request a diagnosis; and 5) If a different person is to pick up a prescription, both persons must be present the first time and Respondent must photocopy and keep a copy of the patient's and designated individual's identifications with signatures and an explanation.

126. As to early refills, Respondents' policies provided that prescriptions could generally be refilled two days ahead of the prescription's finish date. Respondents argued that the early refills described herein were dispensed using their professional discretion in each case.

127. As to physician license verification, Respondent Daher asserted that all physician licenses were to be checked monthly and printed. If they found that the California Medical Board had placed a prescribing physician's license on probation, they were to stop filling the prescription regardless of reason for probation. All physicians were to be telephoned and questioned about their practice. Respondents were to stop filling prescriptions from any physician suspected of any pattern of wrongful activity.

128. Despite the computer error alleged by Respondents in this case, in January 2007, Respondent Daher asserted that he did "not spare any expense on making sure that my records are kept up-to-date." Respondent Daher also testified that, with regard to patient prescription history records showing his initials "AD" as the dispensing pharmacist, it "could have been me" or he speculated that Respondent JSD's staff may have used his initials because he was "there every day" as the pharmacist-in-charge. Respondent Daher did not explain why those records would not be kept "up-to-date" or accurate as he asserted in other testimony. These inconsistencies and lack of explanation cast doubt on Respondent Daher's credibility. Generally, Respondent Daher asserted that he and the other Respondents did nothing wrong. He and Respondent Nabhan each spoke with Bass after Respondent Nabhan initially contacted Bass with his concern about the high doses of narcotic medication. Respondent Daher also spoke to Bass after B.G's mother wrote him a note saying "Don't fill my son's prescription." Bass convinced Respondents that he was a legitimate pain physician treating chronic pain sufferers and that his prescriptions were, therefore, legitimate. Respondent Daher did not feel he could or should impose his own concerns regarding the medication combinations or quantities on the physician.

[5] Respondents purchased and used a machine at the pharmacy that verified identification cards and driver licenses.

He trusted Bass based on Bass' representations and did not believe the amounts of medications Respondents dispensed were so great as to require him to stop dispensing. Respondent Daher asserted that all Respondents counseled patients regularly as to the dangers of the medications and to complying strictly with the dosage instructions. He did not observe any actions or words from the patients that made him believe the patients were addicted to narcotics or other drugs, e.g., the patients were incoherent. He did not observe any actions or words by the patients that made him believe the patients were improperly obtaining the prescriptions for illegitimate purposes. Respondent Daher explained that his criteria for refusing to fill a prescription included suspicious behavior like the patient claiming he or she was "shorted" or lost tablets, or patients coming to the pharmacy with multiple prescriptions from multiple doctors. Respondent Daher explained how Respondents kept the auxiliary warning labels from each prescription, placed them on paper, and had each patient sign next to each label, memorializing Respondents' counseling. Respondents offered numerous such documents into evidence.

129. Respondents' initial belief that Bass was a pain specialist may have been reasonable if no other "red flag" indicators were present. However, as explained later, a physician's self-described pain management specialty does not relieve Respondents from further reasonable inquiry into the prescriber when "red flags", including consistently high volumes of addictive medications and questionable prescribing patterns, emerge.

130. Respondents presented numerous prescriptions and other documents on which they documented communications with various physicians other than Bass and Bamdad, where Respondents were verifying diagnoses, confirming drug choices, or otherwise clarifying prescriptions. For example, Respondent Nabhan documented his own verifications and clarifications on October 26, 2007, for Vicodin E.S., on June 26, 2008, for 10/325 mg. Norco, on June 10, 2008, for duplicate prescriptions for 10/650 Lorcet and 2 mg. Xanax, and other similar communications with physicians other than Bass or Bamdad on May 9, 2008 (diagnosis verification for MS Contin), May 14, 2008 (diagnosis verification for Oxycontin, Xanax, and Cymbalta), May 22, 2008 (diagnosis verification for Norco and Motrin), June 13, 2008 (diagnosis verification for Oxycontin), September 30, 2008 (prescription clarification for MS Contin and Lortab), and November 5, 2008 (diagnosis verification for Oxycontin and Actiq). However, little weight was given to this information as supportive of Respondents' claims since there was no evidence[6] that such communications with prescribers happened for the patients in this case. This information only demonstrates that Respondents were aware that such communications were an important part of pharmacy practice and that they were able to document such communications for some of their patients, but failed to provide any evidence that they did so for these patients in this case.

[6] Other than the instance mentioned in Factual Finding 128 above, Respondents have either failed to provide any other examples of specific inquiry prior to dispensing medications or admitted that they did not inquire because they deferred to Bass' expertise.

131. Generally, Respondent Daher asserted that he and the other Respondents regularly reviewed the patients' drug therapies, their medication records, and their patient profiles, as kept by Respondents at Respondent JSD, before dispensing the prescribed medications to each. Respondent Daher's assertion was similar to Respondent Nabhan's assertions. (Factual Finding 137.) The patient profiles that Respondent kept showed the patients' prescription history, including medication quantities, estimated day's supply, dates of filling/dispensing, payment method, prescriber and patient identification among other things. However, Respondents' self-serving, bare assertions that the reviews were conducted according to their alleged usual and customary practice are insufficient to prove that they were done in this case.

132. Respondent Daher presented character witnesses who testified that he is known in his community as a generous, truthful, caring and trustworthy person and pharmacist. He is a practicing and faithful Roman Catholic. Respondents were cooperative with the Board's investigation.

Respondent Nabhan

133. Respondent Nabhan was a shepherd in Jordan before coming to the United States. In the U.S., he became a licensed respiratory therapist. He eventually entered and graduated from the University of Southern California, School of Pharmacy. He worked as a pharmacist for a county entity for 36 years.

134. Respondent Nabhan did agree that whenever the records showed his initials "AN", that he had filled that prescription. Upon questioning, however, Respondent Nabhan had no memory of the patients' names and the prescriptions in this case. He did testify that his documentation of communications with the prescriber were typically "case-by case" or if "I feel I have to document it." He generally consulted prescribers whenever he needed clarification, including when a prescription was missing things or exceeded the recommended dosing. Although he had no specific recollection of these patients or the prescriptions, he nevertheless asserted that he and the other Respondents did nothing wrong with regard to dispensing Bass' prescriptions to the indicated patients. He asserted that he received no financial incentive to fill more prescriptions. Respondent Nabhan did agree that, generally, any prescription that was "post-dated" was not a legal prescription and that he would not fill it.[7]

135. Early on in the prescription flow from Bass[8], Respondent Nabhan testified that he talked with Bass to discuss his concern about the high doses of pain medication. Bass explained to him that he was a pain physician and was aware of the combination of drugs he was prescribing. Bass told Respondent Nabhan that he was

[7] See Factual Finding 29.

[8] The record is unclear and Respondent did not testify as to the date when this conversation allegedly occurred.

obtaining good results from his drug treatments and that there was no ceiling dose for Norco and that the dosage was left to the physician's discretion. Bass eventually came to Respondent JSD and showed Respondent Nabhan his (Bass') pain management society certificates. Respondents offered photographs of Bass' certificates from the American Academy of Pain Management, American Academy of Pain Medicine, American Pain Society, the American Society of Pain Educators, and the Western Pain Society. The evidence failed to establish the veracity, or substance of these certificates. Respondents accepted Bass' assertions and did not further investigate Bass' qualifications.

136. According to Respondent Nabhan, Respondents discussed their contact with Bass and decided to continue to fill Bass' prescriptions. Based on representations from patients and Bass, Respondent Nabhan believed that many of the younger patients had sports injuries or worked for the Burbank studios building motion picture sets. There was no evidence establishing the patients' sports injuries or that any of them worked for the Burbank movie studios.

137. Respondent Nabhan reiterated Respondent Daher's descriptions of maintaining constant communication with patients and with physicians as needed, having patients sign the warning labels, and being conscious of abuse signs such as lost or accidentally wasted prescriptions, and consistently early refills. He conceded that he did not discuss specific patients with Bass because he was convinced that Bass was a pain-management expert and Bass "knew what he was doing." Despite this admitted deference to Bass' expertise in prescribing pain medications, Respondent Nabhan nevertheless claimed that he and the other Respondents regularly reviewed the patients' drug therapies, their medication records, and their patient profiles, as kept by Respondents at Respondent JSD, before dispensing the prescribed medications to each. According to Respondent Nabhan, once Respondents learned of the patient deaths, Respondents stopped dispensing pain medication for pain management physicians. The evidence was unclear whether Respondents indeed stopped.

138. Respondents contacted Bass' office to confirm prescriptions, diagnoses, and/or dosages on prescriptions for patients other than the patients at issue in this matter on numerous dates including October 31, 2006 (Sonata and Ambien), January 8, 2007 (Norco and Xanax), March 17, 2008 (Oxycontin, Valium, Soma), March 17, 2008 (Norco), March 26, 2008 (Lortab), March 31, 2008 (Norco, Xanax, Soma, and Motrin), April 2, 2008 (Norco), April 2, 2008 (Lorcet, Xanax, and Soma), and April 8, 2007 (Norco). However, in this case and with these patients, Respondent Nabhan admitted that he did not consult Bass regarding each patient prior to dispensing the medications at issue.

Respondent Jun Yamasaki

139. On July 19, 2006, the Board recognized and commended Respondent Yamasaki for 50 years of service as a registered pharmacist. Respondent Yamasaki

asserted generally that he did nothing wrong by dispensing Bass' prescriptions to the indicated patients. The ALJ found that Respondent Yamasaki answered the questions posed during his examination, but at times during the questioning from each counsel, he appeared somewhat unclear in his understanding and he required repetition and additional explanations. The evidence did not establish whether this was due to his age, being hard of hearing, or other factors. At hearing, Respondent Yamasaki acknowledged that whenever the pharmacy's records showed a "Y" initial, that meant that he had approved the prescription and filled it. However, he admitted that he could not specifically recall any patient or prescription in this case. Therefore, when questioned about specific patients or any circumstances surrounding the filling and dispensing of the prescriptions for these patients, Respondent Yamasaki could not explain why prescriptions he filled may have been dispensed early or whether he exercised his corresponding responsibility appropriately in each case prior to dispensing. He did, however, testify that it would only be reasonable for Respondents to fill a prescription early "if we had documentation." He also testified that if he observed that a patient regularly obtained Hydrocodone and then the patient also obtained Suboxone, that he would "think they were an addict."[9]

Additional Assertions by Respondents

140. Overall, Respondents argued that their actions were reasonable, given their duties as pharmacists and not knowing the extent of Bass' and Bamdad's improper actions as physicians. They pointed to an inspection report, dated July 2, 2008, by Bayley. By this date, they argued, Bayley had reviewed the same evidence and data as was presented in the instant matter. However, in that report, after inspecting Respondents, Bayley found "[t]here was insufficient evidence whether [Respondent JSD] was in violation of pharmacy law." Respondents' argument is noted, but Inspector Bayley's conclusions on one report did not preclude a different conclusion thereafter.

The Opinions of Darlene Fujimoto

141. Darlene Fujimoto testified on behalf of Complainant. Since August 2009, Fujimoto has been the Assistant Chief of Pharmacy Regulatory/Compliance and Accreditation for the University of California at San Diego Health Systems Medical Center. She has held positions in the pharmacy industry since July 1986, including a board member of the California Board of Pharmacy (July 1992 to 2001). She holds a Doctor of Pharmacy degree from the University of Southern California, School of Pharmacy. Since February 2007, Fujimoto has been an Assistant Clinical Professor at the University of San Diego, Skaggs School of Pharmacy. Fujimoto has held Assistant Clinical Professorships at the University of California at Irvine, School of Medicine (1987-2003), and the University of California at San Francisco, School of Pharmacy (September 1985-1999).

[9] See Factual Findings 50-58 regarding dispensing dangerous drugs to D.L., who had also been prescribed Suboxone.

142. Fujimoto set forth the applicable standard of care analysis: what a reasonable, prudent pharmacist would do in the same situation. Fujimoto opined that Bass' prescriptions were "red flags" that Respondents should have noticed. Fujimoto identified the red flags as: drug addicts commonly seek the same drug combinations as Bass' prescriptions; high doses whether the prescription was the patient's first or last; the same drug combinations in the same quantities and doses without customizing them for the patients; a great geographic distance between patient and prescriber, and between patient and pharmacy; the patients' age (she described anyone 30 years old or younger as "young"); paying cash for the medications, that is, they did not use health insurance.

143. Fujimoto agreed with Respondents that pharmacists must evaluate prescriptions using their clinical expertise to determine if each prescription is proper. However, according to Fujimoto, the quantity of controlled substances within Bass' prescriptions was excessive and, using their clinical expertise, Respondents should have been aware of the potential dangers of dispensing these combinations of medications to patients with the red flags mentioned previously. Respondents accepted the prescriptions with no consistent periodic evaluation of the patients' treatment histories. Respondents' early refills dispensed additional, highly addictive drugs to patients who displayed several red flags of addiction. Fujimoto explained that filling prescriptions early without contacting the prescriber could impede potentially legitimate drug treatments, including titration efforts.

144. Fujimoto opined that Bass had no professional qualifications to support his self-described pain specialty. She questioned whether the young patients truly had chronic pain, as presumed by Bass' prescriptions. Fujimoto opined that the combination of opioids, benzodiazepines, and muscle relaxants, as prescribed by Bass, was a dangerous combination that could lead to serious medical problems, including respiratory depression and death.

145. Fujimoto opined that a prudent pharmacist would be in frequent contact with the prescriber to check the parameters of any pain contract, question the validity of the prescription, confirm the need to continue all of the medications at the prescribed dose, and document these communications.

146. Instead, Fujimoto found that Respondents did not keep detailed records of any such communications. While Fujimoto believed Respondents should have been checking CURES reports, she conceded that CURES was not readily available online between 2006 and 2008. Nevertheless, she explained that in 2006 through 2008, pharmacists could still request CURES reports by mail and facsimile. Had Respondents utilized CURES, Fujimoto reasoned, Respondents would have uncovered the earlier prescriptions of Subutex, and Suboxone for A.S. and D.L., and the prescription trends showing the use of multiple physicians, multiple pharmacies, and the excessive quantities of highly addictive controlled substances.

147. Fujimoto explained that Respondents had and have an obligation not to defer to prescribing physicians as they did to Bass and Bamdad. They provided little or no oversight over the prescriptions and continued to frequently dispense consistent and virtually uninterrupted large quantities of dangerous combinations of controlled substances. In Fujimoto's opinion, Respondents should have questioned Bass and Bamdad and Respondents should not have taken Bass' word for his actions in light of what Fujimoto opined were highly suspect prescribing practices. She opined that a reasonable pharmacist would have had suspicions about Bass' and Bamdad's patients and practices. Respondents did not document any suspicion about the combination of drugs, the physicians' practices, or the drug combinations. Fujimoto opined that Respondents' failure to contact Bass and Bamdad as to their prescription practices and continue to dispense the prescriptions constituted unprofessional conduct.

The Opinions of Richard R. Abood

148. Richard R. Abood testified on behalf of Respondents. Since 1991, he has been a Professor of Pharmacy Practice at the University of the Pacific, School of Pharmacy in Stockton, California. From 1989 to 1991, Abood was a Professor of Pharmacy Administration at the University of Wyoming, School of Pharmacy, in Laramie, Wyoming, and from 1982 to 1989, he was an Associate Professor of Pharmacy Administration at the same university. He held another professorship in pharmacy at the University of Texas, College of Pharmacy in Austin, Texas, from 1983 to 1984. Abood held pharmacy positions from approximately 1972 to 1982. He obtained a Bachelor's degree in pharmacy in 1972 and a Juris Doctorate in May 1976, both from the University of Nebraska in Lincoln. He obtained a license to practice pharmacy in Nebraska, Iowa, and Wyoming. Since the 1980s, Abood has written numerous articles on the regulatory and legal issues within the pharmacy practice. He has authored a publication entitled "Pharmacy Practice and the Law," 7th Edition (October 2012), with earlier editions in 2011 and 2010 (6th edition), 2007 (5th edition), 2004 (4th edition), and still earlier editions with a co-author from 1994 to 2000.

149. Abood opined that Respondents acted as reasonable pharmacists by dispensing Bass' and Bamdad's prescriptions. Abood acknowledged that some of the patients may have been addicted to drugs, but noted that Respondent's actions should be assessed from the perspective of the reasonably prudent pharmacist and not with hindsight as to the criminal actions of the prescribing physicians or the later knowledge that certain patients were addicts. Abood did not find the typical actions or situations that pharmacists find when patient addicts are trying to obtain greater quantities of controlled substances. Abood identified those actions and situations as patients lying or otherwise attempting to deceive the prescriber or pharmacist (repeated assertions of losing or accidentally wasting medications), noncompliance with directions for use and dosages, and evidence that the patient has sold, stolen, or borrowed prescription drugs.

150. As to some of the "red flags" highlighted by Complainant, Abood opined that while some of the patients were young, young patients also suffer from chronic

pain and therefore, given the other information Respondents received, such as construction industry employment, patient age need not have caused Respondents concern. Regarding the distance between Respondent JSD and patient residences, Abood noted that many physicians do not treat chronic pain and thus, it is reasonable to have chronic pain patients travel longer distances to find available physicians and pharmacies. Abood also opined that 30 to 40 miles is not an unreasonable distance to travel in Los Angeles. Abood pointed to the great number of persons who cannot afford health insurance to support his opinion that cash payments do not constitute addict behavior. Regarding the fact that family members received the same drug regiments, Abood found it "hardly impossible" that family members could share the same pain problems and therefore share the same drug regimen. For this reason, he found nothing significant about B.G. and C.G. obtaining the same prescriptions at same time, even if it was true that the siblings admitted they obtained the prescriptions to support B.G.s addiction, as he believes there was no way Respondents could have known that at the time they dispensed the medications.

151. Regarding the great quantity of controlled substances dispensed, Abood opined that the number of prescriptions appeared greater than generally expected because Bass wrote prescriptions for 10 to 15-day supplies. Most prescribers wrote prescriptions for a 30-day supply, and therefore, Bass's prescriptions would amount to approximately two times more prescriptions. Abood conceded that Bass did not appear to be highly sophisticated in treating pain, but Bass' prescriptions for Norco, Xanax, and Soma, were and are, in his experience, a common combination for treating pain that pharmacists often see. Further, it would not be appropriate for pharmacists to refuse to fill the prescriptions because they disagreed with the medication combination.

152. As to early refills, Abood opined that Respondents did not violate any laws or regulations, as they used their professional judgment to decide to dispense the prescribed quantities of medications to each patient. Abood criticized Complainant for presuming, without direct evidence, that the patients were not following dosage directions and were abusing the drugs resulting in, among other things, acetaminophen toxicity. On this issue, Abood was accurate that there was no evidence establishing the quantity of medication patients consumed. Early refills, however, exposed patients to the risk and danger of acetaminophen toxicity, great amounts of addictive controlled substances, and the potential impeding of medication therapy. In this way, the large doses were nonetheless dangerous to the patients.

153. Abood conceded that CURES is a valuable tool for pharmacists, but he noted that "real-time" CURES data was not available until September 2009, and therefore, using CURES was not the standard of care when Respondents were dispensing the prescriptions at issue in this matter. Abood further opined that the use of CURES by pharmacists is "not likely" the standard of care today.

154. As to Complainant's argument that Respondents failed to adequately evaluate patients, Abood opined that, after Respondents' contact with Bass, he saw no

need for Respondents to assess Bass' existing patients by further contact with the physician and the gathering of medical data supporting the prescriptions. Abood agreed that it is the standard of practice to contact the prescriber to verify the legitimacy of a prescription and ask about the patient's diagnosis if the pharmacist has questions. Abood opined that the information Bass provided to Respondents answered the pharmacists' questions and concerns such that Respondents could thereafter reasonably dispense his prescriptions. Abood believes that had Respondents made contact with Bass again regarding concerning patients, as Complainant argued, Bass would have likely provided the same or similar information to that which he had previously provided to the pharmacists. In such a case, Abood believes Respondents would still have had reason to continue dispensing Bass' prescriptions. Abood further opined that the questioning and verifying of each prescription each time is not the standard of care and not good practice. He also explained that, while helpful, it is not standard of care for pharmacists to obtain physician diagnoses and lab testing, among other medical data.

155. Abood opined that Respondents' actions did not lead to the deaths of the patients at issue in this matter and further asserted that the patient deaths were not foreseeable from their dispensing of Bass' medications. He opined that Respondents acted reasonably, met their corresponding responsibility, dispensed drug combinations that were logical and in reasonable doses and strengths, for lengths of time that were not out of the ordinary for chronic pain sufferers.

156. Regarding A.S., Abood opined that the January 22, 2007 prescription was not an early refill and was more likely a record keeping error, but Abood's opinion on this was not persuasive and failed to account for the fact that Respondents had just dispensed a 10-day supply of Norco three days earlier. That A.S. did not return for more Norco until February 12, 2007, did not negate that A.S. was given 250 tablets of Norco within four days.

The Opinions of Adam Marc Kaye

157. Adam Marc Kaye (Kaye) testified for Respondents. Kaye is a Clinical Professor of Pharmacy Practice at the Thomas J. Long School of Pharmacy and Health Sciences at the University of the Pacific in Stockton, California. He has held that position since 2012. Since 2007, Kaye has been an Associate Clinical Professor of Pharmacy Practice and Coordinator of the Introductory Experience Program at the same university. Since 1999 and to the present, Kaye has worked as a Pharmacy Manager for Walgreens Pharmacy in Stockton. Kaye received his Doctor of Pharmacy degree in 1995 at the University of the Pacific, School of Pharmacy. He holds pharmacist licenses since 1995 in California and Arizona. He is a Fellow of the California Pharmacists Association (since 2001) and a Fellow of the American Society of Consultant Pharmacists (since 1996). Kaye has co-written guidelines on prescribing opioids in non-cancer pain patients for the American Society of International Pain Physicians and numerous other articles on pain medicine and opioid prescribing.

158. Kaye largely echoed Abood's opinions regarding the following issues: Bass' younger patients (Kaye contested that the majority of the patients were young people, relying largely on Respondent's descriptions of their patient population), the seemingly great number of prescriptions for 15-day supplies, the distance between patient residence and Respondent JSD, Bass' drug combinations, prescribing similarly to family members, the repeated and similar medications, quantities, dosage directions, probable computer errors for early refills and lack of prescriber authorization, and the use of CURES between 2006 and 2008. On the issue of CURES, Kaye implicitly agreed with Abood that it is not the current standard of care. Kaye asserted that as of 2012, he was unaware of any pharmacy using CURES online consistently. After considering the opinions of Fujimoto, Abood, and Kaye, there was insufficient evidence to conclude that, at the relevant time for this matter, it was the standard of care for pharmacists to use CURES.

159. In his report, dated June 14, 2012, Kaye opined that the early refills alleged by Complainant were not established by the CURES data because that data only showed when a medication was filled, not when the patient actually obtained the medication. That opinion was unpersuasive and carries no weight because the risk of harm to the patient occurs when a prescription is filled, meaning, when the medication is made available to the patient. The fact that the patient could pick it up at a later date has no bearing on a pharmacist's duty to not put patients at risk of harm by making dangerous drugs available, without justification or proper documentation, earlier than prescribed.

Respondents' Reputation

160. Respondents presented character witnesses who testified that they enjoy a reputation as a good pharmacy within a portion of the local community. No Respondent has suffered any license discipline by the Board in all of their years of pharmacy practice.

161. Tim Stehr (Stehr) testified on behalf of Respondents. Stehr is a former Chief of the Burbank Police Department and spent 32 years as a police officer, six years as a narcotics agent. He has used Respondents as his pharmacy for many years. He has never seen anything out of the ordinary with regard to the over-dispensing of medications. The evidence did not establish that, as a customer/patient, despite his law enforcement background, that Stehr would have noticed the excessive furnishing of medications by Respondents. Stehr recalled one time that a person came in to Respondent JSD with a forged prescription and Respondents immediately called the police. He considers Respondent JSD an upstanding pharmacy with upstanding pharmacists. Other character witnesses corroborated Stehr's opinion.

Costs

162. The ALJ found that Complainant incurred $61,541 in investigative costs and $53,650 in prosecution costs, but reduced the award to $57,595.50. Pursuant to

Business and Professions Code section 125.3(d), this finding is not reviewable by the Board to increase the cost award.

LEGAL CONCLUSIONS

The Standard of Proof

1. Complainant must prove her case by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) Clear and convincing evidence means the evidence is "so clear as to leave no substantial doubt" and is "sufficiently strong to command the unhesitating assent of every reasonable mind." (*Mathieu v. Norrell Corporation* (2004) 115 Cal.App.4th 1174, 1190 [citing *Mock v. Michigan Millers Mutual Ins. Co.* (1992) 4 Cal.App.4th 306, 332-333].)

Applicable Laws and Regulations

2. Business and Professions Code section 4300 provides that the Board may suspend, revoke, or place on probation any Board-issued license, or take any other license disciplinary action, as the Board in its discretion, may deem proper.

3. Business and Professions Code section 4302 provides that the board may deny, suspend, or revoke any license of a corporation where conditions exist in relation to any person holding 10 percent or more of the corporate stock of the corporation, or where conditions exist in relation to any officer or director of the corporation that would constitute grounds for disciplinary action against a licensee.

4. Business and Professions Code section 4301, subdivisions (d), (j), and (o), provide that the Board must take disciplinary action against a licensee who engages in unprofessional conduct. In subdivisions (d), (j), and (o), the Legislature has defined unprofessional conduct to include, but not be limited to:

> (d) The clearly excessive furnishing of controlled substances in violation of Health and Safety Code section 11153.
>
> (j) The violation of any of the statutes of this state, of 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 [Chapter 9 of Division 2 of the Business and Professions Code] 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.

5. Business and Professions Code section 4306.5, subdivisions (b) and (c) define unprofessional conduct to include any of the following:

> (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.

6. Business and Professions Code section 4113, subdivision (c), provides that the pharmacist-in-charge of a pharmacy shall be responsible for that pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy.

7. Business and Professions Code section 4063 provides that no prescription for any dangerous drug may be refilled except upon authorization of the prescriber. The authorization may be given orally or at the time of giving the original prescription, and no prescription for a controlled substance may be designated refillable as needed.

8. Health and Safety Code section 11153, subdivision (a) expresses a "corresponding responsibility" standard of care, and states:

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

9. 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.

10. California Code of Regulations, title 16, section 1707.2, states:

(a) A pharmacist shall provide oral consultation to his or her patient or the patient's agent in all care settings:

(1) upon request; or

(2) whenever the pharmacist deems it warranted in the exercise of his or her professional judgment.

(b)(1) In addition to the obligation to consult set forth in subsection (a), a pharmacist shall provide oral consultation to his or her patient or the patient's agent in any care setting in which the patient or agent is present:

(A) whenever the prescription drug has not previously been dispensed to a patient; or

(B) whenever a prescription drug not previously dispensed to a patient in the same dosage form, strength or with the same written directions, is dispensed by the pharmacy.

[¶] . . . [¶]

(c) When oral consultation is provided, it shall include at least the following:

(1) directions for use and storage and the importance of compliance with directions; and

(2) precautions and relevant warnings, including common severe side or adverse effects or interactions that may be encountered.

(d) Whenever a pharmacist deems it warranted in the exercise of his or her professional judgment, oral consultation shall also include:

(1) the name and description of the medication;

(2) the route of administration, dosage form, dosage, and duration of drug therapy;

[¶] . . . [¶]

(6) therapeutic contraindications, avoidance of common severe side or adverse effects or known interactions, including serious potential interactions with known nonprescription medications and therapeutic contraindications and the action required if such side or adverse effects or interactions or therapeutic contraindications are present or occur;

11. 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.

Applicable Case Law

12. Expert testimony is required to establish the standard of care with respect to a profession. See, *Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 1001; *Williams v. Prida* (1999) 75 Cal.App.4th 1417, 1424.

13. The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke, Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected available material." (Id. at 67-68 [citing *Nevarov v. Caldwell* (1958) 161 Cal.App.2d 762, 767].) Further, the fact finder may reject the testimony of any witness, even an expert, although uncontradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.)

14. The fact that a trier of fact "may disbelieve the testimony of a witness who testifies to the negative of an issue does not of itself furnish any evidence in support of the affirmative of that issue and does not warrant a finding in the affirmative thereof unless there is other [supportive evidence]." (*Hutchinson v. Contractors' State*

License Board (1956) 143 Cal.App. 2d 628, 632 [citing *Marovich v. Central California Traction Co.* (1923) 191 Cal. 295, 304].)

15. In license disciplinary matters, one need not wait for actual injury before imposing discipline, if there is evidence of potentially harmful misconduct. (*In re Kelley* (1990) 52 Cal.3d 487, 495-496; see also *In re Hickey* (1990) 50 Cal.3d 571, 579.)

16. The licensee, if he elects to operate his business through employees must be responsible to the licensing authority for their conduct in the exercise of his license...By virtue of the ownership of a ...license such owner has a responsibility to see to it that the license is not used in violation of the law." *Banks v. Board of Pharmacy* (1984) 161 Cal.App.3d 708, 713, citing *Ford Dealers Assn. v. Department of Motor Vehicles* (1982) 32 Cal.3d 347.

17. A licensee may be disciplined on the basis of ordinary negligence when charged with the "clearly excessive furnishing of controlled substances." *Smith v. State Board of Pharmacy* (1997) 37 Cal.App.4th 229, 246-247.

Analysis

The First Cause for Discipline

18. Complainant established by clear and convincing evidence that Respondent Daher dispensed Hydrocodone/APAP (generic for Norco) to J.S. on January 15 and 22, 2007, respectively, without evidence of the prescribing doctor's authorization. Respondents' explanations as to how or why this might have happened were unpersuasive as discussed at Factual Finding 37. As the P.I.C., Respondent Daher was also responsible for these violations pursuant to Business and Professions Code section 4113, and Respondent JSD is responsible for all acts of its agents and employees at the pharmacy. Consequently, Respondents JSD and Daher violated Business and Professions Code section 4063. Respondents' actions constitute unprofessional conduct pursuant to Business and Professions Code section 4301, subdivision (o).

19. In addition, Complainant established by clear and convincing evidence that Respondent Daher dispensed Hydrocodone/APAP for patient A.S. without prescriber authorization when he filled a prescription on January 22, 2007 that was post-dated January 30, 2007. As the P.I.C., Respondent Daher was responsible for Respondent JSD's compliance with all laws and regulations pertaining to the practice of pharmacy pursuant to Business and Professions Code section 4113, and Respondent JSD is responsible for all acts of its agents and employees at the pharmacy. Consequently, Respondents JSD and Daher violated Business and Professions Code section 4063. Respondent JSD's and Daher's actions constitute

unprofessional conduct pursuant to Business and Professions Code section 4301, subdivision (o).

20. Cause exists to discipline Respondent JSD's pharmacy license and Respondent Daher's pharmacist license for filling prescriptions without the prescriber's authorization, pursuant to Business and Professions Code sections 4300, 4301, subdivision (o), 4302, and 4113, as set forth in Factual Findings 1-5, 18-27, 29-30, 37, 90, 91, 134, 137, and Legal Conclusions 1-4, 6, 7, 12-16, 18, and 19.

The Second and Fourth Causes for Discipline

21. The Administrative Law Judge found that Respondent's patient profiles, as they maintained them, and their familiarity with them at hearing, lent credibility to Respondent's assertions that they reviewed each patient's drug therapy and medication records before they dispensed the patient's prescriptions.[10] However, the law requires more than a familiarity with how records are maintained to support a finding of compliance. The law requires a pharmacist to "consult,"[11] "review,"[12]" and "screen"[13] the patient's records before dispensing. The evidence showed that Respondents failed to carefully or critically evaluate or examine the patients' records prior to dispensing the prescriptions at issue in this case. The evidence showed that despite the high volume of highly addictive medications being dispensed at Jay Scott Drugs over a considerable period of time for different types of patients and despite the risks of dangerous drug combinations for particular patients, Respondents deferred to the prescriber unquestioningly and without further review or examination. Given the fact that Respondents are experienced community pharmacists, the Board does not believe that Respondents could have possibly consulted, reviewed or screened the patient drug therapy, patient medication or other pharmaceutical records before dispensing or dispensing medications "early". If they had, the Board finds that they either would have refused to fill the prescriptions as requested or documented reasons for dispensing these medications after obtaining confirmation of the legitimate medical purpose for such treatment from the prescriber. However, neither of the foregoing occurred in this case.

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[10] Government Code section 11425.50(b) states, in pertinent part, "If the factual basis for the decision includes a determination based substantially on the credibility of a witness, the statement shall identify any specific evidence of the observed demeanor, manner, or attitude of the witness that supports the determination, and on judicial review the court shall give great weight to the determination to the extent the determination identifies the observed demeanor, manner, or attitude of the witness that supports it." The ALJ's findings of credibility did not contain any observations of the demeanor or attitude of Respondents, so the findings are not entitled to great weight.

[11] "Consult" means to "look at carefully; examine." (Webster's New World Dictionary 3rd, ed.(1988) at p. 297.)

[12] "Review" means to "examine or inspect." (Webster's New World Dictionary 3rd. ed. (1988) at p. 1149.)

[13] "Screen" means to "select, reject, consider, or group by examining systematically." Dictionary.com. Dictionary.com Unabridged. Random House, Inc. http://dictionary.reference.com/browse/screen (Web: December 11, 2013).

The evidence also persuasively showed that Respondents could not establish personal knowledge about the patients or the prescriptions, the circumstances surrounding the prescriptions at issue in this case, or that their alleged usual and customary policies and practices regarding the filling of prescriptions were followed in this case. The evidence persuasively showed that Respondents' personal opinions and testimony regarding how a prescription at issue in this case would have been handled at Jay Scott Drugs is speculative and entitled to little weight. Consequently, the Board finds, by clear and convincing evidence, that there was a violation of Business and Professions Code section 4306.5, subdivision (c), California Code of Regulations, title 16, sections 1707.3 or 1761, and that, therefore, violations of Business and Professions Code sections 4301, subdivision (o), 4302, and 4113 were also established.

22. Cause exists to discipline Respondent JSD's pharmacy license and Respondent Daher's pharmacist license for failing to review drug therapy and patient medication records, pursuant to Business and Professions Code sections 4300, 4301, subdivision (o), 4302, and 4113, as set forth in Factual Findings 1-5, 8, 9, 18-131, 134-147, 154, 156 and Legal Conclusions 1-6, 9, 11, 12-16, and 21.

23. Cause exists to discipline Respondents Nabhan's and Yamasaki's pharmacist licenses for failing to review patient profiles before dispensing prescriptions, pursuant to Business and Professions Code sections 4300 and 4301, subdivision (o), as set forth in Factual Findings 1-6, 8, 9, 18-131, 134-147, and Legal Conclusions 1-6, 9, 11, 12-16, and 21.

The Third and Fifth Causes for Discipline

24. In corresponding responsibility cases, pharmacists and pharmacies must determine whether a prescription for a controlled substance was issued for a legitimate medical purpose whenever the surrounding circumstances indicate that such an inquiry should be made. This means that Complainant was required to establish that circumstances were present that would cause a reasonable and prudent pharmacist to question whether a prescription for a controlled substance was issued for a legitimate medical purpose and to show that the Respondents failed to make the required inquiry. Complainant established by clear and convincing evidence that Respondents actions in dispensing large volumes of controlled substances to patients without inquiry fell below the standard of care of a reasonably prudent pharmacist and that Respondents failed to meet their corresponding responsibility. During the times at issue from 2006 to 2008, Respondent JSD, through its licensed personnel, had the duty to determine whether certain prescriptions for controlled substances were issued for legitimate medical purposes. The evidence established that Respondents ignored, dismissed, or made nothing of many factors contained within patient records and information that should have raised their concerns about the legitimacy of the patients' prescriptions.

25. Bass' prescribing patterns were obvious. The prescriptions for all of the patients at issue were for significant quantities of generics for Norco, Xanax, and Soma and to a lesser extent, Lorcet, Oxycontin, and Valium, when considering that Bass was prescribing them at a consistent time interval (approximately every 15 days) without interruption. The prescribed medications were for controlled substances that have significant addictive qualities. Respondents undoubtedly knew that persons with drug addiction generally sought these kinds of controlled substances. Respondents believed that the patients were chronic pain sufferers and that Bass was a pain specialist. However, there was no evidence to support their conclusions. Respondents asserted that it was reasonable for them to defer to Bass' presumed expertise and discretion, and that after general discussions with Bass, their concerns were adequately answered to continue dispensing the prescriptions. However, other factors, together with the significant quantity of medication, should have raised Respondents' suspicions that Bass' prescriptions, or at least, the patients' intentions, were illegitimate. Bass issued virtually the same drug regimen to each patient over a significantly long time. One would reasonably expect that a pain specialist would modify the drugs, doses, strengths, or quantities within each patient's overall treatment time and between different patients. Respondents' choice to ignore these factors readily ascertainable within each patient's prescription profile constituted a failure to exercise their professional judgment.

26. Respondents incorrectly dismissed the distances traveled by the majority of the patients and their cash payments that were also factors that should have raised Respondents' suspicions. Abood's and Kaye's opinions, that the distances of 30 and more miles were not great distances to travel to purchase the medications, bordered on the absurd. The distances of virtually every patient at issue here were unreasonably long and should have raised Respondents' concerns. Similarly, the majority of the patients paying with cash should have alerted Respondents to possible illegitimate prescriptions. Lastly, dispensing similar prescriptions to family members, and at the same time, should have also raised Respondents' suspicions. The failure of these factors to prompt Respondents to suspect possibly illegitimate prescriptions for patients with addictions constitutes Respondents' failure to exercise their professional judgment. The opinions of Fujimoto as to these factors and conclusions were more persuasive than those of Abood and Kaye. These factors should have prompted Respondents to, at the least, contact Bass and verify his diagnoses, his general treatment plans, and question him regarding the quantities and dosages for each patient at issue here. Under these circumstances, a reasonably prudent pharmacist would have made inquiries to the prescriber regarding the drug regimen for these patients and whether other treatment methods had been tried, including using or switching to medications that were less addictive. Respondents correctly asserted that the standard of care does not require them to make such inquiries as to every patient with every pain medication prescription, but the factors discussed in Legal Conclusions 25 and 26 provided enough data to alert the prudent, reasonable pharmacist to inquire further regarding the patients herein, as Fujimoto opined. Had Respondents communicated with Bass, they might have elicited questionable responses that would have prompted them to question Bass' prescribing practices

overall or questioned the patients' intentions. Had Respondents received responses that they deemed adequate to continue dispensing, the question would then have been whether Bass' responses were reasonable. Respondents might well have fulfilled their professional responsibilities by inquiring and assessing Bass' responses without further action. As it stands, however, Respondents chose to defer to Bass' judgment in the face of obviously concerning prescribing patterns that could not and should not have been ignored or dismissed as within the sole discretion of the prescriber. In this way, Respondents did not engage their corresponding responsibility to ensure the legitimacy of the prescriptions at issue. Respondents' failures constitute unprofessional conduct and resulted in the furnishing of excessive quantities of highly addictive controlled substances to numerous patients.

27. The evidence showed that similar "red flags" for Bamdad's patient, A.C, were present. A.C. started visiting Respondent JSD at the age of 22, always paid cash for OxyContin and Xanax, and traveled approximately 40 miles from his residence to pick up his prescriptions. The evidence showed that A.C. would buy OxyContin one day and return the next day to pick up the Xanax portion of his prescription from Jay Scott Drugs. This was an approximate 86-mile round trip. Similar to Dr. Bass' patients, Respondents had no documentation of consultations with Bamdad regarding A.C.'s diagnosis, medication conditions, or the legitimate medical purpose for the prescriptions.

Consistent with Fujimoto's opinion, when the foregoing "flags" emerged, Respondent Daher should have questioned Bamdad before dispensing. A reasonable pharmacist would have had suspicions about Bamdad's patient and practices in light of the foregoing and made inquiries. Respondents' failure to contact Bamdad as to his prescription practices and the continuous dispensing of the prescriptions fell below the standard of care and constituted unprofessional conduct. In light of the foregoing, Respondents had an obligation not to defer to Bamdad, but the evidence showed Respondent Daher provided little or no oversight over the prescriptions and continued to frequently dispense consistent and virtually uninterrupted quantities of controlled substances to A.C. Respondent Daher and Respondent JSD's actions in dispensing controlled substances to A.C., therefore, fell below the standard of care of a reasonably prudent pharmacist and Respondents failed to meet their corresponding responsibility.

28. Cause exists to discipline Respondents' pharmacy and pharmacist licenses for failing to exercise their professional judgment, pursuant to Business and Professions Code sections 4300, 4302, and 4301, subdivisions (d), (j), and (o), Health and Safety Code section 11153, and California Code of Regulations, title 16, Section 1761 as set forth in Factual Findings 1-161, and Legal Conclusions 1-4, 6, 8, 11-17, 24- 27. Additionally, Respondent Daher, as the Pharmacist-in-Charge, was legally responsible for the violations consistent with Business and Professions Code section 4113.

29. Cause exists to discipline Respondents' pharmacy and pharmacist licenses for engaging in unprofessional conduct, pursuant to Business and Professions Code sections 4300, 4301 and 4302, as set forth in Factual Findings 1-161, and Legal Conclusions 1-17, and 24-27. Additionally, Respondent Daher, as the Pharmacist-in-Charge, was legally responsible for the violations consistent with Business and Professions Code section 4113.

Factors Considered for the Appropriate Measure of Discipline

30. According to the Board's Disciplinary Guidelines, violations are examined and categorized to determine the appropriate disciplinary penalty (Category I through Category IV). In this matter, the most serious violations include Category III violations for violations of corresponding responsibility under Health and Safety Code section 11153. In those cases, the Board recommends the maximum penalty of revocation. (See *Manual of Disciplinary Guidelines and Model Disciplinary Orders* at p.15 and p. 77.) However, a determination that cause exists to revoke Respondents' pharmacy and pharmacist licenses does not end the inquiry. The Board has compiled a list of factors to evaluate whether a licensee has been rehabilitated from prior misconduct. That list, found on page 3 of the Board's *A Manual of Disciplinary Guidelines and Model Disciplinary Orders* (Revised 10/2007), is incorporated by reference into the Board's regulations.[14] The criteria considered here include: actual or potential harm to the public; actual or potential harm to any consumer; number and/or variety of current violations; nature and severity of the acts under consideration; aggravating evidence; mitigating evidence; rehabilitation evidence; whether the conduct was negligent or intentional and the financial benefit to the respondent from the misconduct.

31. *Actual or potential harm to the public; actual or potential harm to any consumer.* Protection of the public is the Board's highest priority. The Board fulfills its public mandate by, among other things, imposing discipline. As the record establishes, the drugs were dispensed to these patients without regard for patient health and safety or public safety. The evidence established that some of the patients in this case (A.S., B.G. and A.C.) were addicts. Respondents' violations contributed to the addiction of these patients and put other patients at risk of harm from addiction, overdose or death. Further, patients did overdose on medications that were being regularly filled by Respondents. Their cause of death was, in part, if not entirely, attributable to consuming drugs prescribed by Bass or Bamdad, and dispensed by Respondents. Respondents' misconduct was a contributing factor in the overdoses, as drug overdose was a likely and foreseeable consequence of Respondents' misconduct.

32. In particular, Respondents' misconduct contributed to the drug addiction of A.S., which led to his untimely death at the age of 22 by overdosing on drugs dispensed by Jay Scott Drugs. (Factual Findings 28-37.) Similarly, Respondents'

[14] Cal. Code Regs., tit 16, § 1760.

misconduct contributed to the drug addiction of the four other patients who died from drug overdoses, whether or not any of the drugs consumed that directly caused their demise were dispensed by Jay Scott Drugs. If Respondents contributed to the drug addiction, they contributed to the end result: death.

33. *Number and Variety of Current Violations.* It is very important that the Board's licensees comply with the standards of pharmacy practice and applicable pharmacy laws. The five causes for discipline proven demonstrate that Respondents failed to abide by those standards and laws and acted without due regard for public health or safety. Respondents provided large quantities of controlled substances and at doses and frequencies that fell below the standard of care. The public is protected when pharmacists are knowledgeable about their responsibilities and act as patient advocates in the discharge of those duties.

34. *Nature and Severity of the Acts.* Respondents' violations are serious and demonstrate a fundamental disregard for the public's health and safety. In this case, Respondents chose not to exercise clinical judgment, to communicate and listen, to assess the patients' drug therapies or the effect the drug was having on the patients, to interact with the prescribers, to understand the true nature of the prescriptions or to intervene when there were "red flags." Instead, Respondents appeared to choose profits over patient safety by continuously filling suspect prescriptions without question. This misconduct is serious and warrants revocation.

As explained by the California Court of Appeal in *Vermont & 100th Medical Arts Pharmacy v. Board of Pharmacy* (1981) 125 Cal.App.3d 19, 25:

> "A profession is a vocation or occupation requiring special and advanced education and skill predominately of an intellectual nature. The practice of pharmacy, like the practice of medicine, is a profession.
>
> For this reason, society entrusts to persons in these professions the responsibility for control over a force which, when properly used, has great benefit for mankind, but when abused is a force for evil and human destruction.
>
> It follows that society cannot tolerate the presence of individuals within these professions who abdicate their professional responsibility and permit themselves to be used as a conduit by which these controlled substances reach the illicit market and become that force of evil to which we allude."

35. *Aggravation/Mitigation/Whether the Conduct was Negligent or Intentional.* In aggravation, the Board considered that Respondents Daher, Yamasaki and Nabhan were all experienced community pharmacists who should have recognized the "red flags" presented to them. As a board that includes community pharmacists, the Board finds it inconceivable that when presented with these facts, over and over again over many months, Respondents did not immediately contact the prescribers, ask questions, and document those inquiries in the patients' records. Respondents' own evidence showed they were capable of doing this for other

patients, but Respondents failed to produce any credible evidence that they did so in this case. In addition, the Board considered that Respondent Nabhan is a licensed respiratory therapist, who was well aware of the respiratory dangers of opiods and their use in combination with sedatives. However, he continued to dispense highly dangerous opiods and dangerous drug combinations without further inquiry of the prescriber. In mitigation, Respondents had no previous record of discipline. At best, their violations demonstrate that Respondents fell below the standard of care of what a reasonably prudent pharmacist would do under the same or similar circumstances. However, at worst, Respondents' misconduct exhibits a reckless disregard for the public health and safety.

36. *Rehabilitation Evidence.* Respondents did not present any rehabilitation evidence. Respondents all consistently denied they did anything wrong in this matter. They expressed no remorse for their misconduct. Respondent Daher, in particular, appeared to place blame on the patients for their drug addictions and deaths. These failures to accept any responsibility and minimize the patients as human beings are of concern to the Board. Respondent Daher, Yamasaki, and Nabhan's denials, lack of understanding of their responsibilities as pharmacists, and their lack of remorse demonstrate that Respondents are not able to practice with safety to the public.

37. *Financial Benefit to the Respondent from the Misconduct.* The evidence shows that Respondent JSD received huge financial gains from dispensing controlled substances, particularly from Bass. Respondent JSD was paid approximately $1.7 million dollars in cash for Bass' prescriptions. Respondent Daher admitted his financial interest in continuing to dispense these types of prescriptions in communications with the Board's staff. On April 16, 2008, Respondent Daher wrote Inspector Bayley a letter indicating that he was experiencing a "slow down of our business" and might have to lay off employees if he did not continue to fill prescriptions from doctors like Bass.

Conclusion

38. When considering all of the factors in Legal Conclusions 30-37, outright revocation of Respondents' licenses would be the only discipline appropriate to protect the public. This finding is based upon all Findings of Fact and Legal Conclusions.

Costs

39. Business and Professions Code section 125.3 provides that "upon request of the entity bringing the proceeding, the administrative law judge may 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."

40. The Board must exercise its discretion to reduce or eliminate cost awards in a manner that will ensure the award does not deter licensees with potentially

meritorious claims or defenses from exercising their right to a hearing. (*Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45.) "[T]he Board may not assess the full costs of investigation and prosecution when to do so will unfairly penalize a [licensee] who has committed some misconduct, but who has used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed. The Board must consider the [licensee's] 'subjective good faith belief in the merits of his or her position' [citation] and whether the [licensee] has raised a 'colorable challenge' to the proposed discipline [citation]." (*Ibid.*)

41. The Administrative Law Judge in this matter found it appropriate to reduce the costs of investigation and enforcement ($61,541 & $53,650, respectively), each, by 40 percent. The Administrative Law Judge also found that Respondents cooperated with the Board's investigations. Thus, the ALJ further reduced costs, for a total reduction in the costs of investigation and enforcement, each, by 50 percent. Therefore, Complainant is entitled to $30,770.50, in investigation costs, and $26,825, in enforcement costs. Pursuant to Business and Professions Code section 125.3(d), this determination is not reviewable by the Board to increase the cost award.

42. Cause exists to order Respondents to pay the Board's reasonable costs of investigation and enforcement, a total of $57,595.50, pursuant to Business and Professions Code section 125.3, as set forth in Factual Findings 1-162, and Legal Conclusions 1-41.

ORDERS

Order Re Respondent Daher

1. License number RPH 39189, issued to Respondent Albert Farah Daher, is revoked.

2. Respondent Daher shall relinquish his wall license and pocket renewal license to the board within 10 days of the effective date of this decision. Respondent may not reapply or petition the board for reinstatement of his revoked license for three years from the effective date of this decision.

3. Respondents Daher, Yamasaki, Nabhan and Jay Scott Drugs shall pay the board its costs of investigation and prosecution in the total amount of $57,595.50 within fifteen (15) days of the effective date of this decision.

Order Re Respondent Ahmad Shati Nabhan

1. License number RPH 41754, issued to Respondent Ahmad Shati Nabhan, is revoked.

2. Respondent Nabhan shall relinquish his wall license and pocket renewal license to the board within 10 days of the effective date of this decision. Respondent Nabhan may not reapply or petition the board for reinstatement of his revoked license for three years from the effective date of this decision.

3. Respondents Daher, Yamasaki, Nabhan and Jay Scott Drugs shall pay the board its costs of investigation and prosecution in the total amount of $57,595.50 within fifteen (15) days of the effective date of this decision.

Order Re Respondent Yamasaki

1. License number RPH 19983, issued to Respondent Jun Yamasaki, is revoked.

2. Respondent Yamasaki shall relinquish his wall license and pocket renewal license to the board within 10 days of the effective date of this decision. Respondent Yamasaki may not reapply or petition the board for reinstatement of his revoked license for three years from the effective date of this decision.

3. Respondents Daher, Yamasaki, Nabhan and Jay Scott Drugs shall pay the board its costs of investigation and prosecution in the total amount of $57,595.50 within fifteen (15) days of the effective date of this decision.

Order Re Respondent Jay Scott Drugs

1. Pharmacy Permit number PHY 40912, issued to Respondent Jay Scott Drugs, is revoked (where "Respondent Jay Scott Drugs" is mentioned in this Order, any and all owners of Jay Scott Drugs, its successors and assignees, doing business as Jay Scott Drugs, is intended to be included).

2. Respondent owner shall, by the effective date of this decision, arrange for the destruction of, the transfer to, sale of or storage in a facility licensed by the board of all controlled substances and dangerous drugs and devices. Respondent owner shall provide written proof of such disposition, submit a completed Discontinuance of Business form and return the wall and renewal license to the board within five days of disposition.

3. Respondent owner shall also, by the effective date of this decision, arrange for the continuation of care for ongoing patients of the pharmacy by, at minimum, providing a written notice to ongoing patients that specifies the anticipated closing date of the pharmacy and that identifies one or more area pharmacies capable of taking up the patients' care, and by cooperating as may be necessary in the transfer of records or prescriptions for ongoing patients. Within five days of its provision to the pharmacy's ongoing patients, Respondent owner shall provide a copy of the written

notice to the board. For the purposes of this provision, "ongoing patients" means those patients for whom the pharmacy has on file a prescription with one or more refills outstanding, or for whom the pharmacy has filled a prescription within the preceding sixty (60) days.

This Decision shall become effective on January 27, 2014

IT IS SO ORDERED this 27th day of December, 2013.

STAN C. WEISSER
Board President

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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **Jay Scott Drugs** **PIC Albert Daher** 2200 N. Glenoaks Burbank, CA 91504 **Retail Pharmacy License Number PHY 40912,** **Albert Farah Daher** 456 Audraine Drive Glendale, CA 91202 **Pharmacist License Number RPH 39189,** **Ahmad Shati Nabhan** 3234 Henrietta Ave La Crescenta, CA 91214 **Pharmacist License Number RPH 41754,** and **Jun Yamasaki** 511 E. Mount Curve Ave. Altadena, CA 91001 **Pharmacist License Number RPH 19983** Respondents.	Case No. 3482 FIRST AMENDED ACCUSATION

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Complainant alleges:

PARTIES

1. Virginia K. Herold (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Officer of the Board of Pharmacy.

2. On or about June 27, 1995, the Board of Pharmacy issued Retail Pharmacy License Number PHY 40912 to Jay Scott Drugs (Respondent), located at 220 North Glenoaks, Burbank, California. Albert Farah Daher has been the sole owner of Jay Scott Drugs and Pharmacist-in-Charge of Jay Scott Drugs from 1998 to the present. The Retail Pharmacy License will expire on June 1, 2012, unless renewed.

3. On or about March 12, 1985, the Board of Pharmacy issued Pharmacist License Number RPH 39189 to Albert Farah Daher (Respondent Daher). The Pharmacist License will expire on January 31, 2013, unless renewed.

4. On or about April 20, 1988, the Board of Pharmacy issued Pharmacist License Number RPH 41754 to Ahmad Shati Nabhan (Respondent Nabhan). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2013, unless renewed.

5. On or about July 28, 1956, the Board of Pharmacy issued Pharmacist License Number RPH 19983 to Jun Yamasaki (Respondent Yamasaki). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2014, unless renewed.

JURISDICTION

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

7. Section 4300 of the Code provides, in part, that every license issued by the Board is subject to discipline, including suspension or revocation.

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8. Section 4302 of the Code states:

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

9. Section 4113 of the Code states, in part:

"(b) 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."

10. Section 118, subdivision (b), of the Code provides 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.

11. Section 4301 of the Code states:

"The board shall take action against any holder of a license who is guilty of unprofessional conduct . . . Unprofessional conduct shall include, but is not limited to, any of the following:

. . .

(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."

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12. Section 4306.5 of the Code 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."

13. Section 4063 of the Code states:

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

14. Health and Safety Code section 11153 states:

"(a) 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. Except as authorized by this division, the following are not legal prescriptions: (1) an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of

controlled substances, which is issued not in the course of professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use."

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 1716 states, in part:

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

17. 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

18. Section 125.3 of the Code provides, in 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.

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19. DRUG CLASSIFICATIONS

Brand Name(s)	Generic Name	Dangerous Drug Per Bus. & Prof. Code § 4022	Scheduled Drug per Health & Safety Code	Indications For Use
Adipex	Phentermine HCL	Yes	Schedule IV	Weight Loss
Ambien	Zolpidem (non-barbiturate, non-benzodiazepine sedative hypnotic)	Yes	Schedule IV	Insomnia
Bontril Slow Release	Phendimetrizine	Yes	Schedule III	Weight Loss
Desyrel	Trazodone	Yes	Not scheduled	Depression and anxiety
Halcion	Triazolam (non-barbiturate, benzodiazepine sedative hypnotic)	Yes	Schedule IV	Short-term treatment of insomnia
Heroin	Opium derivative	Not prescribed	Schedule I	no currently accepted medical use
Lorcet	Hydrocodone/ Acetaminophen (APAP)	Yes	Schedule III	Moderate to Severe Pain
Norco[1]	Hydrocodone/ Acetaminophen (APAP)	Yes	Schedule III	Moderate to Severe Pain
OxyContin	Oxycodone	Yes	Schedule II	Moderate to Severe pain
Soma[2]	Carisoprodol	Yes	not scheduled	Muscle relaxant
Subutex, Suboxone	Buprenorphine	Yes	Schedule III	Narcotic Addiction
Valium	Diazepam (non-barbiturate, benzodiazepine sedative hypnotic)	Yes	Schedule IV	Anxiety
Vicodin, Vicodin ES	Hydrocodone/Acetamino phen	Yes	Schedule III	Pain
Xanax	Alprazolam (non-barbiturate, benzodiazepine sedative hypnotic)	Yes	Schedule IV	Anxiety

[1] Norco 10/325 mg contains 10 mg of hydrocodone and 325 mg of acetaminophen (brand name, Tylenol). The maximum daily recommended dosage for acetaminophen is four (4) grams.

[2] Drug abusers combine Soma with hydrocodone to produce similar effects to those of Heroin.

BACKGROUND

20. The Board initiated investigations of Respondents based upon the following:

a. Three (3) complaints against Respondents Jay Scott Drugs and Daher alleging that they excessively dispensed controlled substances to patients, which resulted in the deaths of Patients A.S.[3] and A.C. and the drug addiction of J.S. Patients A.S. and J.S. were Dr. Bernard Bass' patients and Patient A.C. was Dr. Masoud Bamdad's patient.

b. Ventura County Sheriff Department's criminal investigation of Dr. Bass for his involvement in the overdose deaths of seven of his patients, five of which had Dr. Bass' prescriptions filled at Respondent Jay Scott Drugs' facility, namely, A.S., D.L., A.W., L.G., and D.K. Dr. Bass' office was located at 10843 Magnolia Boulevard, North Hollywood, California, which was approximately five miles from Jay Scott Drugs' facility.

c. California Medical Board's investigation into Dr. Bass' medical practice and subsequent discipline, which involved allegations of gross negligence, excessive prescribing of controlled substances, and other violations, with regard to seven (7) patients[4] and subsequent discipline against Dr. Bass' medical license. The California Medical Board's Decision and Order in *In re Matter of the Accusation against Bernard N. Bass, M.D.*, Case No. 05-2005-167939, dated January 21, 2009, provided that Dr. Bass' physician license No. G 28057 was revoked, with revocation stayed, 90 days suspension, placed on seven (7) years probation, and required to surrender his United States Drug Enforcement Administration (DEA) permit to prescribe controlled substances.[5]

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[3] For purposes of patient confidentiality, all patients are referred to by their initials.

[4] The seven patients involved in the California Medical Board's investigation regarding Dr. Bass are not the same seven patients involved in Ventura County Sheriff's investigation.

[5] In or about May 2008 Dr. Bass surrendered his DEA permit to Ventura County Sheriff's detectives.

21. Based on the foregoing and the C.U.R.E.S.[6] data, the Board investigator selected twenty six (26) patients (including deceased patients) of Dr. Bass, who received prescriptions from Jay Scott Drugs, and reviewed their patient profiles and original prescriptions.

22. Patient A.C.'s doctor, Dr. Masoud Bamdad, was investigated and federally indicated by the DEA for illegal drug distribution.[7] On or about July 29, 2010, in the criminal proceeding entitled *USA v. Masoud Bamdad*, United States District Court, Central District of California (Western Division - Los Angeles), Case No. 2:08-cr-00506-GW-1, Dr. Bamdad was convicted of ten felony counts of violating [21 U.S.C. § 841(a)(1), (b)(1)(C), and 18 U.S.C. § 2(b)] (knowing and intentional unlawful distribution of controlled substances) and three felony counts of violating 21 U.S.C. § 841(a)(1), (b)(1)(C), in conjunction 21 U.S.C. § 859 and 18 U.S.C. § 2(b) (unlawful distribution of controlled substances to persons under age 21), as charged in the First Superseding Indictment. Dr. Bamdad was sentenced to prison for 25 years, fined in excess of $1,000,000, and forfeited his real property. Upon release, Dr. Bamdad will be placed on supervised release for a term of six years. The First Superseding Indictment provides that Dr. Bamdad, a physician licensed to practice medicine in the State of California, while acting and intending to act outside the usual course of professional practice and without a legitimate medical purpose, knowingly and intentionally distributed and dispensed, and caused the intentional distribution and dispensing of, Oxycodone, a Schedule II narcotic drug controlled substance, to numerous patients.

23. In or about 2011, the Board conducted a supplemental investigation into Respondents' pharmacy practice. The supplemental investigation revealed that Respondent Jay Scott Drugs and Respondent Daher committed additional violations of the Pharmacy Law.

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[6]The Controlled Substance Utilization Review and Evaluation System or C.U.R.E.S. is a database maintained by the California Department of Justice, Bureau of Narcotic Enforcement, which allows pre-registered users, including licensed healthcare prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards, to access patient controlled substance history information.

[7] According to a press release by United States Attorney's Office, dated May 6, 2009, Dr. Bamdad has been in custody since his arrest in April 2008, by DEA special agents. The Indictment was filed on April 29, 2008.

FIRST CAUSE FOR DISCIPLINE

(Refill of prescriptions without prescriber's authorization)

24. Respondent Jay Scott Drugs and Respondent Daher are subject to discipline pursuant to Code sections 4300, 4301, subdivision (o), 4302, and 4113, on the grounds of unprofessional conduct, in that Respondents refilled prescriptions for controlled substances and dangerous drugs, without authorization, in violation of Code section 4063. Specifically, Respondent Daher refilled prescriptions that did not contain authorized refills on the original prescription as follows:

Patient J.S.

a. On January 15, 2007, Respondent Daher refilled Rx no. 180576 (Norco 10/325 mg, 125 tablets) for J.S. without the prescribing doctor's authorization.

b. On January 22, 2007, Respondent Daher refilled Rx no. 182808 (Norco 10/325 mg, 125 tablets) for J.S. without the prescribing doctor's authorization.

Patient A.S.

c. On January 22, 2007, Respondent Daher dispensed Rx No. 183159 (Norco 10/325mg, 125 tablets), Rx No. 183160 (Xanax 2mg, 60 tablets), Rx 183162 (Soma, 15 tablets) for A.S. without the prescribing doctor's authorization. The prescribing doctor dated these prescriptions January 30, 2007.

SECOND CAUSE FOR DISCIPLINE

(Failure to Review Drug Therapy and Patient Medication Record)

25. Respondent Jay Scott Drugs and Respondent Daher are subject to discipline pursuant to Code sections 4300, 4301, subdivision (o), 4302, and 4113, on the grounds of unprofessional conduct, in that Respondents failed to review the patient's drug therapy and medication record prior to dispensing prescriptions, in violation of Code section 4306.5, subdivision (c), and California Code of Regulations, title 16, sections 1707.3 and 1761. The circumstances are as follows:

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Patient J.S.

26. Respondent Daher filled prescriptions for highly addictive controlled substances early for J.S., without reviewing his patient profile, resulting in over dispensing controlled substances and/or dangerous drugs to J.S., as follows:

a. On January 24, 2007, Respondent Daher dispensed Rx No. 183632 (Norco 10/325mg) and Rx No. 183633 (Xanax 2mg, 60 tablets) for J.S. six (6) days earlier than the written directions indicated. The prescribing doctor dated the prescriptions January 30, 2007.

b. From January 15, 2007, to January 24, 2007, over a 10-day period, Respondent Daher dispensed 500 tablets of Norco, and from January 19, 2007, through January 24, 2007, over a 6-day period, Respondent Daher dispensed 120 tablets of Xanax, to J.S., as set forth in the table below:

Rx #	Drug	Date filled	RPH	Direction	Qty	
180576	Norco 10/325	1/15/07	AD	Take 1-2 tablets every 4 hours	125	Unauthorized refill
182808	Norco 10/325	1/19/07	AD	Take 1-2 tablets every 4 hours	125	
182809	Xanax 2mg	1/19/07	AD	Take 1 tablet every 6 hours	60	
182810	Soma 350 mg	1/19/07	AD	Take 1 tablet every night	10	
182808	Norco 10/325	1/22/07	AD	Take 1-2 tablets every 4 hours	125	Unauthorized refill
183632	Norco 10/325	1/24/07	AD	Take 1-2 tablets every 4 hours	125	Early fill
183633	Xanax 2mg	1/24/07	AD	Take 1 tablet every 6 hours	60	Early fill

The written directions for these medications are Norco 10/325mg, take 1-2 tablets every 4 hours (equals a maximum of 12 tablets per day); Xanax 2mg, take 1 every 6 hours (equals a maximum of 4 tablets per day); and Soma, take 1 tablet every night (1 tablet per day). Based on Respondent Daher's over dispensing, the patient was taking 20 tablets of Xanax per day and 50 tablets of Norco 10/325mg per day, which constitutes 16.25 grams of Tylenol per day. As a result, the patient was exposed to Tylenol toxicity.

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Patient A.S.

27. Respondent Daher filled prescriptions for highly addictive controlled substances for A.S., without reviewing his patient profile, resulting over dispensing controlled substances and/or dangerous drugs to J.S., as follows:

a. On January 22, 2007, Respondent Daher dispensed Rx No. 183159 (Norco 10/325mg, 125 tablets), Rx No. 183160 (Xanax 2mg, 60 tablets), Rx 183162 (Soma, 15 tablets) for A.S. eight (8) days earlier than the written directions indicated. The prescribing doctor dated the prescriptions January 30, 2007.

b. In addition, three days earlier, on January 19, 2007, Respondent Daher had dispensed the identical prescriptions to A.S. (Norco 10/325 mg 125 tablets, Xanax 2mg 60 tablets, Soma 15 tablets). As a result, over a period of four days, from January 19, 2007, through January 22, 2007, Respondent Daher dispensed 250 tablets of Norco, 120 tablets of Xanax, and 30 tablets of Soma to A.S., as set forth in the table below:

Rx #	Date filled	Drug	RPH	Direction	Qty
182811	1/19/07	Norco 10/325	AD	Take 1-2 tablets every 4 hours	125
182812	1/19/07	Xanax 2mg	AD	Take 1 tablet every 6 hours	60
182813	1/19/07	Soma 350 mg	AD	Take 1 tablet every night	15
183159	1/22/07	Norco 10/325	AD	Take 1-2 tablets every 4 hours	125
183160	1/22/07	Xanax 2mg	AD	Take 1 tablet every 6 hours	60
183162	1/22/07	Soma 350 mg	AD	Take 1 tablet every night	15

Based on Respondent Daher's over dispensing, the patient was taking 62 tablets of Norco 10/325mg, 30 tablets of Xanax 2mg, and 7 tablets of Soma per day. 62 tablets of Norco 10/325mg constitute 20 mg of Tylenol, five (5) times the recommended daily dose. As a result, the patient was exposed to Tylenol toxicity.

Patient N.V.

28. On three (3) occasions Respondent Jay Scott Drugs dispensed prescriptions for highly addictive controlled substances early for N.V., without reviewing N.V.'s patient profile.

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By filling the prescriptions early, Respondents over dispensed controlled substances and/or dangerous drugs to N.V., as follows:

a. On May 29, 2007, Respondent Nabhan dispensed a refill of Norco 10/325mg three (3) days early.

b. On June 26, 2007, Respondent Yamasaki dispensed a refill of Norco 10/325mg five (5) days early.

c. On April 4, 2008, Respondent Daher dispensed a refill of Norco 10/325mg three (3) days early.

Patient S.R.

29. On five (5) occasions Respondent Jay Scott Drugs and Respondent Albert Daher dispensed prescriptions for highly addictive controlled substances early for S.R., without reviewing S.R.'s patient profile or CURES. By filling the prescriptions early, Respondents over dispensed controlled substances and/or dangerous drugs to S.R., as follows:

a. On October 10, 2007, Respondent Daher dispensed a refill of APAP/Hydrocodone Bitartrate 650/10 mg five (5) days early.

b. On October 24, 2007, Respondent Daher dispensed a prescription of APAP/Hydrocodone Bitartrate 650/10 mg (6) days early.

c. On November 7, 2007, Respondent Daher dispensed a refill of APAP/Hydrocodone Bitartrate 650/10 mg (6) days early.

d. On November 21, 2007, Respondent Daher dispensed a prescription of APAP/Hydrocodone Bitartrate 650/10 mg (7) days early.

e. On December 19, 2007, Respondent Daher dispensed a prescription of APAP/Hydrocodone Bitartrate 650/10 mg twelve (12) days early.

30. Based on the early fills from October 10, 2007 to January 1, 2008, 750 tablets of Lorcet 10/650mg were furnished to S.R. for 83 days. This meant S.R. was taking nine (9) tablets of Lorcet 10/650mg (10 mg hydrocodone and 650 mg acetaminophen) daily, and the total amount of acetaminophen (Tylenol) consumed by S.R. was 5.9 grams per day, which was well above the maximum recommended dosage of Tylenol, 4 grams.

Patient G.C. III.

30. Respondent Jay Scott Drugs and Respondent Albert Daher dispensed prescriptions for highly addictive controlled substances early for G.C. III., without reviewing his patient profile or CURES.. By filling the prescriptions early, Respondents over dispensed controlled substances and/or dangerous drugs to G.C.III on December 19, 2007, by dispensing a refill of Alprazolam 2mg nine (9) days early.

THIRD CAUSE FOR DISCIPLINE

(Failure to Exercise Professional Judgment)

31. Respondents are subject to discipline pursuant to Code sections 4300 and 4301, subdivision (d), (j) and (o), on the grounds of unprofessional conduct, in that they failed to exercise professional judgment and failed to share a corresponding responsibility with regard to the dispensing or furnishing of controlled substances and/or dangerous drugs, in violation of Code section 4306.5, subdivision (b), Health and Safety Code section 11153, and California Code of Regulations, title 16, section 1761, subdivision (b), which put their patients at risk. Respondents dispensed prescriptions that they knew or had an objective reason to know that said prescriptions were not issued for a legitimate medical purpose. The circumstances are as follows:

Dr. Bass' prescribing pattern

32. Respondents failed to adequately evaluate and/or address Dr. Bass' suspect prescribing pattern or his patients' profiles prior to dispensing controlled substances to Dr. Bass' patients, which presented clear indications that numerous prescriptions written by Dr. Bass were not issued for a legitimate medical purpose. Respondents failed to evaluate the totality of the circumstances presented by Dr. Bass' prescribing pattern, including, but not limited to, the fact that Dr. Bass wrote an unusually large number of controlled substance prescriptions, wrote few if any prescriptions that were not controlled substances except Soma, he prescribed the same drugs with the same dosages, directions and quantities without adjustments for numerous patients, including patients in the same family, he prescribed illogical drug combinations, his practice included an unusually large number of young patients for pain management, who traveled 30 or

40 miles to see Dr. Bass or have their prescriptions filled at Respondent Jay Scott Drugs, and paid for their prescriptions in cash.

Unusually large number of controlled substance prescriptions

33. Dr. Bass wrote an unusually large number of controlled substance prescriptions. From October 2006 through April 2008, Respondent Jay Scott Drugs dispensed 33,742 controlled substance prescriptions written by Dr. Bass, not including the approximately 9,481 prescriptions for Soma.[8] During that period the pharmacy operated approximately 493 days. Therefore, Respondent Jay Scott Drugs dispensed approximately 1775 controlled substance prescriptions written by Dr. Bass per month or an average of approximately 68 controlled substance prescriptions per day for 19 months. The large number of controlled substance prescriptions dispensed per day written by Dr. Bass should have alerted Respondents to carefully monitor patients and carefully document that monitoring, which they failed to do.

Few if any prescriptions other than controlled substances and Soma

34. Respondents failed to consider that Dr. Bass patients had very few if any prescriptions other than those pain medications and Soma ordered by Dr. Bass, filled at Jay Scott Drugs. Normally patients have a number of different types of prescriptions dispensed, not just controlled substance prescriptions. Most patients reviewed either had no other prescriptions for other types of medications or abnormally few other types of prescriptions dispensed by Respondent Jay Scott Drugs.

Same drug regimen

35. The typical drug regimen that Dr. Bass used and was dispensed by Respondent Jay Scott Drug was for the same drugs, Norco 10/325mg, Xanax 2mg (or Valium 10mg), and Soma, with the same dosages, quantities, and directions, as follows:

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[8] Dr. Bass' prescription history with Jay Scott Drugs was 608 pages long for the time period January 1, 2006, through May 8, 2009, with very few prescriptions dispensed during 2006.

Drug name	Quantity (tablet)	Direction
Norco 10/325mg	125	Take 1-2 tablets every 4 hours
Xanax 2mg	60	Take 1 tablet every 6 hours
Soma	60	Take 1 tablet four times a day

The prescriptions were rarely varied for a patient from the first visit to the last or from patient to patient. There were no indications of any dosage adjustments according to the severity of the pain. Dr. Bass rarely prescribed other pain management drugs other than Norco 10/325mg. Respondents failed to adequately evaluate why a pain management specialist, Dr. Bass, would prescribe the same drug regimen for so many of their patients, without differentiation for age, weight, degree of pain, and medical history.

Illogical drug combinations

36. Respondents failed to question illogical drug combinations. There are two subtypes of nonbarbiturate sedative hypnotics, benzodiazepine and non-benzodiazepine. Valium, Xanax, and Halcion are examples of benzodiazepines and Ambien is an example of a non-benzodiazepine hypnotic. Seven (7) of Dr. Bass' patients that filled their prescriptions at Jay Scott Drugs were prescribed more than one non-barbiturate sedative hypnotic, as follows:

a. D.L. - Ambien and Valium

b. D.K. - Xanax; Ambien, and Valium

c. K.P. - Xanax and Valium

d. B.G. - Xanax and Valium

e. D.S. - Xanax, Ambien, and Valium

f. J.V. - Ambien and Halcion

g. L.G. - Xanax and Valium.

There is no documentation of any inquiry of Dr. Bass by Respondents about the duplicate therapy for these patients.

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Unusual Age of Patients for Pain Management

37. Respondents did not consider the fact that most of Dr. Bass' patients for whom he prescribed pain killers on a regular basis were in their 20's or early 30's. The five deceased individuals investigated by Ventura County Sheriff's Department who had prescriptions filled at Respondent Jay Scott Drugs ranged in age from 19 to 31. Respondents dispensed these same controlled substances and Soma to 16 younger adults less than 25 years old, primarily during a 19-month period from October 2006 through April 2008, in addition to other patients of Dr. Bass. Late teens and early 20's is an unusual age for pain management. Most of the teens or young adults were apparently healthy individuals that would be expected to have occasional antibiotics for infections or for the females, perhaps birth control pills. These patients were rarely treated for common medical problems or typical medical care for this age group. They were regularly on very high dosages of pain control medications, benzodiazepine controlled substance anti-anxiety agents, and muscle relaxants.

Distances traveled

38. Respondents failed to consider that many of Dr. Bass' patients traveled approximately 30 or 40 miles or more to see Dr. Bass or have their prescriptions filled at Respondent Jay Scott Drugs, especially since Dr. Bass' patients were allegedly in pain and had to return to see Dr. Bass every 12 to 15 days to obtain a new prescription.

Method of Payment: Cash

39. Respondents failed to consider that numerous patients of Dr. Bass paid for their prescriptions only in cash. For example, Respondent Jay Scott Drugs' Daily Log for Controlled Substance for Schedule III to V, dated September 7, 2007, indicated that 93 out of 132 prescriptions filled on that date were for Dr. Bass' patients. 71 out of 93 prescriptions were paid by cash. Therefore, 76% of prescriptions written by Dr. Bass and dispensed by Respondents were paid by cash on that date. Similarly, the Daily Log on September 19, 2007, for Controlled Substance for Schedule III to V indicated that 75 prescriptions out of 105 prescriptions were for Dr. Bass' patients. 56 out of 75 prescriptions were paid by cash. Therefore, 74% of prescriptions written by Dr. Bass were paid by cash. Also, four out of five patients of both Dr. Bass and

Respondent Jay Scott Drugs who died (A.S., D.L., A.W., L.G., and D.K.) paid only in cash for their prescriptions. Only patient D.L. appeared to have some other method of payment.

Family members

40. Respondents did not question the fact that Dr. Bass wrote the same pain killer prescriptions for family members of his patients, with no differentiation for age, weight or degree of pain.

Patients B.G. and C.G.

a. Per the patient's profile, B.G. and C.G., who are siblings, started to visit Dr. Bass and Respondent Jay Scott Drugs in October 2006, when B.G. was 25 years old and his sister, C.G., was 23 years old. They always paid for their prescriptions in cash. They lived at the same residence and the distance from their residence to Dr. Bass' office or Jay Scott Drugs was approximately 40 miles.

b. Respondents dispensed Dr. Bass' prescriptions for the same drugs (Norco 10/325mg and Xanax 2mg) to B.G. and C.G., who are brother and sister. On eight (8) occasions Respondents dispensed the same drugs on the same day to B.G. and C.G. for a total of 32 such prescriptions. Of these 32 prescriptions, Respondent Daher and Respondent Yamasaki each dispensed 16 such prescriptions to the siblings. Between October 30, 2006, and March 31, 2008, Respondent Jay Scott Drugs dispensed 103 prescriptions written by Dr. Bass for B.G., all for Norco, Xanax, Soma or Valium. Between October 30, 2006, and April 9, 2008, Respondents dispensed 72 prescriptions, written by Dr. Bass for C.G., all for Norco or Xanax.

c. Respondent Jay Scott Drugs did not have any record indicating communication with Dr. Bass about the medical conditions and/or drug therapy of the siblings.

d. B.G. and C.G. later admitted to Ventura County detectives that they had these prescriptions dispensed to support B.G.'s addiction to the drugs. B.G. also admitted that he paid T.P., Dr. Bass' secretary, $80 in cash for prescriptions without seeing Dr. Bass.

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Patient T.P. and Family

e. T.P. was the only employee of Respondent that worked in his office. Respondents dispensed Dr. Bass' controlled substance prescriptions to T.P., her husband, K.P., and their 20-year-old daughter, S.P. Per T.P.'s patient profile, between November 1, 2006, and April 7, 2008, 84 prescriptions, written by Dr. Bass, were dispensed for T.P. 77 out of 84 prescriptions were for drugs most commonly ordered by Dr. Bass, Norco 10/325mg and Soma. Out of these 77 prescriptions, Respondent Daher dispensed 66 prescriptions and Yamasaki dispensed 11 prescriptions. Per K.P.'s patient profile, between November 3, 2006, and April 1, 2008, 134 prescriptions were dispensed for K.P., all written by Dr. Bass. 104 out of 134 prescriptions were for drugs most commonly ordered by Dr. Bass, Norco, Xanax, Valium and Soma, and also OxyContin. Out of these 104 prescriptions, Respondent Daher dispensed 75 prescriptions, Respondent Yamasaki dispensed 23 prescriptions, and Respondent Nabhan dispensed 6 prescriptions. Per S.P.'s patient profile, between September 13, 2007 and April 7, 2008, 23 prescriptions written by Dr. Bass were dispensed for S.P. for drugs most commonly ordered by Dr. Bass, Norco and Soma. Of these 23 prescriptions, Respondent Daher dispensed 21 prescriptions and Respondent Nabhan dispensed two prescriptions. From November 2006, to April 2008 (17 months) Respondents dispensed a total of 9,000 Norco, 1,960 OxyContin, 1,230 Xanax, 480 Valium and 2,765 Soma to this family.

f. Based on family relationship, prescribing the same narcotics, excessive furnishing and association with Dr. Bass, Respondents did not take proper steps to review the family's drug history and failed to verify if prescriptions were for a legitimate medical purpose, or ultimately stop dispensing these prescriptions.

Patient G.C. Jr. and family

g. Dr. Bass prescribed controlled substances and dangerous drugs to G.C. Jr., G.C. Jr.'s son, G.C. III, and his daughter, N.C. (DOB: 05/21/75), who according to their patient profiles, all shared the same phone number. G.C. Jr. and N.C. shared the same residence. They all lived in the City of Ventura. N.C. paid for a majority of her prescriptions in cash. G.C. III always paid for his prescriptions in cash.

h. G.C. Jr. and N.C. were on same medications prescribed by Dr. Bass: Bontril Slow Release 105mg, Adipex 37.5mg, Valium 10mg, and hydrocodone products (Norco 10/325mg, Lorcet 10/650mg, and Vicodin ES). Per their patient profiles, original prescriptions, and CURES data, G.C. Jr. and N.C. regularly came together and picked up their medications at the same time from Jay Scott Drugs or one of them picked up the other's prescriptions from 2006 to 2008. Although G.C. Jr. was 28 years older than N.C., Dr. Bass treated both patients with highly habit forming controlled substances, the same medications (stimulants and relaxants), and the same doses regardless of gender, medical condition, and weight.

i. Dr. Bass always wrote prescriptions for the same medications for G.C. III: hydrocodone products, Xanax, and Soma. G.C. III always paid cash for his prescriptions.

j. Respondent Jay Scott Drugs did not have any record indicating communication with Dr. Bass about the medical conditions and/or the drug therapy for these patients.

Patients S.R. and F.R.

k. Dr. Bass prescribed controlled substances and dangerous drugs to S.R. and F.R. S.R. and F.R. have the same last name. Per their profiles, S.R.'s address was in Ventura and F.R.'s address was in Santa Barbara, which is about 90 miles away from Jay Scott Drugs. They always paid for all their prescriptions in cash. From December 20, 2006 to April 7, 2008, S.R. and F.R. came together to Jay Scott Drugs to pick up their prescriptions or picked up each other's prescriptions. Despite the fact that F.R. is 23 years older than S.R., Dr. Bass always prescribed the same highly addictive medications with the same doses and the same directions to both S.R. and F.R.: Xanax 2mg, Soma, and hyrdrocodone products (Norco 10/325mg or Lorcet 10/650mg). Respondents did not discuss the medication conditions and/or the unusual drug therapy for these two patients with Dr. Bass.

Failed to use C.U.R.E.S.

41. Respondents failed to use the C.U.R.E.S. program as a tool to evaluate new or existing patients to determine if they appeared to be substance abusers, doctor shoppers, utilizing more than one pharmacy, or if the patient was breaking their pain management contract with Dr. Bass, which required that all controlled substances be obtained at the same pharmacy.

Patient J.C.

a. Patient J.C. started having his prescriptions filled by Jay Scott Drugs on October 30, 2006, at the age of 23 years old. J.C. always paid cash for his prescriptions. The distance from the patient's residence to Dr. Bass' office or to Jay Scott Drugs was approximately 17 miles. The CURES data for patient J.C. from January 1, 2006 to October 8, 2007, shows that when J.C. had his first prescriptions filled at Jay Scott Drugs on 10/30/06 and then on 11/10/06, J.C. had been seeing three different doctors, Drs. Bass, John Kukirka and Conchita Goings, for the same prescriptions, which were being filled at three different pharmacies other than Respondent Jay Scott Drugs in the previous seven (7) months. In one instance, J.C. had prescriptions for Norco, which were written by two different doctors, filled on at two different pharmacies on the same day, March 27, 2006. Had Respondents filled the first prescription and then requested information from the CURES system, Respondents would have seen the patient was seeing multiple doctors and using multiple pharmacies and would have known not to fill prescriptions for this patient, as these factors indicate that the prescriptions were not for a legitimate medical purpose.

Failed to adequately evaluate patients

42. Despite the foregoing red flags of excessive prescribing, Respondents did not have records to show Dr. Bass' patients' diagnosis, laboratory testing, or communication with Dr. Bass regarding appropriateness of therapy or legitimate medical need or evaluation of the patients. Respondents' decision to ignore these clear indications of excessive prescribing of controlled substances by Dr. Bass and drug seeking behavior of many of his patients and Respondents' decision to not aggressively work to determine the patients' diagnosis and evaluate patients for potential drug intoxication, adverse effects, signs of addiction or adequate pain control, placed numerous patients at risk, including, but not limited to, Patients A.S., D.L., A.W., L.G., D.K., J.S., and A.C., as follows:

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Patient A.S.

43. Per A.S.' patient profile, A.S. started to visit Dr. Bass and Respondent Jay Scott Drugs in January 2007, at the age of 21. A.S. always paid cash for his prescriptions. The distance from the patient's residence to Dr. Bass' office or to Jay Scott Drugs was approximately 40 miles.

44. Between January 5, 2007, and March 18, 2008 (approximately 14 months), Respondent Jay Scott Drugs dispensed 89 prescriptions for A.S, all written by Dr. Bass. 88 out of 89 prescriptions were for Norco, Xanax, or Soma. During this time period, A.S. received a total of 3,875 tablets of Norco 10/325mg, 1860 tablets of Xanax 2mg, 375 tablets of Soma, and one antibiotic. Of these 88 prescriptions, Respondent Daher dispensed 75 prescriptions, Respondent Yamasaki dispensed nine prescriptions, and Respondent Nabhan dispensed one prescription for this patient.

45. Dr. Bass did not change A.S.' drug regimen. Dr. Bass regularly prescribed Norco 10/325mg and Xanax 2mg in the same quantities with the same directions every 12-15 days, and Respondent Jay Scott Drugs was usually filling these prescriptions every 12 to 15 days.

46. If Respondents obtained a C.U.R.E.S. report for A.S. after December 1, 2007, they would have seen that on October 26, 2007, and November 5, 2007, the patient was treated with Subutex, a drug used to treat opiate addiction. Respondent Jay Scott Drugs would have known to inquire of Dr. Bass before dispensing further prescriptions to an addict. Obtaining a C.U.R.E.S. report would also have informed Respondents that A.S. was filling his controlled substance prescriptions at two other pharmacies, in violation of his pain treatment contract with Dr. Bass. Also, Respondents permitted various other people to pick up A.S.' controlled substance prescriptions.

47. Respondent Jay Scott Drugs did not have any written records supporting consultations with Dr. Bass regarding A.S.' existing diagnosis, medical conditions or legitimate medical purpose of the prescriptions. Respondents failed to continually evaluate the patient's needs and assure each prescription was written for a legitimate need, which ultimately resulted in the patient's death.

48. A.S. died on March 20, 2008, at the age of 22. A.S.' Death Investigation Report states that the cause of death was hydrocodone intoxication. Empty prescription containers for Norco (Hydrocodone/125 tablets) and Xanax (60 tablets), which were prescribed by Dr. Bass and dispensed by Respondent Daher on March 18, 2008, were found near his body.

Patient D.L.

49. Per D.L.'s patient profile, D.L. started to visit Dr. Bass and Respondent Jay Scott Drugs in May 2007, at the age of 24. The distance from the patient's residence to Dr. Bass' office or to Jay Scott Drugs was approximately 40 miles.

50. From May 2, 2007 to March 24, 2008 (10 months), Respondent Jay Scott Drugs dispensed 30 controlled substances and/or dangerous drugs prescriptions for D.L. All of these prescriptions were for drugs most commonly ordered by Dr. Bass, Norco, Soma, Ambien, and Valium. During this time period, D.L. received a total of 2,375 tablets of Norco 10/325mg, 120 tablets of Valium 10mg, 520 tablets of Soma and 90 tablets of Ambien. According to D.L.'s patient profile, Respondent Daher dispensed 23 prescriptions, Respondent Nabhan dispensed three (3) prescriptions, and Respondent Yamasaki dispensed four (4) prescriptions for this patient.

51. If Respondents obtained a C.U.R.E.S. report for D.L. after December 1, 2007, they would have seen that in September 2007 and October 2007, the patient was treated with Suboxone, a drug used to treat opiate addiction. Respondent Jay Scott Drugs would have known to inquire of Dr. Bass before dispensing further prescriptions to an addict.

52. Respondent Jay Scott Drugs did not have any records to show D.L.'s diagnosis, medical history, any laboratory testing, communication with Dr. Bass for patient care, evaluation of D.L.'s condition, and effectiveness of his medication regimen although D.L. was regularly on Norco, Soma, Valium, and Ambien, all prescribed by Dr. Bass. Respondents failed to continually evaluate the patient's needs and assure each prescription was written for a legitimate need, which ultimately resulted in the patient's death.

53. D.L. died on April 10, 2008, at the age of 25. D.L.'s Death Investigation Report states that the cause of death was Ambien, Soma, Valium and Cocaine toxicity. According to the C.U.R.E.S. report, the last prescriptions filled for D.L. before his death were for Norco, Valium,

and Ambien, which were prescribed by Dr. Bass and dispensed by Respondent Jay Scott Drugs on March 24, 2008.

Patient A.W.

54. Per A.W.'s patient profile, A.W. started to visit Dr. Bass and Respondent Jay Scott Drugs in February 2008, at the age of 31. A.W. always paid cash for her prescriptions. The distance from the patient's residence to Dr. Bass' office or to Jay Scott Drugs was approximately 28 miles.

55. Between February 6, 2008, and March 25, 2008 (48 days), Respondent Jay Scott Drugs dispensed 12 controlled substance prescriptions for A.W. All of these prescriptions were for drugs most commonly ordered by Dr. Bass, Norco, Valium and Soma. During this time period, A.W. received a total of 500 tablets of Norco 10/325mg, 300 tablets of Valium 10mg, 240 tablets of Soma. Of these 12 prescriptions, Respondent Daher dispensed nine (9) prescriptions and Respondent Yamasaki dispensed three (3) prescriptions for this patient.

56. Respondent Jay Scott Drugs did not have any records to show A.W.'s diagnosis, medical history, any laboratory testing, communication with Dr. Bass for patient care, evaluation of A.W.'s condition and effectiveness of her medication regimen although A.W. was regularly on Norco, Xanax, and Soma, prescribed by Dr. Bass. Respondents failed to continually evaluate the patient's needs and assure each prescription was written for a legitimate need, which ultimately resulted in the patient's death.

57. A.W. died on April 11, 2008, at the age of 31. A.W.'s Death Investigation Report states that she died from an overdose of Norco 10/325mg, Valium, and Morphine. According to A.W.'s patient profile, A.W.'s last prescriptions filled at Respondent Jay Scott Drugs before her death were Norco, Soma and Valium, prescribed by Dr. Bass and dispensed by Respondent Yamasaki on March 25, 2008.

Patient L.G.

58. Per L.G.'s patient profile, L.G. started to visit Dr. Bass and Respondent Jay Scott Drugs in June 2006, at the age of 19 years old. L.G. always paid cash for his prescriptions. The

distance from the patient's residence to Dr. Bass' office or to Jay Scott Drugs was approximately 30 miles.

59. Between September 20, 2006 and March 28, 2008 (18 months), Respondent Jay Scott Drugs dispensed 117 prescriptions for L.G. Out of 117 prescriptions, 105 were for drugs that were most commonly ordered by Dr. Bass, Norco, Xanax and Soma. During this time period, L.G. received a total of 3,500 tablets of Norco 10/325mg; 2160 tablets of Xanax, 2340 tablets of Soma, and 240 tablets of Desyrel.[9] Of these 105 prescriptions, Respondent Daher dispensed 75 prescriptions, Respondent Yamasaki dispensed 18 prescriptions, and Respondent Nabhan dispensed 12 prescriptions.

60. Respondent Jay Scott Drugs did not know the reason L.G. was taking the medications. There was no documentation of communication with Dr. Bass, documentation of discussions with the patient, or review of C.U.R.E.S. data for a person who was either 19 or 20 years old when he started receiving these prescriptions and paid cash for all of these prescriptions. Respondents failed to continually evaluate the patient's needs and assure each prescription was written for a legitimate need, which ultimately resulted in the patient's death.

61. L.G. died on April 13, 2008, at the age of 21. The Death Investigation Report states that the cause of death was an Oxycodone and Methamphetamine overdose. His toxicology report (blood) detected: Methamphetamine, Soma, benzodiazepines, opiates, and oxycodone 840ng/ml. Per the C.U.R.E.S. report, L.G.'s last prescription before his death was for Norco and Xanax on March 28, 2008, which was prescribed by Dr. Bass and dispensed by Respondent Jay Scott Drugs.

Patient D.K.

62. Per D.K.'s patient profile, D.K. started to visit Dr. Bass and Respondent Jay Scott Drugs in December 2006, at the age of 31. D.K. always paid cash for his prescriptions. The distance from the patient's residence to Dr. Bass' office or to Jay Scott Drugs was approximately 40 miles.

[9] Desyrel is an antidepressant.

63. Between December 7, 2006, and March 14, 2008, the date of D.K.'s death[10] (16 months), Respondent Jay Scott Drugs dispensed approximately 60 prescriptions for D.K. Out of the 60 prescriptions, approximately 57 were for drugs most commonly ordered by Dr. Bass, Norco, Xanax, Soma, Ambien, and Valium. During this period, D.K. received a total of 2,750 tablets of Norco, 1,200 tablets of Xanax, 240 tablets of Valium, and 64 tablets of Ambien. Of these 54 prescriptions, Respondent Daher dispensed 43 prescriptions, Respondent Nabhan dispensed 8 prescriptions, and Respondent Yamasaki dispensed 6 prescriptions.

64. There was no documentation that Respondents ever determined the legitimate need for these prescriptions. Respondent Jay Scott Drugs failed to share a corresponding responsibility while dispensing highly addictive medications to D.K., which put this patient at risk.

Patient J.S.

65. Per J.S.' patient profile, J.S. started to visit Dr. Bass and Respondent Jay Scott Drugs in October 2006, at the age of 21. The distance from the patient's residence to Jay Scott Drugs or Dr. Bass' office was approximately 40 miles. When prescriptions were filled too soon, Respondents alternated payment methods by J.S. between the insurance company and cash in order to dispense prescriptions without consulting Dr. Bass. When a new prescription for the same medication is billed too soon, the prescription insurance company would immediately reject the billing claim. J.S. was alternating types of payment between his insurance and cash because his insurance would not pay for the amount of drugs being prescribed and the frequency it was being dispensed.

66. Between October 31, 2006, and April 5, 2007 (approximately five months), Respondents dispensed a total of 36 controlled substance and/or dangerous drugs prescriptions for J.S., all of which were written by Dr. Bass. During this period, Respondent Daher dispensed a total of 1,625 tablets of Norco (including Nortab 10/500 mg, one incident), a total of 780 tablets of Xanax 2mg, and a total of 120 tablets of Soma, to J.S. Of these 36 prescriptions, Respondent Daher dispensed 22 prescriptions and Respondent Yamasaki dispensed 14 prescriptions to J.S.

[10] D.K. died of lobar pneumonia.

67. Respondents did not provide any records of communication with Dr. Bass regarding any of J.S.' prescriptions. Respondents failed to share a corresponding responsibility while dispensing highly addictive medications to J.S., which put this patient at risk.

68. During this period, J.S. became addicted to these drugs. He became extremely depressed, suicidal and violent. He quit school and could not hold a job. He was in a rehabilitation center on several occasions: December 2006, April 2007, July 2007 and late 2007.

Dr. Bamdad's prescribing pattern.

69. As with Dr. Bass, Respondents failed to evaluate and/or address Dr. Masoud Bamdad's suspect prescribing pattern. Dr. Bamdad's Prescriber Activity Report for the period of December 2006 through May 2008, provided that Respondents dispensed the following prescriptions written by Dr. Bamdad:

a. 543 prescriptions for Schedule II controlled substances, out of which all but eight (8) prescriptions were written for oxycodone products,

b. 136 prescriptions for Schedule III controlled substances, out of which all but two (2) prescriptions were hydrocodone products, mainly Norco,

c. 302 prescriptions for Schedule IV controlled substances, out of which all but 13 prescriptions were written for Xanax or Valium, mainly Xanax 2mg, and

d. 7 prescriptions of Schedule V controlled substances.

70. From December 2006 through May 2008, Respondent Jay Scott Drugs dispensed a total of 1,357 prescriptions written by Dr. Bamdad, out of which 980 prescriptions were controlled substances and 369 were dangerous drugs. This meant that 73% of the prescriptions written by Dr. Bamdad were for controlled substances, which is a much higher percentage of controlled substances written by one prescriber than normal. Despite the foregoing factors, Respondent Jay Scott Drugs continuously filled 1,357 prescriptions for Dr. Bamdad's patients between December 2006 and May 2008.

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Patient A.C.

71. Respondent failed to review A.C.'s patient profiles prior to dispensing controlled substances to him, which presented clear indications that the prescriptions written by Dr. Bamdad for A.C. were generally not issued for a legitimate medical purpose. Per A.C.'s patient profile, A.C. started to visit Dr. Bamdad and Respondent Jay Scott Drugs in December 2007, at the age of 22. A.C. always paid cash for his prescriptions. The distance from the patient's residence to Jay Scott Drugs or Dr. Bamdad's office was approximately 40 miles.

72. From December 11, 2007 to April 10, 2008 (5 months), Respondent Daher filled eight (8) controlled substance prescriptions for A.C., all of which were written by Dr. Bamdad. During this period, Respondent Daher dispensed to A.C. 270 tablets of Oxycodone and 240 tablets of Xanax 2mg.

73. Respondent Jay Scott Drugs did not have any documentation of consultations with Dr. Bamdad regarding A.C.'s diagnosis, medication conditions or the legitimate medical purpose of the prescriptions. Respondent Daher failed to continually evaluate the patient's needs and assure each prescription was written for a legitimate need, which contributed to A.C.'s death.

74. A.C. was found dead on April 14, 2008, at the age of 23. A.C.'s Death Investigation Report states that the cause of death was multiple drug effects, including significantly high Oxycodone levels. His last prescription was on April 10, 2008, for 90 tablets of OxyContin and 60 tablets of Xanax, written by Dr. Bamdad and dispensed by Respondent Daher.

FOURTH CAUSE FOR DISCIPLINE

(Failure to review patient profiles prior to dispensing prescriptions)

75. Respondents Ahmad Nabhan and Jun Respondent Yamasaki are subject to discipline pursuant to Code sections 4300 and 4301, subdivision (o), on the grounds of unprofessional conduct, in that Respondents Nabhan and Yamasaki failed to review N.V.'s profiles prior to dispensing prescriptions, in violation of Code section 4306.5, subdivision (c), and California Code of Regulations, title 16, sections 1707.3. Specifically, Respondent Nabhan and Respondent Yamasaki each filled one (1) prescription of Norco 10/35mg for N.V. early, without

reviewing N.V.'s patient profile, resulting in over dispensing of controlled substances, and/or, dangerous drugs, as set forth in paragraph 28, above.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

76. Respondents are subject to discipline pursuant to Code sections 4300 and 4301, in that Respondents committed unprofessional conduct, as more fully discussed in paragraphs 24 through 75, above.

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 Pharmacist License Number RPH 39189, issued Albert Farah Respondent Daher;

2. Revoking or suspending Pharmacist License Number RPH 41754, issued to Ahmad Nabhan;

3. Revoking or suspending Pharmacist License Number RPH 19983, issued to Jun Respondent Yamasaki;

4. Revoking or suspending Retail Pharmacy License Number PHY 40912, issued to Jay Scott Drugs, with Albert Farah Respondent Daher as Pharmacist-in-Charge;

5. Ordering Jay Scott Drugs, Albert Respondent Daher, Ahmad Nabhan, and Jun Respondent Yamasaki to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

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

DATED: 2/24/12

VIRGINIA K. HEROLD
Executive Officer
Board of Pharmacy
State of California
Complainant

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

In the Matter of the Accusation Against: Jay Scott Drugs PIC Albert Daher 2200 N. Glenoaks Burbank, CA 91504 Retail Pharmacy License Number PHY 40912, Albert Farah Daher 456 Audraine Drive Glendale, CA 91202 Pharmacist License Number RPH 39189, Ahmad Shati Nabhan 3234 Henrietta Ave La Crescenta, CA 91214 Pharmacist License Number RPH 41754, and Jun Yamasaki 511 E. Mount Curve Ave. Altadena, CA 91001 Pharmacist License Number RPH 19983 Respondents.	Case No. 3482 ACCUSATION

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Complainant alleges:

PARTIES

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

2. On or about June 27, 1995, the Board of Pharmacy issued Retail Pharmacy License Number PHY 40912 to Jay Scott Drugs (Respondent), located at 220 North Glenoaks, Burbank, California. Albert Farah Daher has been the sole owner of Jay Scott Drugs and Pharmacist-in-Charge of Jay Scott Drugs from 1998 to the present. The Retail Pharmacy License will expire on June 1, 2011, unless renewed.

3. On or about March 12, 1985, the Board of Pharmacy issued Pharmacist License Number RPH 39189 to Albert Farah Daher (Respondent Daher). The Pharmacist License will expire on January 31, 2011, unless renewed.

4. On or about April 20, 1988, the Board of Pharmacy issued Pharmacist License Number RPH 41754 to Ahmad Shati Nabhan (Respondent Nabhan). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2011, unless renewed.

5. On or about July 28, 1956, the Board of Pharmacy issued Pharmacist License Number RPH 19983 to Jun Yamasaki (Respondent Yamasaki). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2012, unless renewed.

JURISDICTION

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

7. Section 4300 of the Code provides, in part, that every license issued by the Board is subject to discipline, including suspension or revocation.

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8. Section 4302 of the Code states:

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

9. Section 4113 of the Code states, in part:

"(b) 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."

10. Section 118, subdivision (b), of the Code provides 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.

11. Section 4301 of the Code states:

"The board shall take action against any holder of a license who is guilty of unprofessional conduct . . . Unprofessional conduct shall include, but is not limited to, any of the following:

. . .

(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."

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12. Section 4306.5 of the Code 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."

13. Section 4063 of the Code states:

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

14. Health and Safety Code section 11153 states:

"(a) 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. Except as authorized by this division, the following are not legal prescriptions: (1) an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of

controlled substances, which is issued not in the course of professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use."

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 1716 states, in part:

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

17. 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

18. Section 125.3 of the Code provides, in 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.

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19. DRUG CLASSIFICATIONS

Brand Name(s)	Generic Name	Dangerous Drug Per Bus. & Prof. Code § 4022	Scheduled Drug per Health & Safety Code	Indications For Use
Ambien	Zolpidem (non-barbiturate, non-benzodiazepine sedative hypnotic)	Yes	Schedule IV	Insomnia
Desyrel	Trazodone	Yes	Not scheduled	Depression and anxiety
Halcion	Triazolam (non-barbiturate, benzodiazepine sedative hypnotic)	Yes	Schedule IV	Short-term treatment of insomnia
Heroin	Opium derivative	Not prescribed	Schedule I	no currently accepted medical use
Norco[1], Vicodin	Hydrocodone/ Acetaminophen (APAP)	Yes	Schedule III	Moderate to Severe Pain
OxyContin	Oxycodone	Yes	Schedule II	Moderate to Severe pain
Soma[2]	Carisoprodol	Yes	not scheduled	Muscle relaxant
Subutex, Suboxone	Buprenorphine	Yes	Schedule III	Narcotic Addiction
Valium	Diazepam (non-barbiturate, benzodiazepine sedative hypnotic)	Yes	Schedule IV	Anxiety
Vicodin	Hydrocodone/Acetaminophen	Yes	Schedule III	Pain
Xanax	Alprazolam (non-barbiturate, benzodiazepine sedative hypnotic)	Yes	Schedule IV	Anxiety

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[1] Norco 10/325 mg contains 10 mg of hydrocodone and 325 mg of acetaminophen (brand name, Tylenol). The maximum daily recommended dosage for acetaminophen is 4 grams.

[2] Drug abusers combine Soma with hydrocodone to produce similar effects to those of Heroin.

BACKGROUND

20. The Board initiated investigations of Respondents based upon the following:

a. Three (3) complaints against Respondents Jay Scott Drugs and Daher alleging that they excessively dispensed controlled substances to patients, which resulted in the deaths of Patients A.S.[3] and A.C. and the drug addiction of J.S. Patients A.S. and J.S. were Dr. Bernard Bass' patients and Patient A.C. was Dr. Masoud Bamdad's patient.

b. Ventura County Sheriff Department's criminal investigation of Dr. Bass for his involvement in the overdose deaths of seven of his patients, five of which had Dr. Bass' prescriptions filled at Respondent Jay Scott Drugs' facility, namely, A.S., D.L., A.W., L.G., and D.K. Dr. Bass' office was located at 10843 Magnolia Boulevard, North Hollywood, California, which was approximately five miles from Jay Scott Drugs' facility.

c. California Medical Board's investigation into Dr. Bass' medical practice and subsequent discipline, which involved allegations of gross negligence, excessive prescribing of controlled substances, and other violations, with regard to seven (7) patients[4] and subsequent discipline against Dr. Bass' medical license. The California Medical Board's Decision and Order in *In re Matter of the Accusation against Bernard N. Bass, M.D.*, Case No. 05-2005-167939, dated January 21, 2009, provided that Dr. Bass' physician license No. G 28057 was revoked, with revocation stayed, 90 days suspension, placed on seven (7) years probation, and required to surrender his United States Drug Enforcement Administration (DEA) permit to prescribe controlled substances.[5]

21. Based on the foregoing and the C.U.R.E.S.[6] data, the Board investigator selected

[3] For purposes of patient confidentiality, all patients are referred to by their initials. Upon a proper request for discovery, all patient records will be made available to Respondents.

[4] The seven patients involved in the California Medical Board's investigation regarding Dr. Bass are not the same seven patients involved in Ventura County Sheriff's investigation.

[5] In or about May 2008 Dr. Bass surrendered his DEA permit to Ventura County Sheriff's detectives.

[6] The Controlled Substance Utilization Review and Evaluation System or C.U.R.E.S. is a database maintained by the California Department of Justice, Bureau of Narcotic Enforcement, which allows pre-registered users, including licensed healthcare prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law

(continued...)

twenty six (26) patients (including deceased patients) of Dr. Bass, who received prescriptions from Jay Scott Drugs, and reviewed their patient profiles and original prescriptions.

22. Patient A.C.'s doctor, Dr. Bamdad, was investigated and federally indicated by the DEA for illegal drug distribution.[7] According to the indictments and a press release by United States Attorney's Office, dated May 6, 2009, in the criminal proceeding entitled *USA v. Masoud Bamdad*, United States District Court, Central District of California (Western Division - Los Angeles), Case No. 2:08-cr-00506-GW-1, Dr. Bamdad was convicted of 13 felony counts of federal narcotics charges[8] for writing prescriptions for Oxycodone for people he did not examine in exchange for as much as $300 in cash. Three of the charges upon which Bamdad was convicted concern prescriptions that were written for people under the age of 21.

FIRST CAUSE FOR DISCIPLINE

(Refill of prescriptions without prescriber's authorization)

23. Respondent Jay Scott Drugs and Respondent Daher are subject to discipline pursuant to Code sections 4300, 4301, subdivision (o), 4302, and 4113, on the grounds of unprofessional conduct, in that Respondents refilled prescriptions for controlled substances and dangerous drugs, without authorization, in violation of Code section 4063. Specifically, Respondent Daher refilled prescriptions, which did not contain authorized refills on the original prescription as follows:

Patient J.S.

a. On January 15, 2007, Respondent Daher refilled Rx no. 180576 (Norco 10/325 mg, 125 tablets) for J.S. without the prescribing doctor's authorization.

b. On January 22, 2007, Respondent Daher refilled Rx no. 182808 (Norco 10/325 mg, 125 tablets) for J.S. without the prescribing doctor's authorization.

enforcement, and regulatory boards, to access patient controlled substance history information.

[7] According a press release by United States Attorney's Office, dated May 6, 2009, Dr. Bamdad has been in custody since his arrest in April 2008, by DEA special agents.

[8] The jury found Dr. Bamdad guilty of ten felony counts of violating 21 U.S.C. § 841(a)(1), (b)(1)(C) (knowing and intentional unlawful distribution of controlled substances) and three felony counts of violating 21 U.S.C. § 859 (unlawful distribution of controlled substances to persons under age 21).

SECOND CAUSE FOR DISCIPLINE

(Failure to Review Drug Therapy and Patient Medication Record)

24. Respondent Jay Scott Drugs and Respondent Daher are subject to discipline pursuant to Code sections 4300, 4301, subdivision (o), 4302, and 4113, on the grounds of unprofessional conduct, in that Respondents failed to review the patient's drug therapy and medication record prior to dispensing prescriptions, in violation of Code section 4306.5, subdivision (c), and California Code of Regulations, title 16, sections 1707.3. The circumstances are as follows:

Patient J.S.

25. Respondent Daher filled prescriptions for highly addictive controlled substances early for J.S., without reviewing his patient profile, resulting in over dispensing controlled substances and/or dangerous drugs to J.S., as follows:

a. On January 24, 2007, Respondent Daher dispensed Rx No. 183632 (Norco 10/325mg) and Rx No. 183633 (Xanax 2mg, 60 tablets) for J.S. six (6) days earlier than the written directions indicated. The prescribing doctor dated the prescriptions January 30, 2007.

b. From January 15, 2007, to January 24, 2007, over a 10-day period, Respondent Daher dispensed 500 tablets of Norco, and from January 19, 2007, through January 24, 2007, over a 6-day period, Respondent Daher dispensed 120 tablets of Xanax, to J.S., as set forth in the table below:

Rx #	Drug	Date filled	RPH	Direction	Qty	
180576	Norco 10/325	1/15/07	AD	Take 1-2 tablets every 4 hours	125	Unauthorized refill
182808	Norco 10/325	1/19/07	AD	Take 1-2 tablets every 4 hours	125	
182809	Xanax 2mg	1/19/07	AD	Take 1 tablet every 6 hours	60	
182810	Soma 350 mg	1/19/07	AD	Take 1 tablet every night	10	
182808	Norco 10/325	1/22/07	AD	Take 1-2 tablets every 4 hours	125	Unauthorized refill
183632	Norco 10/325	1/24/07	AD	Take 1-2 tablets every 4 hours	125	Early fill
183633	Xanax 2mg	1/24/07	AD	Take 1 tablet every 6 hours	60	Early fill

The written directions for these medications are Norco 10/325mg, take 1-2 tablets every 4 hours (equals a maximum of 12 tablets per day); Xanax 2mg, take 1 every 6 hours (equals a maximum of 4 tablets per day); and Soma, take 1 tablet every night (1 tablet per day). Based on Respondent Daher's over dispensing, the patient was taking 20 tablets of Xanax per day and 50 tablets of Norco 10/325mg per day, which constitutes 16.25 grams of Tylenol per day. As a result, the patient was exposed to Tylenol toxicity.

Patient A.S.

26. Respondent Daher filled prescriptions for highly addictive controlled substances for A.S., without reviewing his patient profile, resulting over dispensing controlled substances and/or dangerous drugs to J.S., as follows:

a. On January 22, 2007, Respondent Daher dispensed Rx No. 183159 (Norco 10/325mg, 125 tablets), Rx No. 183160 (Xanax 2mg, 60 tablets), Rx 183162 (Soma, 15 tablets) for A.S. eight (8) days earlier than the written directions indicated. The prescribing doctor dated the prescriptions January 30, 2007.

b. In addition, three days earlier, on January 19, 2007, Respondent Daher had dispensed the identical prescriptions to A.S. (Norco 10/325 mg 125 tablets, Xanax 2mg 60 tablets, Soma 15 tablets). As a result, over a period of four days, from January 19, 2007, through January 22, 2007, Respondent Daher dispensed 250 tablets of Norco, 120 tablets of Xanax, and 30 tablets of Soma to A.S., as set forth in the table below:

Rx #	Date filled	Drug	RPH	Direction	Qty	
182811	1/19/07	Norco 10/325	AD	Take 1-2 tablets every 4 hours	125	
182812	1/19/07	Xanax 2mg	AD	Take 1 tablet every 6 hours	60	
182813	1/19/07	Soma 350 mg	AD	Take 1 tablet every night	15	
183159	1/22/07	Norco 10/325	AD	Take 1-2 tablets every 4 hours	125	
183160	1/22/07	Xanax 2mg	AD	Take 1 tablet every 6 hours	60	
183162	1/22/07	Soma 350 mg	AD	Take 1 tablet every night	15	

Based on Respondent Daher's over dispensing, the patient was taking 62 tablets of Norco 10/325mg, 30 tablets of Xanax 2mg, and 7 tablets of Soma per day. 62 tablets of Norco

10/325mg constitute 20 mg of Tylenol, five (5) times the recommended daily dose. As a result, the patient was exposed to Tylenol toxicity.

Patient N.V.

27. On seven (7) occasions Respondent Jay Scott Drugs dispensed prescriptions for highly addictive controlled substances early for N.V., without reviewing N.V.'s patient profile. By filling the prescriptions early, Respondents over dispensed controlled substances and/or dangerous drugs to N.V., as follows:

a. On March 29, 2007, Respondent Daher dispensed a refill of Norco 10/325mg six (6) days early.

b. On May 29, 2007 Respondent Nabhan dispensed a refill of Norco 10/325mg seven (7) days early.

c. On June 26, 2007. Respondent Yamasaki dispensed a refill of Norco 10/325mg nine (9) days early.

d. On October 15, 2007, Respondent Daher dispensed a refill of Norco 10/325mg five (5) days early.

e. On February 12, 2008, Respondent Daher dispensed a refill of Norco 10/325mg six (6) days early.

f. On March 13, 2008, Respondent Daher dispensed a refill of Norco 10/325mg five (5) days early.

g. On April 4, 2008, Respondent Daher dispensed a refill of Norco 10/325mg six (6) days early.

THIRD CAUSE FOR DISCIPLINE

(Failure to Exercise Professional Judgment)

28. Respondents are subject to discipline pursuant to Code sections 4300 and 4301, subdivision (d), (j) and (o), on the grounds of unprofessional conduct, in that they failed to exercise professional judgment and failed to share a corresponding responsibility with regard to the dispensing or furnishing of controlled substances and/or dangerous drugs, in violation of Code section 4306.5, subdivision (b), Health and Safety Code section 11153, and California Code of

Regulations, title 16, section 1761, subdivision (b), which put their patients at risk. Respondents dispensed prescriptions that they knew or had an objective reason to know that said prescriptions were not issued for a legitimate medical purpose. The circumstances are as follows:

Dr. Bass' prescribing pattern

29. Respondents failed to adequately evaluate and/or address Dr. Bass' suspect prescribing pattern or his patients' profiles prior to dispensing controlled substances to Dr. Bass' patients, which presented clear indications that numerous prescriptions written by Dr. Bass were not issued for a legitimate medical purpose. Respondents failed to evaluate the totality of the circumstances presented by Dr. Bass' prescribing pattern, including, but not limited to, the fact that Dr. Bass wrote an unusually large number of controlled substance prescriptions, wrote few if any prescriptions that were not controlled substances except Soma, he prescribed the same drugs with the same dosages, directions and quantities without adjustments for numerous patients, including patients in the same family, he prescribed illogical drug combinations, his practice included an unusually large number of young patients for pain management, who traveled 30 or 40 miles to see Dr. Bass or have their prescriptions filled at Respondent Jay Scott Drugs, and paid for their prescriptions in cash.

Unusually large number of controlled substance prescriptions

30. Dr. Bass wrote an unusually large number of controlled substance prescriptions. From October 2006 through April 2008, Respondent Jay Scott Drugs dispensed 33,742 controlled substance prescriptions written by Dr. Bass, not including the approximately 9,481 prescriptions for Soma.[9] During that period the pharmacy operated approximately 493 days. Therefore, Respondent Jay Scott Drugs dispensed approximately 1775 controlled substance prescriptions written by Dr. Bass per month or an average of approximately 68 controlled substance prescriptions per day for 19 months. The large number of controlled substance prescriptions dispensed per day written by Dr. Bass should have alerted Respondents to carefully monitor patients and carefully document that monitoring, which they failed to do.

[9] Dr. Bass' prescription history with Jay Scott Drugs was 608 pages long for the time period January 1, 2006, through May 8, 2009, with very few prescriptions dispensed during 2006.

Few if any prescriptions other than controlled substances and Soma

31. Respondents failed to consider that Dr. Bass patients had very few if any prescriptions other than those pain medications and Soma ordered by Dr. Bass, filled at Jay Scott Drugs. Normally patients have a number of different types of prescriptions dispensed, not just controlled substance prescriptions. Most patients reviewed either had no other prescriptions for other types of medications or abnormally few other types of prescriptions dispensed by Respondent Jay Scott Drugs.

Same drug regimen

32. The typical drug regimen that Dr. Bass used and was dispensed by Respondent Jay Scott Drug was for the same drugs, Norco 10/325mg, Xanax 2mg (or Valium 10mg), and Soma, with the same dosages, quantities, and directions, as follows:

Drug name	Quantity (tablet)	Direction
Norco 10/325mg	125	Take 1-2 tablets every 4 hours
Xanax 2mg	60	Take 1 tablet every 6 hours
Soma	60	Take 1 tablet four times a day

The prescriptions were rarely varied for a patient from the first visit to the last or from patient to patient. There were no indications of any dosage adjustments according to the severity of the pain. Dr. Bass rarely prescribed other pain management drugs other than Norco 10/325mg. Respondents failed to adequately evaluate why a pain management specialist, Dr. Bass, would prescribe the same drug regimen for so many of their patients, without differentiation for age, weight, degree of pain, and medical history.

Illogical drug combinations

33. Respondents failed to question illogical drug combinations. There are two subtypes of nonbarbiturate sedative hypnotics, benzodiazepine and non-benzodiazepine. Valium, Xanax, and Halcion are examples of benzodiazepines and Ambien is an example of a non-benzodiazepine hypnotic. Seven (7) of Dr. Bass' patients that filled their prescriptions at Jay Scott Drugs were prescribed more than one non-barbiturate sedative hypnotic, as follows:

a. D.L. - Ambien and Valium

b. D.K. - Xanax, Ambien, and Valium

c. K.P. - Xanax and Valium

d. B.G. - Xanax and Valium

e. D.S. - Xanax, Ambien, and Valium

f. J.V. - Ambien and Halcion

g. L.G. - Xanax and Valium.

There is no documentation of any inquiry of Dr. Bass by Respondents about the duplicate therapy for these patients.

Unusual Age of Patients for Pain Management

34. Respondents did not consider the fact that most of Dr. Bass' patients for whom he prescribed pain killers on a regular basis were in their 20's or early 30's. The five deceased individuals investigated by Ventura County Sheriff's Department who had prescriptions filled at Respondent Jay Scott Drugs ranged in age from 19 to 31. Respondents dispensed these same controlled substances and Soma to 16 younger adults less than 25 years old, primarily during a 19-month period from October 2006 through April 2008, in addition to other patients of Dr. Bass. Late teens and early 20's is an unusual age for pain management. Most of the teens or young adults were apparently healthy individuals that would be expected to have occasional antibiotics for infections or for the females, perhaps birth control pills. These patients were rarely treated for common medical problems or typical medical care for this age group. They were regularly on very high dosages of pain control medications, benzodiazepine controlled substance anti-anxiety agents, and muscle relaxants.

Distances traveled

35. Respondents failed to consider that many of Dr. Bass' patients traveled approximately 30 or 40 miles to see Dr. Bass or have their prescriptions filled at Respondent Jay Scott Drugs, especially since Dr. Bass' patients were allegedly in pain and had to return to see Dr. Bass every 12 to 15 days to obtain a new prescription.

Method of Payment: Cash

36. Respondents failed to consider that numerous patients of Dr. Bass paid for their prescriptions only in cash. For example, Respondent Jay Scott Drugs' Daily Log for Controlled Substance for Schedule III to V, dated September 7, 2007, indicated that 93 out of 132 prescriptions filled on that date were for Dr. Bass' patients. 71 out of 93 prescriptions were paid by cash. Therefore, 76% of prescriptions written by Dr. Bass and dispensed by Respondents were paid by cash on that date. Similarly, the Daily Log on September 19, 2007, for Controlled Substance for Schedule III to V indicated that 75 prescriptions out of 105 prescriptions were for Dr. Bass' patients. 56 out of 75 prescriptions were paid by cash. Therefore, 74% of prescriptions written by Dr. Bass were paid by cash. Also, four out of five patients of both Dr. Bass and Respondent Jay Scott Drugs who died (A.S., D.L., A.W., L.G., and D.K.) paid only in cash for their prescriptions. Only patient D.L. appeared to have some other method of payment.

Family members

37. Respondents did not question the fact that Dr. Bass wrote the same pain killer prescriptions for family members of his patients, with no differentiation for age, weight or degree of pain.

Patients B.G. and C.G.

a. Per the patient's profile, B.G. and C.G., who are siblings, started to visit Dr. Bass and Respondent Jay Scott Drugs in October 2006, when B.G. was 25 years old and his sister, C.G., was 23 years old. They always paid for their prescriptions in cash. They lived at the same residence and the distance from their residence to Dr. Bass' office or Jay Scott Drugs was approximately 40 miles.

b. Respondents dispensed Dr. Bass' prescriptions for the same drugs (Norco 10/325mg and Xanax 2mg) to B.G. and C.G., who are brother and sister. On eight (8) occasions Respondents dispensed the same drugs on the same day to B.G. and C.G. for a total of 32 such prescriptions. Of these 32 prescriptions, Respondent Daher and Respondent Yamasaki each dispensed 16 such prescriptions to the siblings. Between October 30, 2006, and March 31, 2008, Respondent Jay Scott Drugs dispensed 103 prescriptions written by Dr. Bass for B.G., all for

Norco, Xanax, Soma or Valium. Between October 30, 2006, and April 9, 2008, Respondents dispensed 72 prescriptions, written by Dr. Bass for C.G., all for Norco or Xanax.

c. Respondent Jay Scott Drugs did not have any record indicating communication with Dr. Bass about the medical conditions and/or drug therapy of the siblings.

d. B.G. and C.G. later admitted to Ventura County detectives that they had these prescriptions dispensed to support B.G.'s addiction to the drugs. B.G. also admitted that he paid T.P., Dr. Bass' secretary, $80 in cash for prescriptions without seeing Dr. Bass.

Patient T.P. and Family

e. T.P. was the only employee of Respondent that worked in his office. Respondents dispensed Dr. Bass' controlled substance prescriptions to T.P., her husband, K.P., and their 20-year-old daughter, S.P. Per T.P.'s patient profile, between November 1, 2006, and April 7, 2008, 84 prescriptions, written by Dr. Bass, were dispensed for T.P. 77 out of 84 prescriptions were for drugs most commonly ordered by Dr. Bass, Norco 10/325mg and Soma. Out of these 77 prescriptions, Respondent Daher dispensed 66 prescriptions and Yamasaki dispensed 11 prescriptions. Per K.P.'s patient profile, between November 3, 2006, and April 1, 2008, 134 prescriptions were dispensed for K.P., all written by Dr. Bass. 104 out of 134 prescriptions were for drugs most commonly ordered by Dr. Bass, Norco, Xanax, Valium and Soma, and also OxyContin. Out of these 104 prescriptions, Respondent Daher dispensed 75 prescriptions, Respondent Yamasaki dispensed 23 prescriptions, and Respondent Nabhan dispensed 6 prescriptions. Per S.P.'s patient profile, between September 13, 2007 and April 7, 2008, 23 prescriptions written by Dr. Bass were dispensed for S.P. for drugs most commonly ordered by Dr. Bass, Norco and Soma. Of these 23 prescriptions, Respondent Daher dispensed 21 prescriptions and Respondent Nabhan dispensed two prescriptions. From November 2006, to April 2008 (17 months) Respondents dispensed a total of 9,000 Norco, 1,960 OxyContin, 1,230 Xanax, 480 Valium and 2,765 Soma to this family.

f. Based on family relationship, prescribing the same narcotics, excessive furnishing and association with Dr. Bass, Respondents did not take proper steps to review the family's drug

history and failed to verify if prescriptions were for a legitimate medical purpose, or ultimately stop dispensing these prescriptions.

Failed to use C.U.R.E.S.

38. Respondents failed to use the C.U.R.E.S. program as a tool to evaluate new or existing patients to determine if they appeared to be substance abusers, doctor shoppers, utilizing more than one pharmacy, or if the patient was breaking their pain management contract with Dr. Bass, which required that all controlled substances be obtained at the same pharmacy.

Failed to adequately evaluate patients

39. Despite the foregoing red flags of excessive prescribing, Respondents did not have records to show Dr. Bass' patients' diagnosis, laboratory testing, or communication with Dr. Bass regarding appropriateness of therapy or legitimate medical need or evaluation of the patients. Respondents' decision to ignore these clear indications of excessive prescribing of controlled substances by Dr. Bass and drug seeking behavior of many of his patients and Respondents' decision to not aggressively work to determine the patients' diagnosis and evaluate patients for potential drug intoxication, adverse effects, signs of addiction or adequate pain control, placed numerous patients at risk, including, but not limited to, Patients A.S., D.L., A.W., L.G., D.K., J.S., and A.C., as follows:

Patient A.S.

40. Per A.S.' patient profile, A.S. started to visit Dr. Bass and Respondent Jay Scott Drugs in January 2007, at the age of 21. A.S. always paid cash for his prescriptions. The distance from the patient's residence to Dr. Bass' office or to Jay Scott Drugs was approximately 40 miles.

41. Between January 5, 2007, and March 18, 2008 (approximately 14 months), Respondent Jay Scott Drugs dispensed 89 prescriptions for A.S, all written by Dr. Bass. 88 out of 89 prescriptions were for Norco, Xanax, or Soma. During this time period, A.S. received a total of 3,875 tablets of Norco 10/325mg, 1860 tablets of Xanax 2mg, 375 tablets of Soma, and one antibiotic. Of these 88 prescriptions, Respondent Daher dispensed 75 prescriptions, Respondent

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Yamasaki dispensed nine prescriptions, and Respondent Nabhan dispensed one prescription for this patient.

42. Dr. Bass did not change A.S.' drug regimen. Dr. Bass regularly prescribed Norco 10/325mg and Xanax 2mg in the same quantities with the same directions every 12-15 days, and Respondent Jay Scott Drugs was usually filling these prescriptions every 12 to 15 days.

43. If Respondents obtained a C.U.R.E.S. report for A.S. after December 1, 2007, they would have seen that on October 26, 2007, and November 5, 2007, the patient was treated with Subutex, a drug used to treat opiate addiction. Respondent Jay Scott Drugs would have known to inquire of Dr. Bass before dispensing further prescriptions to an addict. Obtaining a C.U.R.E.S. report would also have informed Respondents that A.S. was filling his controlled substance prescriptions at two other pharmacies, in violation of his pain treatment contract with Dr. Bass..

44. Respondent Jay Scott Drugs did not have any written records supporting consultations with Dr. Bass regarding A.S.' existing diagnosis, medical conditions or legitimate medical purpose of the prescriptions. Respondents failed to continually evaluate the patient's needs and assure each prescription was written for a legitimate need, which ultimately resulted in the patient's death.

45. A.S. died on March 20, 2008, at the age of 22. A.S.' Death Investigation Report states that the cause of death was hydrocodone intoxication. Empty prescription containers for Norco (Hydrocodone/125 tablets) and Xanax (60 tablets), which were prescribed by Dr. Bass and dispensed by Respondent Daher on March 18, 2008, were found near his body.

Patient D.L.

46. Per D.L.'s patient profile, D.L. started to visit Dr. Bass and Respondent Jay Scott Drugs in May 2007, at the age of 24. The distance from the patient's residence to Dr. Bass' office or to Jay Scott Drugs was approximately 40 miles.

47. From May 2, 2007 to March 24, 2008 (10 months), Respondent Jay Scott Drugs dispensed 30 controlled substances and/or dangerous drugs prescriptions for D.L. All of these prescriptions were for drugs most commonly ordered by Dr. Bass, Norco, Soma, Ambien, and Valium. During this time period, D.L. received a total of 2,375 tablets of Norco 10/325mg, 120

tablets of Valium 10mg, 520 tablets of Soma and 90 tablets of Ambien. According to D.L.'s patient profile, Respondent Daher dispensed 23 prescriptions, Respondent Nabhan dispensed three (3) prescriptions, and Respondent Yamasaki dispensed four (4) prescriptions for this patient.

48. If Respondents obtained a C.U.R.E.S. report for D.L. after December 1, 2007, they would have seen that in September 2007 and October 2007, the patient was treated with Suboxone, a drug used to treat opiate addiction. Respondent Jay Scott Drugs would have known to inquire of Dr. Bass before dispensing further prescriptions to an addict.

49. Respondent Jay Scott Drugs did not have any records to show D.L.'s diagnosis, medical history, any laboratory testing, communication with Dr. Bass for patient care, evaluation of D.L.'s condition, and effectiveness of his medication regimen although D.L. was regularly on Norco, Soma, Valium, and Ambien, all prescribed by Dr. Bass. Respondents failed to continually evaluate the patient's needs and assure each prescription was written for a legitimate need, which ultimately resulted in the patient's death.

50. D.L. died on April 10, 2008, at the age of 25. D.L.'s Death Investigation Report states that the cause of death was Ambien, Soma, Valium and Cocaine toxicity. According to the C.U.R.E.S. report, the last prescriptions filled for D.L. before his death were for Norco, Valium, and Ambien, which were prescribed by Dr. Bass and dispensed by Respondent Jay Scott Drugs on March 24, 2008.

Patient A.W.

51. Per A.W.'s patient profile, A.W. started to visit Dr. Bass and Respondent Jay Scott Drugs in February 2008, at the age of 31. A.W. always paid cash for her prescriptions. The distance from the patient's residence to Dr. Bass' office or to Jay Scott Drugs was approximately 28 miles.

52. Between February 6, 2008, and March 25, 2008 (48 days), Respondent Jay Scott Drugs dispensed 12 controlled substance prescriptions for A.W. All of these prescriptions were for drugs most commonly ordered by Dr. Bass, Norco, Valium and Soma. During this time period, A.W. received a total of 500 tablets of Norco 10/325mg, 300 tablets of Valium 10mg, 240

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tablets of Soma. Of these 12 prescriptions, Respondent Daher dispensed nine (9) prescriptions and Respondent Yamasaki dispensed three (3) prescriptions for this patient.

53. Respondent Jay Scott Drugs did not have any records to show A.W.'s diagnosis, medical history, any laboratory testing, communication with Dr. Bass for patient care, evaluation of A.W.'s condition and effectiveness of her medication regimen although A.W. was regularly on Norco, Xanax, and Soma, prescribed by Dr. Bass. Respondents failed to continually evaluate the patient's needs and assure each prescription was written for a legitimate need, which ultimately resulted in the patient's death.

54. A.W. died on April 11, 2008, at the age of 31. A.W.'s Death Investigation Report states that she died from an overdose of Norco 10/325mg, Valium, and Morphine. According to A.W.'s patient profile, A.W.'s last prescriptions filled at Respondent Jay Scott Drugs before her death were Norco, Soma and Valium, prescribed by Dr. Bass and dispensed by Respondent Yamasaki on March 25, 2008.

Patient L.G.

55. Per L.G.'s patient profile, L.G. started to visit Dr. Bass and Respondent Jay Scott Drugs in June 2006, at the age of 19 years old. L.G. always paid cash for his prescriptions. The distance from the patient's residence to Dr. Bass' office or to Jay Scott Drugs was approximately 30 miles.

56. Between September 20, 2006 and March 28, 2008 (18 months), Respondent Jay Scott Drugs dispensed 117 prescriptions for L.G. Out of 117 prescriptions, 105 were for drugs that were most commonly ordered by Dr. Bass, Norco, Xanax and Soma. During this time period, L.G. received a total of 3,500 tablets of Norco 10/325mg, 2160 tablets of Xanax, 2340 tablets of Soma, and 240 tablets of Desyrel.[10] Of these 105 prescriptions, Respondent Daher dispensed 75 prescriptions, Respondent Yamasaki dispensed 18 prescriptions, and Respondent Nabhan dispensed 12 prescriptions.

57. Respondent Jay Scott Drugs did not know the reason L.G. was taking the medications. There was no documentation of communication with Dr. Bass, documentation of

[10] Desyrel is an antidepressant.

discussions with the patient, or review of C.U.R.E.S. data for a person who was either 19 or 20 years old when he started receiving these prescriptions and paid cash for all of these prescriptions. Respondents failed to continually evaluate the patient's needs and assure each prescription was written for a legitimate need, which ultimately resulted in the patient's death.

58. L.G. died on April 13, 2008, at the age of 21. The Death Investigation Report states that the cause of death was an Oxycodone and Methamphetamine overdose. His toxicology report (blood) detected: Methamphetamine, Soma, benzodiazepines, opiates, and oxycodone 840ng/ml. Per the C.U.R.E.S. report, L.G.'s last prescription before his death was for Norco and Xanax on March 28, 2008, which was prescribed by Dr. Bass and dispensed by Respondent Jay Scott Drugs.

Patient D.K.

59. Per D.K.'s patient profile, D.K. started to visit Dr. Bass and Respondent Jay Scott Drugs in December 2006, at the age of 31. D.K. always paid cash for his prescriptions. The distance from the patient's residence to Dr. Bass' office or to Jay Scott Drugs was approximately 40 miles.

60. Between December 7, 2006, and March 14, 2008, the date of D.K.'s death[11] (16 months), Respondent Jay Scott Drugs dispensed approximately 60 prescriptions for D.K. Out of the 60 prescriptions, approximately 57 were for drugs most commonly ordered by Dr. Bass, Norco, Xanax, Soma, Ambien, and Valium. During this period, D.K. received a total of 2,750 tablets of Norco, 1,200 tablets of Xanax, 240 tablets of Valium, and 64 tablets of Ambien. Of these 54 prescriptions, Respondent Daher dispensed 43 prescriptions, Respondent Nabhan dispensed 8 prescriptions, and Respondent Yamasaki dispensed 6 prescriptions.

61. There was no documentation that Respondents ever determined the legitimate need for these prescriptions. Respondent Jay Scott Drugs failed to share a corresponding responsibility while dispensing highly addictive medications to D.K., which put this patient at risk.

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[11] D.K. died of lobar pneumonia.

Patient J.S.

62. Per J.S.' patient profile, J.S. started to visit Dr. Bass and Respondent Jay Scott Drugs in October 2006, at the age of 21. The distance from the patient's residence to Jay Scott Drugs or Dr. Bass' office was approximately 40 miles. When prescriptions were filled too soon, Respondents alternated payment methods by J.S. between the insurance company and cash in order to dispense prescriptions without consulting Dr. Bass. When a new prescription for the same medication is billed too soon, the prescription insurance company would immediately reject the billing claim. J.S. was alternating types of payment between his insurance and cash because his insurance would not pay for the amount of drugs being prescribed and the frequency it was being dispensed.

63. Between October 31, 2006, and April 5, 2007 (approximately five months), Respondents dispensed a total of 36 controlled substance and/or dangerous drugs prescriptions for J.S., all of which were written by Dr. Bass. During this period, Respondent Daher dispensed a total of 1,625 tablets of Norco (including Nortab 10/500 mg, one incident), a total of 780 tablets of Xanax 2mg, and a total of 120 tablets of Soma, to J.S. Of these 36 prescriptions, Respondent Daher dispensed 22 prescriptions and Respondent Yamasaki dispensed 14 prescriptions to J.S.

64. Respondents did not provide any records of communication with Dr. Bass regarding any of J.S.' prescriptions. Respondents failed to share a corresponding responsibility while dispensing highly addictive medications to J.S., which put this patient at risk.

65. During this period, J.S. became addicted to these drugs. He became extremely depressed, suicidal and violent. He quit school and could not hold a job. He was in a rehabilitation center on several occasions: December 2006, April 2007, July 2007 and late 2007.

Dr. Bambad's prescribing pattern.

66. As with Dr. Bass, Respondents failed to evaluate and/or address Dr. Masoud Bamdad's suspect prescribing pattern. Dr. Bamdad's Prescriber Activity Report for the period of December 2006 through May 2008, provided that Respondents dispensed the following prescriptions written by Dr. Bamdad:

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a. 543 prescriptions for Schedule II controlled substances, out of which all but eight (8) prescriptions were written for oxycodone products,

b. 136 prescriptions for Schedule III controlled substances, out of which all but two (2) prescriptions were hydrocodone products, mainly Norco,

c. 302 prescriptions for Schedule IV controlled substances, out of which all but 13 prescriptions were written for Xanax or Valium, mainly Xanax 2mg, and

d. 7 prescriptions of Schedule V controlled substances.

67. From December 2006 through May 2008, Respondent Jay Scott Drugs dispensed a total of 1,357 prescriptions written by Dr. Bamdad, out of which 980 prescriptions were controlled substances and 369 were dangerous drugs. This meant that 73% of the prescriptions written by Dr. Bamdad were for controlled substances, which is a much higher percentage of controlled substances written by one prescriber than normal. Despite the foregoing factors, Respondent Jay Scott Drugs continuously filled 1,357 prescriptions for Dr. Bamdad's patients between December 2006 and May 2008.

Patient A.C.

68. Respondent failed to review A.C.'s patient profiles prior to dispensing controlled substances to him, which presented clear indications that the prescriptions written by Dr. Bamdad for A.C. were generally not issued for a legitimate medical purpose. Per A.C.'s patient profile, A.C. started to visit Dr. Bamdad and Respondent Jay Scott Drugs in December 2007, at the age of 22. A.C. always paid cash for his prescriptions. The distance from the patient's residence to Jay Scott Drugs or Dr. Bamdad's office was approximately 40 miles.

69. From December 11, 2007 to April 10, 2008 (5 months), Respondent Daher filled eight (8) controlled substance prescriptions for A.C., all of which were written by Dr. Bamdad. During this period, Respondent Daher dispensed to A.C. 270 tablets of Oxycodone and 240 tablets of Xanax 2mg.

70. Respondent Jay Scott Drugs did not have any documentation of consultations with Dr. Bamdad regarding A.C.'s diagnosis, medication conditions or the legitimate medical purpose of the prescriptions. Respondent Daher failed to continually evaluate the patient's needs and

assure each prescription was written for a legitimate need, which contributed to A.C.'s death.

71. A.C. was found dead on April 14, 2008, at the age of 23. A.C.'s Death Investigation Report states that the cause of death was multiple drug effects, including significantly high Oxycodone levels. His last prescription was on April 10, 2008, for 90 tablets of OxyContin and 60 tablets of Xanax, written by Dr. Bamdad and dispensed by Respondent Daher.

FOURTH CAUSE FOR DISCIPLINE

(Failure to review patient profiles prior to dispensing prescriptions)

72. Respondents Ahmad Nabhan and Jun Respondent Yamasaki are subject to discipline pursuant to Code sections 4300 and 4301, subdivision (o), on the grounds of unprofessional conduct, in that Respondents Nabhan and Yamasaki failed to review N.V.'s profiles prior to dispensing prescriptions, in violation of Code section 4306.5, subdivision (c), and California Code of Regulations, title 16, sections 1707.3. Specifically, Respondent Nabhan filled one (1) prescription and Respondent Yamasaki filled one (1) prescription for N.V. early, namely Norco, without reviewing N.V.'s patient profile, resulting in over dispensing of controlled substances, and/or, dangerous drugs, as set forth in paragraph 25, above.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

73. Respondents are subject to discipline pursuant to Code sections 4300 and 4301, in that Respondents committed unprofessional conduct, as more fully discussed in paragraphs 23 through 72, above.

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 Pharmacist License Number RPH 39189, issued Albert Farah Respondent Daher;

2. Revoking or suspending Pharmacist License Number RPH 41754, issued to Ahmad Nabhan;

3. Revoking or suspending Pharmacist License Number RPH 19983, issued to Jun Respondent Yamasaki;

4. Revoking or suspending Retail Pharmacy License Number PHY 40912, issued to Jay Scott Drugs, with Albert Farah Respondent Daher as Pharmacist-in-Charge;

5. Ordering Jay Scott Drugs, Albert Respondent Daher, Ahmad Nabhan, and Jun Respondent Yamasaki to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

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

DATED: 8/4/10

VIRGINIA K. HEROLD
Executive Officer
Board of Pharmacy
State of California
Complainant

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Maximiliano Martinez Jr.

ATTORNEY GENERAL LOS ANGELES

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