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

In the Matter of the Accusation Against: **PETER CRAIG CALDWELL, doing Business as L M CALDWELL PHARMACIST** **PETER CRAIG CALDWELL, OWNER** **Pharmacy Permit No. PHY 30911** **PETER CRAIG CALDWELL, doing Business as L M CALDWELL PHARMACIST** **PETER CRAIG CALDWELL, OWNER** **Pharmacy Permit No. PHY 30912** **PETER CRAIG CALDWELL** **RPH 25356** **ABDUL YAHYAVI** **RPH 30041** Respondents.	Case No. 4867 OAH No. 2015100819 **AS TO PETER CRAIG CALDWELL DOING BUSINESS AS L M CALDWELL PHARMACIST (PHY30911), PETER CRAIG CALDWELL DOING BUSINESS AS L M CALDWELL PHARMACIST (PHY 30912) ONLY**

DECISION AND ORDER

The attached Stipulated Surrender of License and Order is hereby adopted by the Board of Pharmacy, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective at 5:00 p.m. on November 23, 2016.

It is so ORDERED on October 24, 2016.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By _____
Amy Gutierrez, Pharm.D.
Board President

KAMALA D. HARRIS
Attorney General of California
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **PETER CRAIG CALDWELL doing business as L M CALDWELL PHARMACIST** **PETER CRAIG CALDWELL, OWNER** **1509 State St.** **Santa Barbara, CA 93101** **Pharmacy Permit No. PHY 30911** **PETER CRAIG CALDWELL doing business as L M CALDWELL PHARMACIST** **PETER CRAIG CALDWELL, OWNER** **235 West Pueblo St.** **Santa Barbara, CA 93105** **Pharmacy Permit No. PHY 30912** **PETER CRAIG CALDWELL** **1509 State St.** **Santa Barbara, CA 93101** **Pharmacist License No. RPH 25356** **ABDUL YAHYAVI** **1624 La Coronilla Drive.** **Santa Barbara, CA 93109** **Pharmacist License No. RPH 30041** Respondents.	Case No. 4867 OAH No. 2015100819 **STIPULATED SURRENDER OF LICENSE AND ORDER** **AS TO PETER CRAIG CALDWELL DOING BUSINESS AS L M CALDWELL PHARMACIST (PHY 30911), PETER CRAIG CALDWELL DOING BUSINESS AS L M CALDWELL PHARMACIST(PHY 30912) ONLY**

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IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Virginia Herold (Complainant) is the Executive Officer of the Board of Pharmacy. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Cristina Felix, Deputy Attorney General.

2. On or about December 1, 1984, the Board of Pharmacy issued Pharmacy Permit Number PHY 30911 to Peter Caldwell to do business as L M Caldwell Pharmacist located at 1509 State Street, Santa Barbara, CA 93101. Peter C. Caldwell has been the individual licensed owner since December 13, 1984. The Pharmacy Permit was in full force and effect at all times relevant to the charges brought in the Second Amended Accusation No. 4867 and will expire on December 1, 2016, unless renewed. Peter Craig Caldwell has been the individual licensed owner of Respondent State Street Pharmacy since December 13, 1984. Peter Craig Caldwell has been the Pharmacist-In-Charge of Respondent State Street Pharmacy since December 13, 1984.

3. On or about December 1, 1984, the Board of Pharmacy issued Pharmacy Permit Number PHY 30912 to LM Caldwell to do business as L M Caldwell Pharmacist located at 235 West Pueblo Street, Santa Barbara, CA 93105. Peter Craig Caldwell has been the individual licensed owner since December 13, 1984. The Pharmacy Permit was in full force and effect at all times relevant to the charges in the Second Amended Accusation No. 4867 and will expire on December 1, 2016, unless renewed.

4. Peter Craig Caldwell doing business as L M Caldwell Pharmacist (PHY 30911), and Peter Craig Caldwell doing business as L M Caldwell Pharmacist (PHY 30912) and Respondent Owner Peter Craig Caldwell (Respondents) are represented in this proceeding by attorney William C. Haggerty, Esq., whose address is One World Trade Center, 27th Floor, Long Beach, CA 90831.

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JURISDICTION

5. Second Amended Accusation No. 4867 was filed before the Board of Pharmacy (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Second Amended Accusation and all other statutorily required documents were properly served on Respondents on June 30, 2016. Respondents timely filed their Notice of Defense contesting the Accusation. A copy of Second Amended Accusation No. 4867 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

6. Respondents have carefully read, fully discussed with counsel, and understands the charges and allegations in Second Amended Accusation No. 4867. Respondents have also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

7. Respondents are fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Second Amended Accusation; the right to confront and cross-examine the witnesses against them; the right to present evidence and to testify on their own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondents voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondents understand that the charges and allegations in Second Amended Accusation No. 4867, if proven at a hearing, constitute cause for imposing discipline upon their Pharmacy Permits.

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10. For the purpose of resolving the Second Amended Accusation without the expense and uncertainty of further proceedings, Respondents agree that, at a hearing, Complainant could establish a factual basis for the charges in the Second Amended Accusation and that those charges constitute cause for discipline. Respondents hereby give up their right to contest that cause for discipline exists based on those charges.

11. Respondents understand that by signing this stipulation they enables the Board to issue an order accepting the surrender of his Pharmacy Permits without further process.

RESERVATION

12. The admissions made by Respondents in this stipulation are only for the purposes of this proceeding, or any other proceedings in which the Board of Pharmacy or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

13. This stipulation shall be subject to approval by the Board of Pharmacy. Respondents understand and agree that counsel for Complainant and the staff of the Board of Pharmacy may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondents or their counsel. By signing the stipulation, Respondents understand and agree that they may not withdraw their agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Order, including Portable Document Format (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

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15. This Stipulated Surrender of License and Order is intended by the parties to be an integrated writing representing the complete, final, and exclusive embodiment of their agreement. It supersedes any and all prior or contemporaneous agreements, understandings, discussions, negotiations, and commitments (written or oral). This Stipulated Surrender of License and Order may not be altered, amended, modified, supplemented, or otherwise changed except by a writing executed by an authorized representative of each of the parties.

16. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Pharmacy Permit No. PHY 30911 issued to Peter Caldwell doing business as L M Caldwell Pharmacist, and that Pharmacy Permit No. PHY 30912 issued to Peter Caldwell doing business as L M Caldwell Pharmacist, are surrendered and the surrender is accepted by the Board of Pharmacy.

1. The surrender of Respondents' Pharmacy Permits and the acceptance of the surrendered licenses by the Board shall constitute the imposition of discipline against Respondents. This stipulation constitutes a record of the discipline and shall become a part of Respondents' license history with the Board of Pharmacy.

2. Respondents and Respondent owner shall lose all rights and privileges as a Pharmacy in California as of the effective date of the Board's Decision and Order.

3. The surrender of Respondents' pharmacy permits is stayed until February 1, 2017, to allow for the sale of each pharmacy. Respondents shall lose all rights and privileges as a pharmacy effective February 1, 2017. Before then, each Respondent must engage an independent consultant, approved in advance by the Board or its designee, to conduct monthly audits of the pharmacy's operations until such time as the sale is complete and a new license is issued. The independent consultant must be a licensed pharmacist who does not have a pending Accusation filed against them and who is not on probation with the Board. During the time that Respondent Peter C. Caldwell's pharmacist license (RPH 25356) is active and has not been surrendered or revoked, Respondent L M Caldwell-Pharmacist State Street's independent consultant must

conduct weekly audits of the pharmacy's operations. Failure to have such a consultant in place is cause for the pharmacy permit(s) to be deemed surrendered immediately.

4. If the pharmacies are not sold by February 1, 2017, Respondents, within ten (10) days of the effective date of the surrender, Respondents must 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. Respondents shall further provide written proof of such disposition and submit a completed Discontinuance of Business form according to board guidelines.

5. If the pharmacies are not expected to be sold by February 1, 2017, Respondents shall also, by that date, arrange for the continuation of care for ongoing patients that specifies the anticipated closing date of the pharmacies 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 pharmacies' ongoing patients, Respondent 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.

6. If the pharmacies are not sold by February 1, 2017, Respondent owner shall cause to be delivered to the Board the pocket licenses for Respondents and, if one was issued, the wall certificates on or before the effective date of the Decision and Order.

7. If Respondent owner ever applies for licensure or petition for reinstatement in the State of California, the Board shall treat it as a new application for licensure. Respondent owner stipulates that should he or she apply for any license from the board on or after the effective date of this decision, all allegations set forth in the Second Amended Accusation shall be deemed to be true, correct and admitted by respondent when the board determines whether to grant or deny the application. Respondent owner shall satisfy all requirements applicable to that license as of the date the application is submitted to the board. Respondent owner is required to report this surrender as disciplinary action.

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8. Respondents must pay the Board its costs of investigation and enforcement in the amount of $15,000. The full amount must be paid within ninety (90) days of the effective date of the Decision. During the ninety days, Respondents may make payments pursuant to a payment plan, including payment of costs every thirty days, until payment is made in full. Respondents are jointly and severally responsible for payment of the costs of investigation and prosecution in this matter. Payment shall be made by cashier check or money order payable to "Board of Pharmacy" and mailed to the Board of Pharmacy at 1625 North Market Boulevard, Suite N219, Sacramento, CA 95834-1924 and indicate reference: "LM Caldwell, Case No. 4867."

9. If Respondent owner should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Second Amended Accusation, No. 4867 shall be deemed to be true, correct, and admitted by Respondents for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

10. Respondent owner shall not apply to the Board for licensure or petition for reinstatement for three years from the effective date of the Board's Decision and Order.

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, William C. Haggerty, Esq. I understand the stipulation and the effect it will have on my Pharmacy Permit. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: 8/17/2016

PETER CRAIG CALDWELL DOING BUSINESS
AS L M CALDWELL PHARMACIST
(PHY 30911)
PETER CRAIG CALDWELL, OWNER
Respondent

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, William C. Haggerty, Esq. I understand the stipulation and the effect it will have on my Pharmacy Permit. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: 8/17/2016

PETER CRAIG CALDWELL DOING BUSINESS
AS L M CALDWELL PHARMACIST
(PHY 30912)
PETER CRAIG CALDWELL, OWNER
Respondent

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I have read and fully discussed with Peter Craig Caldwell doing business as L M Caldwell Pharmacist (PHY 30911), Peter Craig Caldwell doing business as L M Caldwell Pharmacist (PHY 30912), Peter Craig Caldwell, Owner, the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: August 18, 2016

WILLIAM C. HAGGERTY, ESQ.
FORD, WALKER, HAGGERTY & BEHAR
AttorneyS for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Board of Pharmacy of the Department of Consumer Affairs.

Dated:

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
THOMAS L. RINALDI
Supervising Deputy Attorney General

CRISTINA FELIX
Deputy Attorney General
Attorneys for Complainant

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I have read and fully discussed with Peter Craig Caldwell doing business as L M Caldwell Pharmacist (PHY 30911), Peter Craig Caldwell doing business as L M Caldwell Pharmacist (PHY 30912), Peter Craig Caldwell, Owner, the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: _____

WILLIAM C. HAGGERTY, ESQ.
FORD, WALKER, HAGGERTY & BEHAR
AttorneyS for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Board of Pharmacy of the Department of Consumer Affairs.

Dated: 08/18/2016

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
THOMAS L. RINALDI
Supervising Deputy Attorney General

CRISTINA FELIX
Deputy Attorney General
Attorneys for Complainant

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KAMALA D. HARRIS
Attorney General of California
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E-mail: Cristina.Felix@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the Accusation Against: **PETER CRAIG CALDWELL doing business as L M CALDWELL PHARMACIST** **PETER CRAIG, OWNER** **1509 State St.** **Santa Barbara, CA 93101** **Pharmacy Permit No. PHY 30911** **L M CALDWELL PHARMACIST doing business as L M CALDWELL PHARMACIST** **PETER CRAIG, OWNER** **235 West Pueblo St.** **Santa Barbara, CA 93105** **Pharmacy Permit No. PHY 30912** **PETER CRAIG CALDWELL** **1509 State St.** **Santa Barbara, CA 93101** **Pharmacist License No. RPH 25356** **ABDUL YAHYAVI** **1624 La Coronilla Drive.** **Santa Barbara, CA 93109** **Pharmacist License No. RPH 30041** Respondents.	Case No. 4867 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about December 1, 1984, the Board of Pharmacy issued Pharmacy Permit Number PHY 30911 to Peter Caldwell to do business as L M Caldwell Pharmacist located at 1509 State Street, Santa Barbara, CA 93101 (Respondent L M Caldwell Pharmacist-State Street). Peter C. Caldwell has been the individual licensed owner since December 13, 1984. The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on December 1, 2016, unless renewed. Peter C. Caldwell has been the individual licensed owner of Respondent State Street Pharmacy since December 13, 1984. Peter C. Caldwell has been the Pharmacist-In-Charge of Respondent State Street Pharmacy since December 1, 1984.

3. On or about December 1, 1984, the Board of Pharmacy issued Pharmacy Permit Number PHY 30912 to LM Caldwell to do business as L M Caldwell Pharmacist located at 235 West Pueblo Street, Santa Barbara, CA 93105 (Respondent L M Caldwell Pharmacist- Pueblo Street). Peter C. Caldwell has been the individual licensed owner since December 13, 1984. The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on December 1, 2016, unless renewed. Abdul Yahyavi was the Pharmacist-In-Charge of Respondent Pueblo Street Pharmacy from December 1, 1984 to October 8, 2014. Catherine Young Nance was the Pharmacist in Charge from October 1, 2014 to December 24, 2014. Eleonora Volf became the Pharmacist in Charge on December 24, 2014.

4. On or about January 9, 1968, the Board of Pharmacy issued Pharmacist Number 25356 to Peter Craig Caldwell (Respondent Caldwell). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2017, unless renewed.

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5. On or about December 10, 1975, the Board of Pharmacy issued Pharmacist Number 30041 to Abdul Yahyavi (Respondent Yahyavi). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2016, unless renewed.

JURISDICTION

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

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

8. Section 4300 of the Code states:

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

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

(1) Suspending judgment.

(2) Placing him or her upon probation.

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

(4) Revoking his or her license.

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

. . .

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

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9. Section 4300.1 of the Code states:

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

10. Section 4307 of the Code states:

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

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

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

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

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

STATUTORY AUTHORITY

11. Section 4301 of the Code states:

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

(a) Gross immorality.

(b) Incompetence.

(c) Gross negligence.

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

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

. . .

(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.

. . .

12. Section 4022 of the Code states

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

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

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

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

13. Section 4059 of the Code states:

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

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

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

(d) Any records that are maintained electronically shall be maintained so that the pharmacist-in-charge, the pharmacist on duty if the pharmacist-in-charge is not on duty, or, in the case of a veterinary food-animal drug retailer or wholesaler, the designated representative on duty, shall, at all times during which the licensed premises are open for business, be able to produce a hard copy and electronic copy of all records of acquisition or disposition or other drug or dispensing-related records maintained electronically.

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

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

14. Section 4081 of the Code states:

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

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

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

15. Section 4105 of the Code states:

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

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

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

(d) Any records that are maintained electronically shall be maintained so that the

pharmacist-in-charge, the pharmacist on duty if the pharmacist-in-charge is not on duty, or, in the case of a veterinary food-animal drug retailer or wholesaler, the designated representative on duty, shall, at all times during which the licensed premises are open for business, be able to produce a hard copy and electronic copy of all records of acquisition or disposition or other drug or dispensing-related records maintained electronically.

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

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

(f) When requested by an authorized officer of the law or by an authorized representative of the board, the owner, corporate officer, or manager of an entity licensed by the board shall provide the board with the requested records within three business days of the time the request was made. The entity may request in writing an extension of this timeframe for a period not to exceed 14 calendar days from the date the records were requested. A request for an extension of time is subject to the approval of the board. An extension shall be deemed approved if the board fails to deny the extension request within two business days of the time the extension request was made directly to the board.

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

17. Health and Safety Code section 11153 states in pertinent part:

(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.

(b) Any person who knowingly violates this section shall be punished by imprisonment in the state prison or in the county jail not exceeding one year, or by a fine not exceeding twenty thousand dollars ($20,000), or by both a fine and imprisonment.

(c) No provision of the amendments to this section enacted during the second year of the 1981-82 Regular Session shall be construed as expanding the scope of practice of

a pharmacist.

18. Health and Safety Code section 11200 states in pertinent part:

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

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

(c) No prescription for a Schedule II substance may be refilled.

STATE REGULATORY AUTHORITY

19. California Code of Regulations, title 16, section 1711, states:

(a) Each pharmacy shall establish or participate in an established quality assurance program which documents and assesses medication errors to determine cause and an appropriate response as part of a mission to improve the quality of pharmacy service and prevent errors.

. . .

(d) Each pharmacy shall use the findings of its quality assurance program to develop pharmacy systems and workflow processes designed to prevent medication errors. An investigation of each medication error shall commence as soon as is reasonably possible, but no later than 2 business days from the date the medication error is discovered. All medication errors discovered shall be subject to a quality assurance review.

(e) The primary purpose of the quality assurance review shall be to advance error prevention by analyzing, individually and collectively, investigative and other pertinent data collected in response to a medication error to assess the cause and any contributing factors such as system or process failures. A record of the quality assurance review shall be immediately retrievable in the pharmacy. The record shall contain at least the following:

1. the date, location, and participants in the quality assurance review;

2. the pertinent data and other information relating to the medication error(s) reviewed and documentation of any patient contact required by subdivision (c);

3. the findings and determinations generated by the quality assurance review; and,

4. recommend changes to pharmacy policy, procedure, systems, or processes, if any. The pharmacy shall inform pharmacy personnel of changes to pharmacy policy, procedure, systems, or processes made as a result of recommendations generated in the quality assurance program.

. . .

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

. . .

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

. . .

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

. . .

21. California Code of Regulations, title 16, section 1716, states:

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. Nothing in this regulation is intended to prohibit a pharmacist from exercising commonly-accepted pharmaceutical practice in the compounding or dispensing of a prescription.

22. California Code of Regulations, title 16, section 1745, states:

. . .

(b) A "partially filled" prescription is a prescription from which only a portion of the amount for which the prescription is written is filled at any one time; provided that regardless of how many times the prescription is partially filled, the total amount dispensed shall not exceed that written on the face of the prescription.

. . .

(d) A pharmacist may partially fill a prescription for a controlled substance listed in Schedule II, if the pharmacist is unable to supply the full quantity ordered by the prescriber. The pharmacist shall make a notation of the quantity supplied on the face of the written prescription. The remaining portion of the prescription may be filled within 72 hours of the first partial filling. If the remaining portion is not filled within the 72-hour period, the pharmacist shall notify the prescriber. The pharmacist may not supply the drug after 72 hour period has expired without a new prescription.

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23. 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.

FEDERAL REGULATORY AUTHORITY

24. 21 Code of Federal Regulations, part 1306, section 13.06.13 states, in pertinent part:

(a) The partial filling of a prescription for a controlled substance listed in Schedule II is permissible if the pharmacist is unable to supply the full quantity called for in a written or emergency oral prescription and he makes a notation of the quantity supplied on the face of the written prescription, written record of the emergency oral prescription, or in the electronic prescription record. The remaining portion of the prescription may be filled within 72 hours of the first partial filling; however, if the remaining portion is not or cannot be filled within the 72-hour period, the pharmacist shall notify the prescribing individual practitioner. No further quantity may be supplied beyond 72 hours without a new prescription.

COSTS

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

DRUGS

26. Acetaminophen is a Schedule III controlled substance as designated in Health and Safety Code section 11056(e)(2) and is categorized as a dangerous drug pursuant to section 4022 of the Code.

27. Alprazolam, sold under the brand name Xanax, is a Schedule IV controlled substance under Health and Safety Code section 11057 and a dangerous drug under Business and Professions Code Section 4022. Alprazolam is used to treat anxiety disorders and panic disorder. Alprazolam is in a class of medications called benzodiazepines. Alprazolam comes as a tablet, An extended-release tablet, and an orally disintegrating tablet. The tablet and orally disintegrating

table usually are taken two to four times a day. The extended-release tablet is taken once daily, usually in the morning. Alprazolam may heighten the euphoric effect resulting from the use of an Oxycodone.

28. Diazepam, a generic for the brand name Valium, a Benzodiazepam derivative, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(9) and is categorized as a dangerous drug pursuant to section 4022 of the Code.

29. Dilaudid is a trade name for Hydromorphone, an Opium derivative, which is classified as a Schedule II Controlled Substance pursuant to Health and Safety Code section 11055, subdivision (b)(1), and is a dangerous drug within the meaning of Business and Professions Code section 4022.

30. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(c)(8) and is a dangerous drug pursuant to Business and Professions Code section 4022.

31. Hydrocodone is in Schedule II of the Controlled Substances Act. Lortab, Norco and Vicodin, brand/trade names of preparations containing hydrocodone in combination with other non-narcotic medicinal ingredients, are in Schedule III pursuant to Health and safety Code section 11056(e)(4), and are categorized as dangerous drugs pursuant to section 4022.

32. Methadone, is a synthetic opiate, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(c)(14) and a dangerous drug according to Business and Professions Code section 4022.

33. Morphine Sulfate, the narcotic substance is a preparation of Morphine, the principal alkaloid of Opium. It is classified as a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivisions (b)(1)(L) and (b)(2). It is categorized as a dangerous drug pursuant to Business and Professions Code section 4022.

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34. Norco is the brand name for the combination narcotic, Hydrocodone and Acetaminophen, and is a Schedule II[1] controlled substance pursuant to Health and Safety Code section 11055 (b)(1) (I) and is categorized as a dangerous drug pursuant to Business and Professions Code section 4022

35. Opana ER is an opioid and schedule II controlled substance.

36. Opiates are types of narcotic drugs that act as depressants in the central nervous system. They come from opium, which can be produced naturally form poppy plants or derived form semi-synthetic alkaloids. Some of the most common opiates include morphine, codeine, heroin, hydrocodone and oxyodone. Opiates are pain killers and can produce drowsiness, nausea, constipation and slow breathing.

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

38. Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M) and is a dangerous drug pursuant to Business and Professions Code section 4022. Oxycodone is a narcotic analgesic used for moderate to severe pain and it has a high potential for abuse.

39. Suboxone, the brand name of buprenorphine and naloxone, is classified as a Schedule IV controlled substance pursuant to Health and Safety Code section 11058(d), and is a dangerous drug pursuant to Business and Professions Code section 4022. It is used for the treatment of opiate addiction.

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[1] Effective October 6, 2014, the Drug Enforcement Administration rescheduled Hydrocodone combination products from schedule III to schedule II of the Controlled Substances Act. (See 21 CFR Part 1308 § 1308.12; 21 U.S.C. 812 (c))

40. Tranquilizers are central nervous system depressant drugs classified as sedative-hypnotics and are classified into two main categories: minor tranquilizers (anxiolytic, or anti-anxiety agents) and major tranquilizers (neuroleptics) drugs used to treat sever mental illnesses. Minor tranquilizers may include Valium (diazepam), Librium/Novopoxide (chlordiazepoxide), Halcion (triazolam), ProSom (estazolam), Xanax and Ativan.

FACTS

RESPONDENTS

41. Respondent L M Caldwell Pharmacist-State Street and Respondent L M Caldwell Pharmacist-Pueblo Street (collectively Respondents L M Caldwell Pharmacists) are pharmacies operating in the Santa Barbara area.

42. Respondent Caldwell is the Pharmacist in Charge at Respondent L M Caldwell Pharmacist-State Street, and Respondent Yahyani was the Pharmacist in Charge at Respondent L M Caldwell Pharmacist- Pueblo Street up to October 1, 2014.

43. Pharmacy Technician DLM[2] was employed at Respondent Caldwell Pharmacist-State Street in 2011.

RESPONDENT LM CALDWELL PHARMACIST-STATE STREET AND RESPONDENT CALDWELL

Records of Acquisition, Disposition and Storage of Drugs

44. Drugs acquired by Respondents L M Caldwell Pharmacist were stored at Respondent L M Caldwell Pharmacists-State Street. Drugs were sent to Respondent L M Caldwell Pharmacist-Pueblo Street as needed. Drug recordkeeping included a transfer document which showed the bottles sent to Respondent L M Caldwell Pharmacist-Pueblo Street. Also, the records for Respondent L M Caldwell Pharmacist-Pueblo Street were located at Respondent L M Caldwell Pharmacist-State Street.

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[2] Names are not being used to protect identities but individuals will be identified during the course of discovery.

45. Between November 15, 2009 and July 13, 2011, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not account for an inventory overage (disposition greater than acquisition) of 55,370 tablets of Hydrocodone/Acetaminophen (HC/AP) 10/325 mg and 165 tablets of Oxycodone SR 80 mg. Between August 6, 2011 and January 15, 2013, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not account for an inventory overage of 78,746 tablets of HC/AP 10/325 mg.

46. Between January 5, 2010 and January 15, 2013, Respondent L M Caldwell Pharmacist -State Street and Respondent Caldwell could not account for prescription hardcopies for Prescriptions Nos. 793824, 793825, 793826, 789177, 789188, 793189, 793190, 805552, 782075, 792283, 793432, 793184, 791387, 797610, 787609, 790594, 790595, 790597, 795658, 804361, 792346, 793090, 795652, 776675, 773787, 779441, 780927, 790980, 792044, 792920, 792935 and 792928.

Operational Standards and Security

47. Respondent Caldwell was responsible for the security and record keeping at Respondents L M Caldwell Pharmacists. Between November 15, 2009 to July 13, 2011, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not account for the loss of 5,360 tablets of Hydromorphone 8 mg. Between August 6, 2011 to January 15, 2013, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not account for the loss of 8,800 tablets of Hydromorphone 8 mg and for the loss of 605 tablets of Oxycodone 30 mg.

48. Respondents L M Caldwell Pharmacists and Respondent Caldwell failed to maintain an effective control of the security of the prescription department against theft or loss of controlled substances/ dangerous drugs.

Furnishing and Purchasing of Dangerous Drugs or Devices Without Adequate Sales and Purchase Records

49. Between July 23, 2010 and December 28, 2012, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell sold HC/AP 10/325 mg to Respondent L M Caldwell Pharmacist- Pueblo Street without adequate sales records.

Prescriptions Dispensed by L M Caldwell Pharmacist- State Street and Respondent Caldwell

50. Between January 1, 2011 and December 5, 2012, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell, dispensed a total of 11,817 controlled substance prescriptions of which 1,492 were prescriptions written by Dr. Julio Gabriel Diaz, a family practice prescriber. The prescriptions were dispensed without regard to the following factors:

(1) Pattern of patients willing to drive long distance to obtain controlled substance prescriptions from Dr. Diaz and to fill the prescriptions at L M Caldwell Pharmacists and other pharmacies;

(2) Percentage of cash patients specific to listed prescribers and pattern of patients willing to pay cash for highly expensive prescriptions when insurance did not cover;

(3) Same or similar prescribing patterns for multiple patients, including at least three opiates and one to two tranquilizers;

(4) Irregular pattern of early refills/ patient returning too frequently.

51. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell failed in their corresponding responsibility to appropriately scrutinize patients' drug therapy with readily available tools such as CURES [3] reports and its own pharmacy records. Respondents did not have a process to validate prescriptions. As a result, they repeatedly dispensed controlled substances early in certain instances to patients who habitually engaged in doctor shopping and multiple pharmacy activity. Questionable drug therapies were visible from Respondent L M Caldwell-State Street's own records and showed the prescribing pattern of Dr. Diaz was repetitive and redundant with respect to the same controlled substances prescribed repeatedly for the

[3] CURES is an acronym for "California Utilization Review and Evaluation System." It contains over 100 million entries of controlled substance drugs that were dispensed in California. Pharmacists and prescribers can register with the Department of Justice to obtain access to the CURES data through the California Prescription Drug Monitoring Program (PDMP). Patient Activity Reports (PARs) are provided and reflect all controlled substances dispensed to an individual. CURES herein refers to CURES in general and PARs. Pharmacies are required to report to the California Department of Justice every schedule II, II and IV drug prescription under Health and Safety Code section 1165, subdivision (d).

majority of his patients. His prescribing habits included numerous large quantities of opiates in combination with minor tranquilizers. Patients received on average three to four pain medications with one to two anti-anxiety drugs. The patients included, but were not limited to, VA, BA, KB, CD, LD, TF, JH, MM, AM, SM, SS, JS, NS, VS, and CW. A review of CURES and their own records would have been a red flag for Respondents. For example:

a. Patient VA went to 4 prescribers and 18 pharmacies from January 1, 2009 to April 8, 2013, including in Santa Maria, Arleta, Santa Barbara and Ventura. He lived in Oxnard and traveled approximately 37.34 miles to Santa Barbara to see prescriber Dr. Diaz. LM Caldwell-State Street was approximately 39.67 miles from Patient VA's home and 1.85 miles from Dr. Diaz's office. Patient VA paid cash for his prescriptions. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. He mainly went to Dr. Diaz while having prescriptions dispensed at Respondent LM Caldwell Pharmacist- State Street. Most pain medication was prescribed by Dr. Diaz, despite him not being a pain specialist. He received numerous prescriptions for HC/AP 10/325 mg and Methadone prescribed by Dr. Diaz on or around the same time he had them dispensed at different pharmacies. In the month of August 2010, for example, Patient VA received 960 tablets of HC/AP 10/325 mg within 30 days. He received 10,400 mg per day, well above the recommended dose of (Acetaminophen) per day of 4,000 mg per day. In July of 2011, for example, Patient VA received 1,080 tablets of HC/AP 10/325 mg within 30 days. Patient VA received 13,000 mg per day. In January of 2011, for example, Patient VA received a 30 day supply of Methadone 10 mg from one pharmacy and then received another 30 day supply from another pharmacy, LM Pharmacist-State Street, ten days later on, January 25, 2011;

b. Patient BA only saw one prescriber, Dr. Diaz, and went to 12 pharmacies from January 1, 2009 to April 8, 2013. He lived in Ventura and traveled approximately 31.53 miles to Santa Barbara to see prescriber Dr. Diaz. Respondent LM Caldwell-State Street was approximately 33.86 miles from Patient BA's home and 1.85 miles from Dr. Diaz's office. Patient BA paid cash for his prescriptions. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Patient BA received numerous prescriptions

for HC/AP 10/325 mg and Methadone prescribed by Dr. Diaz on or around the same time he had them dispensed at different pharmacies. Most pain medication was prescribed by Dr. Diaz, despite him not being a pain specialist. In March of 2010, for example, Patient BA received 1200 tablets of HC/AP 10/325 within 30 days. He received 13,000 mg per day of Acetaminophen, well above the recommended dose of 4,000 mg per day. In February of 2011, for example, Patient BA received 720 tablets of HC/AP 10/325. He received 7800 mg per day of Acetaminophen;

c. Patient KB saw 5 prescribers and went to 11 pharmacies from January 1, 2009 to April 8, 2013, including in Carpentaria, Hollywood, Lompoc, Santa Barbara and Solvang. He lived in Santa Inez and traveled approximately 31.99 miles to Santa Barbara to see prescriber Dr. Diaz. Respondent LM Caldwell-State Street was approximately 29.10 miles from Patient VA's home and 1.85 miles from Dr. Diaz's office. Patient VA paid cash for his prescriptions. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. He received most pain medication from Dr. Diaz, despite him not being a pain specialist. Patient KB was dispensed 595 tablets of Oxycodone 30 mg in one month in Prescriptions 788268, 788632 and 789490. Patient KB, for example, was dispensed Oxycodone 30 mg at both Respondent L M Caldwell- State Street and at Respondent L M Caldwell- Pueblo Street on June 18, 2010, October 5, 2010, November 2, 2010 and November 29, 2010. Patient KB was placed on Suboxone, used for the treatment of narcotic addiction, prior to going to LM Caldwell Pharmacists- State Street;

d. Patient LD saw 4 prescribers and went to 2 pharmacies from January 1, 2009 to April 8, 2013, including in Carpentaria, Hollywood, Lompoc, Santa Barbara and Solvang. Patient LD lived in Santa Barbara and paid cash for his prescriptions. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. He received most pain medication from Dr. Diaz, despite him not being a pain specialist. While going to Respondent LM Caldwell Pharmacist-State Street, Patient LD mainly saw Dr. Diaz but saw two prescribers after Dr. Diaz. Several questionable prescriptions were filled including: Prescription No. 773360(HC/AP) and 773361 (HC/ibuprofen) which were both dispensed on September 21, 2010 and both had hydrocodone; Prescription Nos. 789181 (HC/ Ibuprofen), 789182

(Oxycodone/Ibuprofen) and 789180 (Oxycodone) were all dispensed on August 23, 2011 and contained the same drugs; and Prescription Nos. 790459, 790460 and 790458 had dates that were not written in the prescriber's handwriting; Prescription No. 792432 (Lorazepam) was for a large quantity of 300 pills and Respondent dispensed 120 pills and did not verify with the prescribers;

e. Patient TF saw 1 prescriber, Dr. Diaz, and went to 8 pharmacies January 1, 2009 to April 8, 2013, including in Lompoc, Goleta, San Luis Obispo, Santa Maria and Orcutt. He lived in Santa Barbara and paid cash for his prescriptions Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed;

f. Patient JH saw 4 prescribers and went to 12 pharmacies from February 13, 2009 to April 8, 2013. He saw prescribers in Santa Barbara, Lompoc and Temecula and went to pharmacies in Santa Maria, Santa Barbara, Temecula, Buelton, and Lompoc. He lived in Santa Maria and traveled approximately 61.53 miles to Santa Barbara to see prescriber Dr. Diaz. Respondent LM Caldwell-State Street was approximately 58.68 miles from Patient JH's home and 1.85 miles from Dr. Diaz's office. Patient JH paid cash for his prescriptions. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. He received only pain medication from Dr. Diaz, despite him not being a pain specialist. He did not have significant pain history one month prior to February 2009 and had a history of Anxiety 8 months prior to August 2009 and before seeing Dr. Diaz. Respondent LM Caldwell Pharmacist-State Street should have questioned the following prescriptions dispensed to Patient JH on November 25, 2011: Prescription Nos. 793748 (Morphine Sulfate 30 mg), 793749 (Methadone 10 mg),793750 (HC/AP 10/325 mg), 793751 (Oxycodone 30 mg), 793756 (Hydromorphone 8 mg), 793757 (Alprazolam 2 mg). Records also show that the quantity and therapy duplication combination was reduced from November 30, 2009 to September 22, 2010, during the period that JH did not go to Dr. Diaz. He again began to receive large quantities and therapy duplication combinations when he went back to Dr. Diaz on September 30, 2010.

g. Patient MM saw 19 prescribers and went to 20 pharmacies from January 1, 2009 to April 8, 2013. She went to prescribers in Santa Barbara, Lompoc, Stanford, Encinitas, Santa Maria, Solvang, San Luis Obispo and San Francisco and went to pharmacies in Santa Barbara,

Lompoc, Orcutt, San Luis Obispo, Pismo Beach, Buelton, and Santa Maria. He lived in Lompoc and traveled approximately 56.30 miles to Santa Barbara to see prescriber Dr. Diaz. Respondent LM Caldwell-State Street was approximately 53.69 miles from Patient MM's home and 1.85 miles from Dr. Diaz's office. Patient MM paid cash and paid through insurance for his prescriptions. For example, he paid $2,585.80 for Oxycontin 60 mg (Prescription No. 319145). Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. MM received numerous prescriptions for Oxycontin prescribed by Dr. Diaz on or around the same time and went to different pharmacies to get dispensed, including LM Caldwell Pharmacist- Pueblo Street;

h. Patient SM saw 7 prescribers and went to 11 pharmacies from January 1, 2009 to April 8, 2013, including L M Caldwell- Pueblo Street. He lived in Santa Barbara and paid cash for his prescriptions. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Respondent L M Caldwell- State Street dispensed questionable prescriptions for Oxycodone in which instructions for use seemed too high (including receiving 16-24 tablets per day), including Prescription Nos. 782797, 777041, 789979 and 786575. Patient SM was placed on Suboxone, used for the treatment of narcotic addition, after no longer seeing Dr. Diaz. SM received only pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist;

i. Patient SS saw 2 prescribers and went to 4 pharmacies from January 1, 2009 to April 8, 2013. He lived in Santa Barbara and paid cash for his prescriptions when insurance did not cover the cost. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. He showed no significant pain or anxiety history prior to 11/23/2010. L M Caldwell- State Street dispensed the following questionable prescriptions: Prescription Nos. 780807 and 783547 for Fentanyl patches above the recommended dosing interval of 72 hours. The pharmacy dispensed it for every 48 hours; Prescription Nos. 79027, 790597, 782251, and 782250 in which the patient received Diazepam 10 mg and Alprazolam 2 mg at the same time. Patient SS received most pain medication from Dr. Diaz, despite him not being a pain specialist;

j. Patient JS saw 4 prescribers and went to 4 pharmacies from January 1, 2009 to April 8, 2013. He lived in Lompoc and traveled approximately 55.98 miles to Santa Barbara to see prescriber Dr. Diaz. Respondent LM Caldwell-State Street was approximately 53.37 miles from Patient JH's home and 1.85 miles from Dr. Diaz's office. Patient JS had the same address as Patient NS. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Prior to going to Respondent LM Caldwell Pharmacist-State Street, Patient JS went to multiple pharmacies for Dr. Diaz's prescriptions. There was no significant pain history 6 months prior to June 18, 2009 and Dr. Diaz. Patient JS received only pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist;

k. Patient NS saw 3 prescribers and went to 5 pharmacies from January 1, 2009 to April 8, 2013. He lived in Lompoc and traveled approximately 55.98 miles to Santa Barbara to see prescriber Dr. Diaz. Respondent LM Caldwell-State Street was approximately 53.37 miles from Patient NS's home and 1.85 miles from Dr. Diaz's office. Patient NS had the same address as Patient JS. Patient NS paid cash for his prescriptions when the cost was not covered by insurance. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Prior to going to Respondent LM Caldwell Pharmacist-State Street, Patient JS went to multiple pharmacies for Dr. Diaz's prescriptions. While going to L M Caldwell Pharmacist- State Street, he continued to use other pharmacies. Patient NS received only pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist;

l. Patient VS saw 3 prescribers and went to 5 pharmacies from January 1, 2009 to April 8, 2013, including Respondent LM Caldwell Pharmacist-State Street. He lived in Lompoc a and traveled approximately 55.47 miles to Santa Barbara to see prescriber Dr. Diaz. LM Caldwell-State Street was approximately 52.86 miles from Patient VS's home and 1.85 miles from Dr. Diaz's office. Patient VS paid cash for his prescriptions when the cost was not covered by insurance. Patient VS paid over $200.00 for Oxycodone several times. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Patient VS went to multiple pharmacies for Dr. Diaz's prescriptions. Respondent L M Caldwell - State Street dispensed the following questionable prescriptions: Hydromorphone 8 mg and

Hydromorphone 4 mg were dispensed on January 1, 2011, February 2, 2011, March 2, 2011, March 30, 2011 and April 27, 2011. Oxycodone 30 mg and Oxycodone 5 mg was dispensed on April 27, 2011. The different strength of the prescriptions should have been red flags. Patient VS received only pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist;

m. Patient CW saw 2 prescribers and went to 2 pharmacies from January 1, 2009 to April 8, 2013. Patient CW lived in Santa Barbara and paid cash when the cost was not covered by insurance. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Respondent L M Caldwell- State Street dispensed questionable prescriptions, including the following: Amphetamine 30 mg and Amphetamine 20 mg dispensed at same time in Prescription Nos. 772453, 772454, 773785, 773783, 775368, 775363, 776678, 776679, 780924, 780923, 779437, 779438, 771122 and 771123 and Suboxone was prescribed by Dr. Diaz for pain on numerous occasions. Patient CW received mostly pain, and anxiety medications prescribed by Dr. Diaz, despite him not being a pain specialist.

52. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell did not know the diagnosis for patients VA, BA, KB, CD, LD, TF, JH, MM, AM, SM, SS, JS, NS, VS, and CW, and knew that Dr. Diaz was a family practitioner and not a pain management physician. Also, L M Caldwell Pharmacist-State Street and Respondent Caldwell failed to maintain records or files on drug therapy for these patients.

53. When reviewing the records for patients VA, BA, KB, CD, LD, TF, JH, MM, AM, SM, SS, JS, NS, VS, and CW, it was noted that nine out of these fifteen patients lived outside Dr. Diaz's and Respondent LM Caldwell Pharmacist-State Street's normal trading area . Due to the number of readily accessible pharmacies throughout California, the common trading area is considered to be 5 miles. The range of distance travelled for the selected patients was between 3.7 miles for the shortest to 122.06 for the longest. The average distance traveled by the patient was 59.18 miles and the total distance these patients travelled to obtain controlled substances was excessive. Four of the fifteen patients' home addresses were not recognized by Mapquest. Two patients had the same address, NS and JS.

54. Respondent LM Caldwell Pharmacist-State Street dispensed a total of 11,817 controlled substances prescriptions from January 1, 2011 to December 5, 2012 and 1,492 were prescribed by Dr. Diaz. 31.64 % (407 out of 1,492) of Dr. Diaz' patients paid cash, including when the medication was not covered by their insurance or to get early refills. Some patients had insurance/Medicaid, however, were willing to pay a large sum of cash for controlled substances which were not covered by the plans, including those on Medicaid.

55. There was excessive furnishing of controlled substances prescribed by Dr. Diaz. The dispensing ratio of prescriptions by Dr. Diaz by Respondent L M Caldwell Pharmacists-State Street and Respondent Caldwell was greatly unbalanced when compared to other neighboring pharmacies, including the following three pharmacies: Federal Drugs PHY37078 (located 1.92 miles from L M Caldwell Pharmacist-State Street), Rite-Aid #5785 PHY 42255 (located 1.65 miles from L M Caldwell Pharmacist-State Street), and CVS#9392 PHY 494473 (located .41 miles from L M Caldwell Pharmacist-State Street). Respondent L M Caldwell Pharmacist-State Street filled tens of thousands more controlled substances prescribed by Dr. Diaz when compared to neighboring pharmacies for the time period specified of January 1, 2011 through December 5, 2012. The CURES data for the Respondent L M Caldwell Pharmacists-State Street and three surrounding pharmacies, for example, was as follows:

Pharmacy	Total controlled substances dispensed between 1/1/2011-12/5/2012	Total Dr. Diaz's RX from 1/1/2011-12/5/2012	Total quantity for Dr. Diaz's RX from 1/1/2011-12/5/2012	% of total controlled substance RX dispensed for Dr. Diaz
Respondent LM Caldwell Pharmacist – State Street	**11, 817**	**1,492**	**195,041**	**12.62%**
Federal Drugs PHY 37078 (1.92 miles from LM Caldwell)	18, 282	0	0	0%
Rite-Aid #5785 PHY 42255 (.065 miles from LM Caldwell	3,584	0	0	0%

Pharmacist				
CVS # 9392 PHY 49473 (.41 miles from LM Caldwell)	13,365	44	6,599	.33%

Pattern of Early Refills and Duplicate Medications

56. Between January 1, 2010 and December 5, 2012, Respondent LM Caldwell- State Street and Respondent Caldwell engaged in a pattern of early refills, including for patients KB, CD, LD, TF, JH, AM, SM, NS, VS, and CW, including, for example, 23 days early for patient LD (prescription Nos. 764100 & 764468), 29 days early for patient AM (prescription Nos. 791702 & 793219), 21 days early for patient SM (prescription Nos. 786128 & 786573), and 14 days early for patient CW (prescription Nos. 782792 & 782792).

57. Also, the patient profile from 2010 to 2012 for patient SS,[4] for example, showed numerous therapy duplicate medications prescribed by Dr. Diaz and dispensed by L M Caldwell Pharmacists- State Street and Respondent Caldwell[5]. The profile showed the following:

a. On January 18, 2011, when L M Caldwell Pharmacists-State Street started dispensing Fentanyl 100 mcg/hr to Patient SS (Prescription No. 778213), the pharmacists should have questioned the high doses of Fentanyl and whether Patient SS was previously on Fentanyl 100 mcg/hr prior to getting his prescription from L M Caldwell Pharmacist-State Street;

b. Patient SS was prescribed Methadone 3 tablets every twelve (12) hours on July 19, 2011 and on August 17, 2011 (Prescription Nos. 787609 & 788989) and each month thereafter, his dose was increased, four (4) tablets every twelve (12) hours on September 22, 2011 (Prescription No. 790594), and five (5) tablets every 12 hours on October 27, 2011 (Prescription No. 792268);

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[4] Patient SS died in May 2012 allegedly as a result of a drug overdose.

[5] No prescriptions were dispensed by Respondent L M Caldwell-State Street or Respondent Caldwell for Patient SS from January 10, 2010 to December 30, 2010.

c. On March 15, 2011, ten (10) patches of Fentanyl 100 mcg/hr were dispensed, each for a thirty (30) day supply (Prescription No. 780807). Seven days later, on March 22, 2011, another 10 patches of Fentanyl 100 mcg/hr were prescribed and entered as a file only as "FO" (Prescription No. 782067);

d. On March 22, 2011, Prescription No. 784841 for Morphine Sulfate 10 mg/5ml solution was written with no quantity written on the prescription, but the quantity box of "151 & over" was marked and 360 mls were dispensed by Respondent L M Caldwell-State Street and Respondent Caldwell. This prescription was incomplete and the prescriber, Dr. Diaz, should have been contacted and the quantity documented after clarification from the prescriber;

e. On May 20, 2011, Patient SS was prescribed three different narcotic pain medications: Hydromorphone 8 mg one tablet daily (Prescription No. 784840) with Fentanyl 100 mcg/hour patch every forty-eight (48) hours (Prescription No. 784839) and Morphine Sulfate 10 mg, 5ml every two (2) to four (4) hours (Prescription No. 784841). Prescription No. 784839 was dispensed by Respondent L M Caldwell-State Street and Respondent Caldwell, for Fentanyl 100 mcg/hour with directions to apply every forty-eight (48) hours. However, the manufacturer's direction was to change the patch every seventy-two (72) hours;

f. On July 18, 2011, Prescription No. 787610 for Morphine 20 mg/ml solution was written for 400 mls, but 360 mls was dispensed. This was a variation from the quantity prescribed;

Exceeding the Day Supply For Controlled Substance Refills

58. The patient profile from 2010 to 2012 for patient SS, also showed that the day supply was exceeded for controlled substance refills, for example, as follows:

a. A review of SS patient profile revealed that alprazolam and diazepam, classified as benzodiazepines were also dispensed by LM Caldwell Pharmacist-State Street and Respondent Caldwell from December 2010 to September 2011. Prescription No. 782251 for Alprazolam, a Schedule IV controlled substance, was originally dispensed on March 25, 2011 for a 30 day supply. Prescription No. 782251 was then refilled five times, each for a 30 day supply, on April 22, 2011, May 18, 2011, June 16, 2011, July 18, 2011 and August 17, 2011 by Respondent L M

Caldwell-State Street and Respondent Caldwell. A total of 150-day supply was dispensed, exceeding a 120-day supply as required by Health and Safety code section 11200;

b. Prescription No. 782250 for Diazepam, a schedule IV controlled substance, was originally dispensed on March 25, 2011 then refilled five times, each for a 30 day supply, on April 22, 2011, May 18, 2011, June 16, 2011, July 18, 2011 and August 17, 2011 by Respondent L M Caldwell-State Street and Respondent Caldwell. A total of 150-day supply was dispensed, exceeding a 120-day supply as required by Health and Safety code section 11200.

Patient JJ

59. On September 12, 2013, the Board received a report of settlement judgment or arbitration award, San Bernardino Superior Court, Case No. 2012-112565, regarding Patient JJ, from Liberty Insurance Underwriter, Inc. for Respondent Caldwell, without the admission of guilt. Improper Management and dispensing of controlled substance resulting in addiction and death was alleged in the civil suit. Patient JJ presented prescriptions from a medical doctor which Respondent Caldwell dispensed. Patient JJ alleged that she became addicted to drugs because Respondent Caldwell dispensed the prescriptions to her.

60. A review of Respondent L M Caldwell Pharmacists-State Street's profile for Patient JJ revealed that she was mostly dispensed controlled substances by Respondent Caldwell which were prescribed by Dr. Diaz, who was not a pain specialist. A review of CURES revealed that Patient JJ went to multiple doctors at the same time and had prescriptions dispensed at multiple pharmacies during the same time period. Patient JJ received numerous refills and received above the recommended dose of 400 mg per day of Acetaminophen. On certain months, Patient JJ received over 600 tablets of Hydrocodone. If Respondent Caldwell would have checked CURES, he would been able to determine JJ was going to several pharmacies and several doctors. Respondent Caldwell knew that patient was getting drugs from Dr. Diaz, prior to being indicted, and then continued to dispense prescriptions from other doctors to this patient.

61. Patient JJ had a pattern of early refills on Oxycodone 30 mg, for the management of moderate to severe pain, and Morphine Sulfate 30 mg, for the management of severe pain. Both medications are for the immediate relief of pain. LM Caldwell Pharmacist-State Street and

Respondent Caldwell failed to contact the prescriber to determine the logic of this combination. Also, Prescription Nos. 768630 and 768631 were dated July 1, 2010. LM Caldwell Pharmacist-State Street and Respondent Caldwell received and dispensed them on June 11, 2010.

62. From January 1, 2010 to January 1, 2013, Patient JJ had 145 prescriptions for controlled substances dispensed from various prescribers and pharmacies. 85 of the 145 prescriptions (58.96 %) were for cash.

63. From January 1, 2010 to January 1, 2013, LM Caldwell Pharmacist-State Street and Respondent Caldwell failed to assume their corresponding responsibility when they failed to appropriately scrutinize Patient JJ's drug therapy with readily available tools such as CURES reports and its own pharmacy records. Respondents should have looked at the repetitive prescribing pattern for highly abused controlled substances, the location of prescriber's practice in relation to the location of JJ's residence, and Patient's payment methods. As a result, Respondents dispensed controlled substances for Patient JJ who was habitually engaged in doctor shopping and multiple pharmacy activity. Respondents should have questioned the legitimacy of Prescriptions, including Prescription Nos. 758920, 767530, 767531, 768630, 768631, 758920 (for 1/18/2010, 3/19/2010, 2/18/2011, 2/18/2011), 782598 (for 4/1/2011, 5/17/2011), 803536, 803537, 803963,803965, 803966, 805071, 805072, 805074, 806756, 806757, 807683, 807684, 807699 and 807700.

Patient AM

64. On February 3, 2014, the Board received a report of settlement judgment or arbitration award, Case No. 1414079, regarding Patient AM, from Chicago Insurance Company for Respondent Caldwell- State Street, without the admission of guilt. Patient AM, presented a prescriptions from a medical doctor which Respondent Caldwell dispensed. On November 25, 2011, Patient AM died from acute complications from narcotic abuse.

65. A review of Respondent L M Caldwell Pharmacist-State Street's profile for Patient AM revealed that Patient AM received the following controlled substances, that were prescribed by Dr. Diaz, at LM Caldwell Pharmacists-State Street, and had a pattern of being dispensed early:

RX Dispensed	RX #	QTY	Day Supply	Date dispensed	RX#	QTY	Day Supply	Days Early from Prior RX
10/24/11	792077	120	30	11/14/11	793124	120	30	9 days
11/14/11	793104	150	19	11/15/11	793216	90	30	19
11/15/11	793105	150	19	11/15/11	793218	90	30	19
11/15/11	791702	120	30	11/15/11	793219	60	20	29

66. The Board could not find the exact patient address on Mapquest in Solvang, California. Patient AM traveled 35.56 miles from Solvang to Santa Barbara where Dr. Diaz was located. Patient AM lived approximately 70.09 miles away from Respondent LM Caldwell-State Street. Patient AM paid cash for his medication and Dr. Diaz was the prescriber. Respondents did not have access to CURES during the time Dr. Diaz dispensed to AM so it was not accessed. The pharmacy did not have a process to validate the prescriptions. As long as the Dr. wrote the prescription, the pharmacy dispensed it.

67. A review of Respondent L M Caldwell Pharmacist-Pueblo Street's profile for Patient AM and CURES records also revealed that Patient AM saw 4 prescribers and went to 8 pharmacies from January 1, 2009 to April 8, 2013. Patient AM saw prescribers in Santa Barbara, Solvang, and Shell Beach. Patient AM received only pain medication form Dr. Diaz, despite him not being a pain specialist.

68. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell would have been able to determine there were unusual prescribing patterns for Dr. Diaz and that Patient AM was going to multiple pharmacies. While going to Respondent L M Caldwell Pharmacist-State Street, Patient AM went to multiple pharmacies and received multiple prescriptions for Hydrocodone 8 mg on or around the same time form Dr. Diaz which AM dispensed at different pharmacies. For example:

a. On February 23, 2010, he received Hydrocodone (#60-5 day supply) dispensed at Sansum Clinic, Prescription No. 2272072, and Hydrocodone (#200-17 day supply) at The Medicine Shoppe Prescription No. 1142240;

b. On October 14, 2010, he received Hydrocodone (#60-4 day supply) dispensed at Sansum Clinic, Prescription No. 2277704, and Hydrocodone (#260-21 day supply) at Respondent LM Caldwell Pharmacists-Pueblo Street, Prescription No. 322231;

c. On January 5, 2011, he received Hydrocodone (#180-16 day supply) dispensed at Respondent LM Caldwell Pharmacist-Pueblo Street, Prescription No. 324789, and on January 7, 2011, he received Hydrocodone (#180-30 day supply) at LM Caldwell Pharmacists-State Street, Prescription No. 778577;

d. On November 11, 2011, he received Hydrocodone (#120-15 day supply) dispensed at Respondent LM Caldwell Pharmacist-Pueblo Street, Prescription No. 609846. On November 14, 2011, he received Hydrocodone (#150- 19 day supply) at LM Caldwell Pharmacists-State Street, Prescription No. 793104. On November 15, 2013, he received Hydrocodone (#90-30 day supply) dispensed at LM Pharmacist – State Street, Prescription No. 793216.

69. While going to Respondent L M Caldwell Pharmacist –State Street, Patient AM went to multiple pharmacies and received multiple prescriptions for Oxycodone 30 mg on or around the same time from Dr. Diaz which Patient AM had dispensed at different pharmacies. For example:

a. On July 21, 2010 he received Oxycodone (#60-15 day supply) dispensed at Sansum Clinic Pharmacy, Prescription No. 2275679 and on July 26, 2010 he received Oxycodone (#60-15 day supply) dispensed at L M Caldwell Pharmacist - State Street, Prescription No. 770660;

b. On January 5, 2011, he received Oxycodone (#180-15 day supply) dispensed at Respondent LM Caldwell Pharmacist-State Street, Prescription No. 324788, and on January 7, 2011, he received Oxycodone (#180-15 day supply) at LM Caldwell Pharmacists-State Street, Prescription No. 778578;

c. On November 11, 2011, he received Oxycodone (#97-12 day supply) dispensed at San Ysidro Pharmacy, Prescription No. 609848. On November 14, 2011, he received Oxycodone (#150- 19 day supply) at Respondent LM Caldwell Pharmacists-State Street, Prescription No. 793105. On November 15, 2013, he received Oxycodone (#90-30 day supply) dispensed at Respondent LM Pharmacist – State Street, Prescription No. 793218.

RESPONDENT LM CALDWELL PHARMACIST-PUEBLO STREET AND RESPONDENT YAHYAVI

Records of Acquisition, Disposition and Storage of Drugs

70. Between December 18, 2010 and December 17, 2012, Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyani could not account for an inventory overage of 53,811 tablets of HC/AP 10/325 mg.

71. On January 16, 2013, Respondent LM Caldwell Pharmacist - Pueblo Street and Respondent Yahyavi were unable to provide the original prescription documents for RX # 327435, 334405, 317892, 317893, 317894, 330297, 323526, 324203, 325803, 325881, 312027, 316180, 315861, 322717, 322718, 319209, 322715, 330610, 333178, 334336, 318220, 331648, 322460, 332461, 326892, 327949, 332102, and 336005.

Furnishing and Purchasing of Dangerous Drugs or Devices Without Adequate Sales and Purchase Records

72. Between July 23, 2010 and December 28, 2012, Respondent L M Caldwell Pharmacist-Pueblo Street purchased HC/AP 10/325 mg from Respondent L M Caldwell Pharmacist-State Street without adequate purchase records.

Variation from Prescription Without Prior Consent of Prescriber

73. Review of prescriptions from January 1, 2010 to January 15, 2013 revealed that Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi deviated from the requirements of a prescription without the prior consent of the prescriber. Specifically, between January 1, 2010 and January 15, 2013, they dispensed the following prescriptions incorrectly:

a. Prescription No. 321310, was for Oxycodone 30 mg 1-2 every 6 hour as needed for pain. Respondents dispensed it as 1 tablet four times daily as needed for pain;

b. Prescription No. 321312, was for Xanax mg 1-2 times daily for panic. Respondents dispensed it as 1 tablet four times daily;

c. Prescription No. 325038, was for 30 mg 1-2 HC/AP 7.5/750 mg. Prescriber wrote 1 tablet every 6 hours as needed for pain and Respondents dispensed it as 1 tablet every 4-6 hours as needed for pain;

d. Prescription No. 331728, was for Dilaudid 8 mg, 1 every 6 hours #120. Respondents dispensed Hydromorphone 8 mg, 1-2 tablets every 6 hours;

e. Prescription No. 332908, was for Methadone 10 mg 7 tablets every 12 hours #400. Respondents dispensed it as 6 tablets every 12 hours;

f. Prescription No. 335645, was for Oxycodone IR 30 mg 1 tablet every 4-6 hour. Respondents dispensed Oxycodone IR 30 mg 1 tablet every 6 hours.

Dispensing The Balance of Schedule II Prescriptions Beyond 72 hours

74. Review of prescriptions, from January 1, 2010 to January 15, 2013, revealed that Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi partially filled prescriptions for controlled substances listed in Schedule II and then dispensed the balance of the prescription after the 72 hour period allowed for dispensing the balance of prescriptions. Specifically between January 1, 2010 to January 15, 2013, Respondents dispensed Prescription Nos. 329771, 331396, 332230, and 33265, then dispensed the balance of the prescriptions after 72 hours.

Prescriptions Dispensed by Respondent L M Caldwell Pharmacist- Pueblo Street and Respondent Yahyavi

75. Between January 1, 2011 and December 5, 2012, L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi dispensed at total of 11,215 controlled substance prescriptions of which 1,418 prescriptions were written by Dr. Diaz. The prescriptions were dispensed without regard to the following factors:

(1) Pattern of patients willing to drive long distance to obtain controlled substance prescriptions from Dr. Diaz and to fill the prescriptions at L M Caldwell Pharmacists and other pharmacies;

(2) Percentage of cash patients specific to listed prescribers and pattern of patients willing to pay cash for highly expensive prescriptions when insurance did not cover;

(3) Same or similar prescribing patterns for multiple patients, including at least three opiates and one to two tranquilizers;

(4) Irregular pattern of early refills/ patient returning too frequently.

76. Respondent L M Caldwell Pharmacists- Pueblo Street and Respondent Yahyavi failed to appropriately scrutinize patients' drug therapy with readily available tools such as CURES[6] reports and its own pharmacy records. Respondents did not have a process to validate prescriptions. As a result, they repeatedly dispensed controlled substances early in certain instances to patients who habitually engaged in doctor shopping and multiple pharmacy activity. Questionable drug therapies were visible from Respondent L M Caldwell- Pueblo Street's own records and showed the prescribing pattern of Dr. Diaz was repetitive and redundant with respect to the same controlled substances prescribed repeatedly for the majority of his patients. His prescribing habits included numerous large quantities of opiates in combination with minor tranquilizers. Patients received on average three to four pain medications with one to two anti-anxiety drugs. The patients included, but were not limited to GA, RB, CB, CC, JF, CG, GJ, IJ, ML, KM, MM, SP, VS, MS, and RS. Four of these patients were on Suboxone/Subtex, used for treating opiate addiction, prior to, during and/or after treatment by Dr. Diaz. A review of CURES and their own records would have been a red flag for Respondents. For example:

a. Patient GA went to 4 prescribers, in Goleta and Santa Barbara, and 3 pharmacies in Santa Barbara from January 1, 2009 to April 9, 2013. Patient GA had no anxiety history prior to April 21, 2011 and prior to seeing Dr. Diaz. However, Dr. Diaz started him with a high dose of Alprazolam 2 mg. Patient VA paid cash for his prescriptions when insurance did not cover the cost. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. He mainly went to Dr. Diaz while having prescriptions dispensed at Respondent LM Caldwell Pharmacist- Pueblo Street. Most pain medication was prescribed by Dr. Diaz, despite him not being a pain specialist. He received numerous prescriptions for HC/AP 10/325 mg and Methadone prescribed by Dr. Diaz on or around the same time he had them dispensed at different pharmacies. In the month of August 2010, for example, Patient VA received 960 tablets of HC/AP 10/325 mg within 30 days and received 10,400 mg per day, well above the recommended dose (of Acetaminophen) of 4,000 mg per day. In July of 2011, for

[6] Respondent Yahyavi advised the Board that he obtained access to CURES at the end of 2011.

example, Patient VA received 1,080 tablets of HC/AP 10/325 mg within 30 days. Patient VA received 13,000 mg per day. In January of 2011, for example, Patient VA received a 30 day supply of Methadone 10 mg from one pharmacy and then received another 30 day supply from another pharmacy, LM Pharmacist- Pueblo Street, ten days later on, January 25, 2011;

b. Patient RB went to 3 prescribers in Santa Barbara and 4 pharmacies, in Ojai and Santa Barbara from January 1, 2009 to April 9, 2013. He lived in OakView and traveled approximately 30.33 miles to Santa Barbara to see prescriber Dr. Diaz. Respondent LM Caldwell-Pueblo Street was approximately 33.17 miles from Patient RB's home and 2.88 miles from Dr. Diaz's office. Patient RB paid cash for his prescriptions and paid over $200.00 for Oxycodone and Hydromorphone. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. He mainly went to Dr. Diaz while having prescriptions dispensed at Respondent LM Caldwell Pharmacist- Pueblo Street. Most pain medication was prescribed by Dr. Diaz, despite him not being a pain specialist. The following prescriptions dispensed by LM Caldwell Pharmacists-Pueblo Street for Oxycodone were questionable: Prescription Nos. 347843, 347918, and 338143 were written by Dentist Jeff Peppard;

c. Patient CB went to 4 prescribers in Santa Barbara and 11 pharmacies, in Ojai and Santa Barbara, Port Hueneme, Sacramento and St. Louis Missouri from January 1, 2009 to April 9, 2013. He lived in Santa Barbara (although the exact address he listed could not be found through mapquest) and paid cash for his prescriptions. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. He mainly went to Dr. Diaz while having prescriptions dispensed at Respondent LM Caldwell Pharmacist- Pueblo Street. Most pain and anxiety medication was prescribed by Dr. Diaz, despite him not being a pain specialist. CB received multiple prescriptions for HC/AP 10/325 mg and Alprazolam @mg on or around the same time by Dr. Diaz which he had dispensed at different pharmacies, including for example: On March 26, 2010 Patient CB received HC/AP 10/325 #200 (25 day supply) dispensed at Rite Aid #5782 (Prescription No. 676053) and on April 9, 2010 he received HC/AP 10/325#240(30 day supply) dispensed at Respondent LM Caldwell Pharmacists-Pueblo Street (Prescription No. 316460). The prescriptions were refilled again at Ride Aid on April 29,

2010, May 29, 2010, June 14, 2010, July 10, 2010 and at Respondent L M Caldwell- Pueblo Street on May 24, 2010 and July 15, 2010. Patient CB received 440 tablets of HC/AP in 30 days, 5200 mg per day of Acetaminophen, well above the recommended 4,000 mg dose per day. In addition, September 27, 2010, Respondent L M Caldwell Pharmacists- Pueblo Street received 2 different prescriptions for Oxycodone 30 mg form Dr. Diaz's office for Patient CB. After Dr. Diaz was investigated, Patient CB did not get any prescriptions dispensed at L M Caldwell Pharmacist-Pueblo Street nor did patient CB have any significant history of pain or anxiety drug treatment.

d. Patient CC went to 22 prescribers and 13 pharmacies from January 1, 2009 to April 9, 2013. He went to prescribers in Bakersfield, Goleta, Isla Vista, Long Beach, Santa Barbara and Santa Maria. He went to pharmacies in Goleta, Santa Barbara, Torrance and Wilmington. Prior to and while going to Respondent L M Caldwell Pharmacist-Pueblo Street, Patient CC went to numerous prescribers and pharmacies. He lived in Goleta (although the exact two addresses he listed could not be found through mapquest) and paid cash for his prescriptions of HC/AP, Carisoprodol, Oxycodone/AP and Hydromorphine. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. He mainly went to Dr. Diaz while having prescriptions dispensed at Respondent LM Caldwell Pharmacist-Pueblo Street. Most pain medication was prescribed by Dr. Diaz, despite him not being a pain specialist. For example, Patient CC received 5,200 mg of Acetaminophen, an amount above the recommended dose of Acetaminophen of 4,000 mg in October and November of 2011 through the following prescriptions dispensed at Respondent L M Caldwell Pharmacists- Pueblo Street: Prescription No. 334473 for AP/Oxycodone 10/325 mg #240 (30 day supply) on October 20, 2011, Prescription No. 333957 for HC/AP 10/325 mg #240 (30 day supply) on October 31, 2011, Prescription No. 335134 for AP/Oxycodone 10/325 mg #240 (30 day supply) on November 14, 2011, Prescription No. 333957 for AP/HC 10/325 mg #240 (30 day supply) on November 23, 2011. On August 2, 2010, Respondent L M Caldwell Pharmacist –Pueblo Street dispensed 2 prescriptions for Alprazolam 2 mg, Prescription No. 318318 and 319040 on the same day. Patient CC continued to have most of his prescriptions dispensed at Respondent L M Caldwell

Pharmacist- Pueblo Street after Dr. Diaz. The number of pain medications and quantities were reduced.

e. Patient JF went to 1 prescriber, Dr. Diaz in Santa Barbara, and 4 pharmacies, in Ojai, Goleta, and Santa Barbara from January 1, 2009 to April 9, 2013. He lived Santa Barbara and paid for his prescriptions through insurance. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Patient JF had no significant pain history one year prior to January 20, 2010 and obtaining prescriptions from Dr. Diaz. However, Dr. Diaz began his treatment with Oxycontin 80 mg, Morphine Sulfate 100 mg and Oxycodone 30 mg. Also, Patient JF did not have a history of anxiety nine months prior to obtaining prescriptions from Dr. Diaz. However Dr. Diaz began treatment with Lorazepam 2 mg. Most pain medication was prescribed by Dr. Diaz, despite him not being a pain specialist. JF was prescribed the long acting opiates, Opana ER, Oxycontine, and MS Contin by Dr. Diaz at the same time and were dispensed by Respondent L M Caldwell Pharmacist-Pueblo Street. These long acting drugs are usually not prescribed together. Patient JF did not get any prescriptions dispensed at Respondent LM Caldwell Pharmacist- Pueblo Street after Dr. Diaz;

f. Patient CG went to 10 prescribers and 5 pharmacies in Santa Barbara from January 1, 2009 to April 9, 2013. She went to prescribers in Lompoc, Santa Barbara, Carpentaria and Sacramento. She lived in Carpentaria and traveled 10.63 miles to get to Dr. Diaz's Office in Santa Barbara and Respondent L M Caldwell Pharmacist- Pueblo Street was located 13.63 miles away from Patient CG's home. Patient CG paid for her prescriptions through insurance. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Patient CG mostly went to Respondent L M Caldwell Pharmacist-Pueblo Street while going to Dr. Diaz. Most pain medication was prescribed by Dr. Diaz, despite him not being a pain specialist. Respondent L M Caldwell Pharmacist- Pueblo Street dispensed prescriptions in November 2009 through February 2010 above the 4,000 mg recommended dose of Acetaminophen. Respondent L M Caldwell Pharmacist- Pueblo Street also dispensed numerous prescriptions for Suboxone, used for treatment of opioid addiction, from Dr. Diaz while prescribing other narcotics. Respondent L M Caldwell Pharmacist- Pueblo Street also dispensed

Prescription Nos. 312135, 312136, 333177, 333178, 335385, 33586 for the long action opiates, Opana ER and Oxycontine. Patient CG continued to get most pain and anxiety prescriptions dispensed at Respondent L M Caldwell Pharmacist-Pueblo Street after Dr. Diaz, but the quantity and therapy duplication was reduced by other prescribers. Respondent L M Caldwell Pharmacist-Pueblo Street dispensed Prescription Nos. 319209, 319172, 319173 which were telephoned by the prescriber's office but did not note the name of the agent of the prescriber nor the pharmacist who transcribed it;

g. Respondent L M Caldwell Pharmacist-Pueblo Street dispensed Prescription Nos. 337054, 337055 and 337056 with no prescriber signature and date to Patient IJ on January 3, 2012;

h. Patient ML went to 2 prescribers and 3 pharmacies, in Ojai, Goleta, and Santa Barbara from January 1, 2009 to April 9, 2013. She lived in Santa Barbara (same address as Patient IJ and Patient GJ) and paid cash for her prescriptions when not covered by insurance. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. While going to Respondent L M Caldwell Pharmacist-Pueblo Street, she mainly went to Dr. Diaz. Patient ML received various HC/AP drugs prescribed by Dr. Diaz on or around the same time which she had dispensed at multiple pharmacies, including Respondent L M Caldwell Pharmacist- Pueblo Street. ML Received 5,166 mg per day of Acetaminophen, for example in September of 2009, an amount over the recommended dose of Acetaminophen of 4,000 mg per day. She received 7,100 mg per day of Acetaminophen in November, 2010 from Respondent L M Caldwell Pharmacist- Pueblo Street and January 2011. Patient ML only had one pain prescription dispensed at Respondent L M Caldwell Pharmacist-Pueblo Street after Dr. Diaz. A review of Patient ML's Profile revealed she received mostly pain medication from Dr. Diaz, who was not a pain specialist;

i. Patient KM went to 4 prescribers in Santa Barbara and Lompoc and 13 pharmacies from January 1, 2009 to April 9, 2013. She went to pharmacies in Lompoc, Santa Barbara, Santa Maria, Orcutt and San Luis Obispo. She lived in Lompoc (same address as Patient MM) and traveled 55. 81 miles to Dr. Diaz's office and lived 53.28 miles from Respondent L M Caldwell

Pharmacist- Pueblo Street. Patient KM paid cash for her prescriptions and paid over $350.00 for Oxycodone and Hydromorphone. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. She received only pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist. On January 12, 2011, Patient KM received Oxycodone #180 and January 19, 2011 received Oxycodone #60. On February 11, 2011 he received #180 and on February 15, 2011, he received #60. KM should have had enough tablets and the unusual dosage changes should have been questioned by Respondent L M Caldwell Pharmacist- Pueblo Street. Patient KM did not get any pain or anxiety prescriptions dispensed at Respondent L M Caldwell Pharmacist- Pueblo Street after Dr. Diaz;

j. Patient MM went to 17 prescribers and 20 pharmacies from January 1, 2009 to April 8, 2013. She went to prescribers in Santa Barbara, Lompoc, Lodi, Encinitas, San Luis Obispo, Santa Maria, Solvang and Stanford and went to pharmacies in Lompoc, Santa Barbara, Santa Maria, Orcutt, Buellton, San Luis Obispo and Pismo Beach. Prior to going to Respondent L M Caldwell –Pueblo Street, she went to multiple pharmacies and prescribers. She lived in Lompoc (same address as Patient KM) and traveled 55. 81 miles to Dr. Diaz's office and lived 53.28 miles from Respondent L M Caldwell Pharmacist-Pueblo Street. Patient KM paid cash when early refills were obtained and/or when medication was not covered by insurance. Patient KM paid $327.00 for Oxycodone and $1,585.00 for Oxycontin. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. She received only pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist. Patient MM received multiple Oxycodone 30 mg prescriptions on or around the same time from Dr. Diaz which she had dispensed at multiple pharmacies. She also received multiple Oxycontin 80 mg prescriptions on or around the same time from Dr. Diaz which she had dispensed at multiple pharmacies, including at Respondent L M Caldwell Pharmacist-Pueblo Street. Patient MM also received Suboxone, prior to and while going to Respondent L M Caldwell Pharmacist-Pueblo Street. Patient MM did not get any pain or anxiety prescriptions dispensed at LM Caldwell Pharmacist- Pueblo Street after Dr. Diaz. Patient MM received only pain and anxiety medication

from Dr. Diaz, despite him not being a pain specialist. Patient MM paid $1,585.80 cash for Oxycontin 60 mg on July 4, 2010;

k. Patient SP went to 6 prescribers in Santa Barbara and 7 pharmacies from January 1, 2009 to April 9, 2013. She went to pharmacies in Lompoc, Santa Barbara, and Goleta. She lived in Santa Barbara and paid for her medication through insurance. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Patient SP received mostly pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist. Respondent L M Caldwell Pharmacist-Pueblo Street dispensed Prescription No. 33143 for Oxycodone IR (1 Tablet, twice daily #60) for a 30 day supply on July 18, 2011 and then again on July 28, 2011 (Prescription No. 33176, 1-3 tablets every 4-6 hours #240.) Patient SP also received therapy duplication in the form of Diazepam and Alprazolam and HC/AP and HC/Ibuprofen from Respondent L M Caldwell Pharmacist- Pueblo Street. Patient SP continued to get one pain medication dispensed at Respondent L M Caldwell Pharmacist- Pueblo Street after Dr. Diaz. The number of pain drugs prescribed by other prescribers was reduced. Patient SP was placed on Suboxone and did not have significant pain or anxiety after Dr. Diaz;

l. Patient VS went to 3 prescribers and 6 pharmacies from January 1, 2009 to April 8, 2013. She went to prescribers in Santa Barbara, Lompoc and Goleta and went to pharmacies in Lompoc, Santa Barbara, and Santa Maria. She lived in Lompoc (same address as Patient MM) and traveled 55. 81 miles to Dr. Diaz's office and lived 53.28 miles from Respondent L M Caldwell Pharmacist- Pueblo Street. Patient VS paid cash for her prescriptions when insurance did not cover the cost of medication. Patient VS paid over $250.00 for Oxycodone and $220.00 Hydromorphone. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Patient VS received mostly pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist. Respondent L M Caldwell Pharmacist- Pueblo Street dispensed Prescription Nos. 33225, 033221, 33220, 33223 and 33222 with a written date that was not in the prescriber's handwriting. Patient VS received Hydromorphone 4 mg and 8 mg at or around the same time prescribed by Dr. Diaz which he had dispensed sometimes at the same pharmacy, including Respondent L M Caldwell Pharmacist- Pueblo Street. Patient VS did not get

any pain or anxiety medication dispensed at LM Caldwell Pharmacist- Pueblo Street after September 14, 2011 and did not have any significant pain or anxiety history after Dr. Diaz was investigated.

m. Patient MS went to 7 prescribers and 12 pharmacies from January 1, 2009 to April 9, 2013. She went to prescribers in Santa Barbara, Solvang, and Goleta and to pharmacies in Lompoc, Santa Barbara, Oxnard, Santa Ynez Santa Maria and Goleta. She lived in Santa Barbara and paid cash for her medication. She paid approximately $350.00 for Hydromorphone, $103 for Methadone, $130.00 for Alprazolam, $218.00 for HC/AP, and $200.00 for Oxycodone. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Patient MS went to multiple pharmacies and mainly went to Dr. Diaz. Patient MS received mostly pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist. Patient MS received multiple prescriptions for AC/AP 10/325 mg from Dr. Diaz which she dispensed at multiple pharmacies. She received 600-840 tablets of HC/AP within 30 days and received 7,800 mg per day to 9,750 mg per day of Acetaminophen. The practice of Patient MS receiving multiple prescriptions dispensed at multiple pharmacies began in March of 2010 and continued monthly until November of 2011. Patient MS received multiple prescriptions for Alprazolam 2 mg from Dr. Diaz which she dispensed at multiple pharmacies. MS received 240-360 tablets of Alprazolam within 30 days. Patient MS had a couple of pain prescriptions dispensed at Respondent L M Caldwell Pharmacist-Pueblo Street after Dr. Diaz and the quantities and therapy duplications prescribed by other prescribers were reduced;

n. Patient RS went to 2 prescribers in Santa Barbara and 6 pharmacies in Santa Barbara and Goleta from January 1, 2009 to April 9, 2013. She lived in Santa Barbara and paid cash for her medication. She paid approximately $225.00 for Hydromorphone, $175.00 for HC/AP, and $107 for Alprazolam. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Patient MS went to multiple pharmacies and mainly went to Dr. Diaz. Patient MS received mostly pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist. Patient RS had no significant pain or anxiety history prior to going to Dr. Diaz. However, Dr. Diaz began by prescribing him Methadone 10 mg, Hydromorphone 8 mg,

HC/AP 10/325 mg and Alprazolam 2 mg. Patient RS received multiple prescriptions for HC/AP 10/325 mg from Dr. Diaz which he dispensed at multiple pharmacies. Patient RS received 480 tablets of HC/AP within 30 days and received 5,200 mg per day of Acetaminophen. The practice of Patient RS getting multiple prescriptions dispensed at multiple pharmacies began in August of 2011 and continued monthly until December of 2011. Patient RS did not get any pain or anxiety prescriptions dispensed at Respondent LM Caldwell Pharmacist – Pueblo Street after Dr. Diaz. Respondent L M Caldwell Pharmacist- Pueblo Street dispensed Prescription No. 336005 for Buprenorphine, used for treatment of narcotic addiction on December 1, 2011, prescribed by Dr. Diaz.

77. L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi did not know the diagnosis for patients GA, RB, CB, CC, JF, CG, GJ, IJ, ML, KM, MM, SP, VS, MS, RS, and knew that Dr. Diaz was a family practitioner and not a pain management physician. Also, L M Caldwell Pharmacist-Pueblo Street and Respondent Caldwell failed to maintain records or files on drug therapy for these patients, and failed to check data in CURES.

78. When reviewing the records for patients GA, RB, CB, CC, JF, CG, GJ, IJ, ML, KM, MM, SP, VS, MS, and RS, it was noted that eight out of these fifteen patients lived outside Dr. Diaz's trading area and five out of nine lived outside of Respondent LM Caldwell Pharmacist-Pueblo Street normal trading area. The range of distance travelled for the selected patients was between 6.97 miles for the shortest to 111.97 for the longest. The average distance traveled by the patient was 35.26 miles and the total distance these patients travelled to obtain controlled substances was excessive. Five of the fifteen patient home addresses were not recognized by Mapquest. In addition seven of the fifteen patients had the same address. Eight of the fifteen patients reviewed lived outside of Dr. Diaz's normal trading area and five of fifteen lived outside of L M Caldwell Pharmacist-Pueblo Street normal trading area.

79. Most of the patients paid cash, including when the medication was not covered by their insurance or to get early refills. Some patients had insurance/Medicaid, however, were willing to pay a large sum of cash for controlled substances which were not covered by the plans, including those on Medicaid.

80. There was excessive furnishing of controlled substances prescribed by Dr. Diaz. The dispensing ratio of prescriptions by Dr. Diaz by L M Caldwell Pharmacist -Pueblo Street and Respondent Yahyavi was greatly unbalanced when compared to other neighboring pharmacies, including the following three pharmacies: Federal Drugs PHY37078 (located 1.83 miles from L M Caldwell Pharmacist-Pueblo Street), Rite-Aid #5785 PHY 42255 (located 1.72 miles from L M Caldwell Pharmacist-Pueblo Street), and CVS#9392 PHY 494473 (located 1.46 miles from L M Caldwell Pharmacist-Pueblo Street). Respondent L M Caldwell Pharmacist-Pueblo Street filled tens of thousands more controlled substances prescribed by Dr. Diaz when compared to neighboring pharmacies for the time period specified of January 1, 2011 through December 5, 2012. The CURES data for the L M Caldwell Pharmacist- Pueblo Street and three surrounding pharmacies, for example, was as follows:

Pharmacy	Total controlled substances dispensed between 1/1/2011-12/5/2012	Total Dr. Diaz's RX from 1/1/2011-12/5/2012	Total quantity for Dr. Diaz's RX from 1/1/2011-12/5/2012	% of total controlled substance RX dispensed for Dr. Diaz
Respondent LM Caldwell Pharmacist – Pueblo Street	**11,215**	**1,418**	**215,186**	**12.64%**
Federal Drugs PHY 37078 (1.92 miles from LM Caldwell)	18, 282	0	0	0%
Rite-Aid #5785 PHY 42255 (.065 miles from LM Caldwell Pharmacist	3,584	0	0	0%
CVS # 9392 PHY 49473 (.41 miles from LM Caldwell)	13,365	44	6,599	.33%

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Pattern of Early Refills and Duplicate Medications

81. Between January 1, 2010 and December 7, 2012, LM Caldwell-Pueblo Street engaged in a pattern of early refills, including for Patients GA, RB, CB, CC, JF, CG, GJ, IJ, ML, KM, MM, SP, VS, MS and RS, including, for example, 22 days early for Patient RB (Prescription Nos. 335933 & 336232), 24 days early for Patient CB (Prescription Nos. 328602 & 328602) 25 days for Patient CC (Prescription Nos. 325881 & 326067), 16 days early for Patient CG (Prescription Nos. 312824 & 312824), 25 days early for Patient GJ (Prescription Nos. 329632 & 329632), 18 days early for Patient IJ (Prescription Nos. 328627 & 328627) 27 days early for Patient ML (Prescription Nos. 317889 & 31789), 29 days early for Patient MM (Prescription Nos. 326892 & 326705), and 16 days early for Patient MS (Prescription Nos. 331092 & 331728).

Patient AM

82. On December 10, 2013, the Board received a medical malpractice payment report, Santa Barbara Superior Court, Case No. 1414079, from American Casualty Co. of Reading PA for Respondent Yahyavi, without admission of negligence or liability. On February 3, 2014, the Board received a report of settlement judgment or arbitration award, Case No. 1414079, from Chicago Insurance Company for Respondent Yahyavi, without the admission of guilt. Prescribing of narcotic medication which led to death was alleged in the civil suit. The Board confirmed that both settlement reports were regarding Patient AM and the insurance companies split the costs of settlement. Patient AM, presented prescriptions from a medical doctor which Respondent Yahyavi dispensed. On November 25, 2011, Patient AM died from acute complications from narcotic abuse. At the time of his death, Patient AM had multiple controlled substances in his system.

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83. A review of Respondent L M Caldwell Pharmacists- Pueblo Street's profile for Patient AM revealed that Patient AM received the following controlled substances at Respondent LM Caldwell Pharmacists-Pueblo Street:

RX Date	RX #	Drug	Prescriber
8/23/2010	320263	Hydromorphone 8 mg 2 tablets every 6 hours as needed for pain #240	Dr. Diaz
	230234	Oxycodone 30 mg 2 tablet every 6 hours as needed for pain. #240	
9/20/2010	321036	Hydromorphone 8 mg 2 tablets every 4-6 hours as needed for pain #240	Dr. Diaz
		Oxycodone 30 mg 2 tablet every 4-6 hours as needed for pain. #240	
10/14/2010	322230	Oxycodone 30 mg 2 tablet every 2-4 hours #260	Dr. Diaz
	322231	Hydromorphone 8 mg 2 tablets every 2-4 hours #260	
	322232	Methadone 10 mg 2 pills every 12 hours #120	
11/11/2010	323197	Hydromorphone 8 mg 2 tablets every 4-6 hours #260	Dr. Diaz
	323198	Oxycodone 30 mg 2 tablet every 4-6 hours #260	

84. A review of Respondent L M Caldwell Pharmacists- Pueblo Street's profile for Patient AM and CURES records also revealed that Patient AM saw 4 prescribers and went to 8 pharmacies from January 1, 2009 to April 8, 2013. Patient AM saw prescribers in Santa Barbara, Solvang, and Shell Beach. Patient AM received only pain medication from Dr. Diaz, despite him not being a pain specialist. Patient AM traveled over 70 miles from home in Solvang to obtain the prescriptions from Dr. Diaz and then to Respondent LM Caldwell Pharmacists-Pueblo Street to have the prescriptions dispensed. Patient AM paid cash for his medication.

85. Respondent LM Caldwell Pharmacists-Pueblo Street and Respondent Yahyavi dispensed 9 prescriptions for AM. However, if they would have checked CURES data, they would have been able to determine there were unusual prescribing patterns for Dr. Diaz and that Patient AM was going to multiple pharmacies. Patient AM, for example, went to 2 separate pharmacies on the same day to get Oxycodone and Hydromorphone. Since Respondent Yahyavi knew Dr. Diaz as the "Candy Man," he should have questioned the legitimacy of his prescriptions.

86. From January 1, 2010 to January 1, 2014, Respondent LM Caldwell Pharmacists-Pueblo Street and Respondent Yahyavi, failed to exercise best professional judgment while dispensing controlled substance prescriptions for Patient AM prescribed by Dr. Diaz. There were significant, objective factors of irregularity in AM's prescriptions, including repetitive prescribing patterns for highly abused controlled substances, the location of prescriber's practice in relation to the location of AM's residence, and the patient's payment methods. Respondent Yahyavi also failed to appropriately scrutinize patients' drug therapy with readily available tools such as CURES reports and its own pharmacy records. The result of this negligence was the dispensing of controlled substances for AM who habitually engaged in doctor shopping and multiple pharmacy activity. Respondent Yahyavi should have questioned the legitimacy of the prescriptions it and Respondent L M Caldwell Pharmacists-Pueblo Street dispensed to Patient AM.

Patient ES

87. On May 4, 2015, the Board received a settlement payment report, Santa Barbara Superior Court, Case No. 1439529, from Chicago Insurance Company for Respondent Yahyavi, without admission of negligence or liability. On May 7, 2015, the Board received a report of settlement judgment or arbitration award, Case No. 1439529, from American Casualty Co. of Reading for Respondent Yahyavi, without the admission of guilt. The Board confirmed that both settlement reports were regarding Patient ES and the insurance companies split the costs of settlement. Patient ES presented prescriptions from a medical doctor, Dr. Diaz, which Respondent Yahyavi dispensed. The civil complaint alleged that ES became addicted to

prescription medications and ultimately died resulting from negligent prescribing by Dr. Diaz and negligent dispensing by Respondent L M Caldwell Pharmacists-Pueblo Street and Respondent Yahyavi. The complaint further alleged that the pharmacists failed to conduct an appropriate drug utilization review of patient prescription data in dispensing ES's prescriptions. The coroner determined ES's death was an "accidental death due to multiple drug ingestion."

88. A review of the PAR for Patient ES revealed that all but two of ES's prescriptions filled in 2009 and 2010 were written by Dr. Diaz. The PAR for ES contained 32 entries for controlled substance prescriptions filled in 2009 and 37 entries for controlled prescriptions filled in 2010. Starting in July 15, 2009, ES received all but three of her prescriptions from LM Caldwell Pharmacists- Pueblo Street. No documentation was found supporting verification of ES's prescriptions or regarding communication with Dr. Diaz regarding ES's prescriptions. Further, the irregularities found in the prescriptions remained unresolved even if Dr. Diaz would have been consulted.

89. The majority of the prescriptions ES received in 2010 were controlled substances. Of 70 prescriptions ES received in 2010, 55 prescriptions (78.57%) were written for controlled substances and 15 were written for non-controlled substances. These prescriptions included pain medications prescribed by Dr. Diaz, despite him not being a pain specialist. Of the 15 non-controlled substance prescriptions, 9 prescriptions were written for Carisoprodol 350 mg federally classified as a controlled substance on January 11, 2012 due to its potential for abuse and diversion. Accordingly, as of 2012, 64 out of 70 prescriptions were considered controlled substances (91.4%). ES received 11 different medications from LM Caldwell Pharmacists-Pueblo Street in 2010. Indications for the medications ES received included attention deficit disorder, muscle spasms, anxiety, diarrhea, pain, diabetes, asthma, and seizures or migraine headaches.

90. ES receive very large daily dose of narcotic pain relievers. The following table includes prescriptions ES received in June 2010:

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Drug	Quantity	Days Supply	Mg per day	Morphine Equivalent Daily Dose[7]
Hydromorphone 8 mg	180	30	48 mg	192 mg
Hydrocodone/acetaminophen 10/325mg	180	25	72 mg (hydrocodone)	72 mg
Methadone 10 mg	90	30	30 mg	240 mg
Hydrocodone/acetaminophen 7.5/750 mg	150	30	37.5 mg (hydrocodone)	37.5 mg
				Total 541.5 mg

91. ES received excessive quantities and doses of narcotic pain relievers. For example, ES received 600 tablets of narcotic pain relievers in June 2010, an average of over 19 tablets per day. If ES took these four medications concurrently and as directed, she would have received a daily dose of Morphine equivalent to approximately 541 mg. ES received potentially duplicative therapy including two strengths of the same medication, hydrocodone/acetaminophen 7.5/750 mg and hydrocodone/acetaminophen 10/325 mg. Between June 21, 2010 and August 23, 2010, ES received prescriptions for two different strengths of hydrocodone/acetaminophen combinations. Taken together, these two medications contained between 5,258 mg and 5,892 mg per day - more than the recommended maximum daily dose of acetaminophen, 4 g (4,000 mg).[8] A patient receiving more than 4 g of acetaminophen per day represents a significant irregularity which would warrant a pharmacist's conference with the prescriber to attempt to resolve the dosing issue. The combination of a benzodiazepine (clonazepam) and methadone along with three other narcotic pain relievers (hydrocodone/acetaminophen 10/325 mg, hydrocodone acetaminophen

[7] The Morphine Equivalent Dose of a medication can be considered the dose of Morphine which would achieve the same effect as a dose of the given medication.

[8] The maximum daily dose of acetaminophen in 2010 was 4 g (4,000 mg) per day. In 2014, the recommended maximum daily dose was decreased to 3, 250 mg per day but doses up to 4, 000 may still be used under provider supervision.

7.5/750 mg, and hydromorphone) was a significant irregularity in ES's profile. ES received prescriptions for methadone and clonazepam despite a potentially serious drug interaction between these two drugs in that clonazepam may increase the respiratory depressant effect of methadone. Dr. Diaz's prescriptions for ES, which included high dose narcotics and medications to treat anxiety and attention-deficit disorder, were inconsistent with his self-reported areas of practice on the public Breeze of general practice, geriatric medicine and pathology.

92. Also, because Respondent Yahyavi knew Dr. Diaz as the "Candy Man," as stated above, he should have questioned the legitimacy of his prescriptions.

93. Respondent LM Caldwell Pharmacists-Pueblo Street and Respondent Yahyavi failed to exercise best professional judgment while dispensing controlled substance prescriptions for Patient ES prescribed by Dr. Diaz. There were significant, objective factors of irregularity in ES's prescriptions from Dr. Diaz that should have indicated to LM Caldwell Pharmacists-Pueblo Street and Respondent Yahyavi that these prescriptions were not issued in the usual course of professional treatment. These factors include: ES's dispensing history for 2010 containing 91.4% controlled substances or Carisopodol, the receipt of more than 4 mg of acetaminophen per day, the combination of a benzodiazephine (clonazepam) and methadone along with three other narcotic pain relievers (hydrocodone/acetaminophen 10/325 mg, hydrocodone acetaminophen 7.5/750 mg, and hydromorphone), and the repetitive prescribing patterns for highly abused controlled substances. Respondent Yahyavi should have questioned the legitimacy of the prescriptions it and Respondent L M Caldwell Pharmacists-Pueblo Street dispensed to Patient ES.

Conviction and Medical Board Disciplinary Action

94. On April 29, 2011, the Board received an arrest report from the California Department of Justice for Pharmacy Technician DLM who had been arrested on allegations that he stole Oxycontin from his employer Respondent L M Caldwell Pharmacist-State Street and sold the drugs to an undercover detective. In May of 2011, Pharmacy Technician DLM, following a plea, was convicted of the sale of a controlled substance Oxycontin under Health and Safety Code section 11352, subdivision (a).

95. On January 5, 2012, the Board received notification that Dr. Diaz was allegedly linked to a string of deaths involving prescriptions drugs and had been arrested for allegedly prescribing an excessive amount of painkillers to his patients. On May 13, 2014, the California Medical Board revoked Dr. Diaz's license as a general practitioner and his specialty in Geriatrics and Pathology for gross negligence in the care and treatment of a patient, prescribing excessive narcotic medications to patients, and failing to maintain adequate and accurate records.

Board Inspections and Audits

96. On July 13, 2011, January 1, 2013, and January 15, 2013, the Board inspected Respondent L M Caldwell Pharmacist-State Street. The Board also conducted audits of Respondent L M Caldwell Pharmacist-State Street from 2009 to January 2013.

97. On January 16, 2013, the Board inspected Respondent L M Caldwell Pharmacist-Pueblo Street. During the inspection, Respondent Yahyavi admitted to the inspector that he knew Dr. Diaz as the "Candy Man." The Board also conducted audits of Respondent L M Caldwell Pharmacist-Pueblo Street from 2009 to January 2013.

98. On April 8, 2013, the Board issued a written Notice of Noncompliance to Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell. The Board also issued a written Notice of Noncompliance to Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyani.

99. On July 31, 2013, the Board issued a written Notice of Noncompliance to Respondent L M Caldwell Pharmacists-Pueblo Street and Respondent Yahyavi.

100. On August 7, 2013, the Board issued another written Notice of Noncompliance to Respondent L M Caldwell Pharmacists-State Street and Respondent Caldwell.

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FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Lack of Operational Standards and Security- Pharmacy)

(Against Respondent L M Caldwell Pharmacist -State Street)

101. Respondent L M Caldwell Pharmacist-State Street is subject to discipline under section 4301, subsection (o) of the Code, and/or California Code of Regulations, title 16, section 1714, subsection (b), for failure to maintain its facilities, space, fixtures, and equipment so that drugs are safely and properly prepared, maintained, secured and distributed. The circumstances are that between November 15, 2009 to July 13, 2011, Respondent L M Caldwell Pharmacist-State Street could not account for the loss of 5,360 tablets of Hydromorphone 8 mg. Between August 6, 2011 to January 15, 2013, Respondent L M Caldwell Pharmacist-State Street could not account for the loss of 8,800 tablets of Hydromorphone 8 mg and the loss of 605 tablets of Oxycodone 30 mg. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraphs 44 through 46, as though set forth fully.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Lack of Operational Standards and Security- Pharmacist)

(Against Respondent Caldwell)

102. Respondent Caldwell is subject to discipline under section 4301, subdivision (o), of the Code, and California Code of Regulations, title 16, section 1714, subdivision (d), for failure to maintain the security of the prescription department, including provisions for effective control against theft or diversion of dangerous drugs and devices, and records for such drugs and devices and to ensure that possession of a key to the pharmacy where dangerous drugs and controlled substances are stored is restricted to pharmacists. The circumstances are that between November 15, 2009 to July 13, 2011, Respondent Caldwell could not account for the loss of 5,360 tablets of Hydromorphone 8 mg. Between August 6, 2011 to January 15, 2013, Respondent Caldwell could not account for the loss of 8,800 tablets of Hydromorphone 8 mg and the loss of 605 tablets of Oxycodone 30 mg. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraphs 44 through 46, as though set forth fully.

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THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Records of Acquisition and Disposition of Dangerous Drugs)

(Against Respondent L M Caldwell Pharmacist- State Street, Respondent L M Caldwell Pharmacist- Pueblo Street, Respondent Caldwell, and Respondent Yahyavi)

103. Respondent L M Caldwell Pharmacist-State Street, Respondent L M Caldwell Pharmacist-Pueblo Street, Respondent Caldwell and Respondent Yahyavi, are each and severally subject to disciplinary action under section 4081, subdivision (a), and section 4105, subdivision (a) of the Code, for failure to maintain all records of sale, acquisition or disposition of dangerous drugs at all times open to inspection and preserved for at least three years from the date of making. The circumstances are as follows:

a. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not account for the records of acquisition and disposition and the current inventory. Between November 15, 2009 and July 13, 2011, Respondent L M Caldwell Pharmacist- State Street and Respondent Caldwell could not account for an inventory overage (disposition greater than acquisition) of 55,370 tablets of HC/AP 10/325 mg and 165 tablets of Oxycodone SR 80 mg. Between August 6, 2011 and January 15, 2013, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not account for an inventory overage of 78,746 tablets of HC/AP 10/325 mg. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraphs 44 through 45, as though set forth fully.

b. Between January 5, 2010 and January 15, 2013, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not account for prescription hardcopies for Prescriptions Nos. 793824, 793825, 793826, 789177, 789188, 793189, 793190, 805552, 782075, 792283, 793432, 793184, 791387, 797610, 787609, 790594, 790595, 790597, 795658, 804361, 792346, 793090, 795652, 776675, 773787, 779441, 780927, 790980, 792044, 792920, 792935 and 792928. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraphs 46, as though set forth fully.

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c. Between December 18, 2010 and December 17, 2012, Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi could not account for an inventory overage of 53,811 tablets of HC/AP 10/325 mg. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraph 70, as though set forth fully.

c. On January 16, 2013, LM Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi were unable to provide the original prescription documents for RX # 327435, 334405, , 317892, 317893, 317894, 330297, 323526, 324203, 325803, 325881, 312027, 316180, 315861, 322717, 322718, 319209, 322715, 330610, 333178, 334336, 318220, 331648, 322460, 332461, 326892, 327949, 332102, and 336005. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraph 71, as though set forth fully.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Provide Drug Sales and Purchase Records After Furnishing Dangerous Drugs) (Against Respondent L M Caldwell Pharmacist-State Street, Respondent L M Caldwell Pharmacist- Pueblo Street, Respondent Caldwell and Respondent Yahyavi)

104. Respondent L M Caldwell Pharmacist-State Street, Respondent L M Caldwell Pharmacist-Pueblo Street, Respondent Caldwell and Respondent Yahyavi, are each and severally subject to disciplinary action under section 4059, subdivision (b), of the Code, for furnishing a dangerous drug or dangerous device to each other without sales and purchase records that correctly give the date, names and addresses of the supplier and buyer, the drug or device and the quantity. The circumstances are as follows:

a. Between July 23, 2010 and December 28, 2012, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell sold HC/AP 10/325 mg to Respondent Caldwell Pharmacist- Pueblo Street without adequate sales records. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraph 49, as though set forth fully.

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b. Between July 23, 2010 and December 28, 2012, L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi purchased HC/AP 10/325 mg from Caldwell Pharmacist-State Street without adequate purchase records. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraph 72, as though set forth fully.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Failure to Exercise Corresponding Responsibility)

(Against Respondent L M Caldwell Pharmacist- State Street, Respondent L M Caldwell Pharmacist- Pueblo Street, Respondent Caldwell and Respondent Yahyavi)

105. Respondent L M Caldwell Pharmacist-State Street, Respondent L M Caldwell Pharmacist- Pueblo Street, Respondent Caldwell and Respondent Yahyavi are each and severally subject to disciplinary action under section 4301, subdivisions (d) and (j), of the Code, Health and Safety code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, subdivisions (a) and (b), for excessive furnishing of controlled substances with an established history of a high potential for abuse despite multiple cues of irregularity and uncertainty related to patient and prescriber factors, and in failing to comply with their corresponding responsibility to ensure that controlled substances are dispensed for a legitimate medical purpose:

a. Specifically, between January 1, 2011 and December 5, 2012, Respondent L M Caldwell Pharmacist- State Street, and Respondent Caldwell dispensed 1,492 controlled substance prescriptions written by Dr. Julio Diaz with disregard to the following factors: distance from the pharmacy to Dr. Diaz's office, distance from the pharmacy to each patient's home, percentage of cash patients specific to listed prescribers, pattern of patients willing to pay cash for highly expensive prescriptions, and same or similar prescribing patterns for individual patients from alleged pain specialists. Respondent L M Caldwell Pharmacist-State Street, and Respondent Caldwell failed to appropriately scrutinize patients' drug therapy with readily available tools such as CURES reports and its own pharmacy records, including to Patients VA, BA, KB, CD, LD, TF, JH, MM, AM, SM, SS, JS, NS, VS and CW. From January 1, 2010 to January 1, 2013, LM Caldwell Pharmacist-State Street and Respondent Caldwell failed to exercise their corresponding

responsibility with regard to Patient JJ. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraphs 50 through 69 as though set forth fully.

b. Specifically, between January 1, 2011 and December 7, 2012, Respondent L M Caldwell Pharmacist- Pueblo Street, and Respondent Yahyavi dispensed 1,418 controlled substance prescriptions written by Dr. Julio Diaz with disregard to the following factors: distance from the pharmacy to Dr. Diaz's office, distance from the pharmacy to each patient's home, percentage of cash patients specific to listed prescribers, pattern of patients willing to pay cash for highly expensive prescriptions, and same or similar prescribing patterns for individual patients from alleged pain specialists. Respondent L M Caldwell Pharmacist-Pueblo Street, and Respondent Yahyavi failed to appropriately scrutinize patients' drug therapy with readily available tools such as CURES reports and its own pharmacy records, including to Patients GA, RB, CB, CC, JF, CG, IJ, ML, KM, MM, SP, VS, MS and RS. From January 1, 2010 to January 1, 2014, LM Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi also failed to exercise their corresponding responsibility with regard to Patient AM. From January 11, 2010 to October 8, 2010, LM Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi failed to exercise their corresponding responsibility with regard to Patient ES. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraphs 75 through 95, as though set forth fully.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Dispensing Prescriptions Which Contains Significant Error, Omission, Irregularity, Uncertainty, Ambiguity or Alteration)

(Against Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell)

106. Respondent L M Caldwell Pharmacist- State Street, and Respondent Caldwell are each and severally subject to disciplinary action under section 4301, subdivision (o), of the Code, and California Code of Regulations section 1761, subdivisions (a) and (b), for dispensing a prescription which contained a significant error, omission, irregularity, uncertainty, ambiguity, or alteration, for failing to contact the prescriber to obtain information to validate the prescription, and/or for dispensing a controlled substance knowing or having the objective reason to know that

the prescription was not issued for a legitimate purpose, even after conferring with the prescriber. The circumstances are as follows:

a. On March 22, 2011, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell dispensed Prescription No. 784841 for Morphine Sulfate 10 mg/ml solution that was written with no quantity on the prescription with the quantity box for "151 & over" marked. Respondent L M Caldwell Pharmacist- State Street and Respondent Caldwell dispensed 360 mls of Morphine Sulfate solutions with no documentation on the prescription indicating that the prescribing physician, Dr. Diaz, was contacted to clarify the quantity. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraph 57, subparagraph (d), as though set forth fully.

b. On May 20, 2011, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell dispensed Prescription No. 784839 for Fentanyl 100 mcg/hour with directions to apply every 48 hours. The manufacturer's direction was to change the patch every 72 hours. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraph 57, subparagraph (e), as though set forth fully.

SEVENTH CAUSE FOR DISCIPLINE

(Exceeding the Day Supply for Controlled Substance Refills)

(Against Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell)

107. Respondent L M Caldwell Pharmacist-State Street, and Respondent Caldwell are each and severally subject to disciplinary action under Health and Safety Code section 11200, subdivision (b) for refilling a prescription for Schedule II or IV substance more than five times and/or in an amount, for all refills of that prescription taken together, exceeding a 120-day supply. The circumstances are as follows:

a. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell dispensed Prescription No. 782251 for Alprazolam, a Schedule IV controlled substance, on March 25, 2011 for a 30 day supply. They then refilled Prescription No. 782251 five times on April 22, 2011, May 18, 2011, June 16, 2011, July 18, 2011 and August 17, 2011, for a total of five (5) refills for a total of a 150-day supply. Complainant refers to, and by this reference,

incorporates the allegations set forth above in paragraph 58, subparagraph (a), as though set forth fully.

b. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell dispensed Prescription No. 782250 for Diazepam, a Schedule IV controlled substance, on March 25, 2011 for a 30 day supply. They then refilled Prescription No. 782250 on April 22, 2011, May 18, 2011, June 16, 2011, July 18, 2011 and August 17, 2011, for a total of five (5) refills for a total of a 150-day supply. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraph 58, subparagraph (b), as though set forth fully.

EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Variation from Prescription)

(Against Respondent L M Caldwell Pharmacist–Pueblo Street and Respondent Yahyavi)

108. Respondent L M Caldwell Pharmacist-Pueblo Street, and Respondent Yahyavi are each and severally subject to disciplinary action under section 4301, subdivision (o), of the Code, and California Code of Regulations section 1716, when they deviated from the requirements of a prescription without the prior consent of the prescriber. Specifically, between January 1, 2010 and January 15, 2013, they dispensed the following prescriptions incorrectly:

(1) Prescription No. 321310, was for Oxycodone 30 mg 1-2 every 6 hour as needed for pain. Respondents dispensed it as 1 tablet four times daily as needed for pain;

(2) Prescription No. 321312, was for Xanax mg 1-2 times daily for panic. Respondents dispensed it as 1 tablet four times daily;

(3) Prescription No. 325038, was for 30 mg 1-2 HC/AP 7.5/750 mg. Prescriber wrote 1 tablet every 6 hours as needed for pain and Respondents dispensed it as 1 tablet every 4-6 hours as needed for pain;

(4) Prescription No. 331728, was for Dilaudid 8 mg, 1 every 6 hours #120. Respondents dispensed Hydromorphone 8 mg, 1-2 tablets every 6 hours;

(5) Prescription No. 332908, was for Methadone 10 mg 7 tablets every 12 hours #400. Respondents dispensed it as 6 tablets every 12 hours;

(6) Prescription No. 335645, was for Oxycodone IR 30 mg 1 tablet every 4-6 hour. Respondents dispensed Oxycodone IR 30 mg 1 tablet every 6 hours.

Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraph 73, subdivisions (a) through (f) as though set forth fully.

NINTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Dispensing Balance of Schedule II Prescriptions Beyond 72 hours)

(Against Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi)

109. Respondent L M Caldwell Pharmacist-Pueblo Street, and Respondent Yahyavi are each and severally liable to disciplinary action under section 4301, subdivision (o), of the Code, and California Code of Regulations section 1745, subdivision (d), as it related to Code of Federal Regulations 1306.13, subdivision (a) as follows:

a. Review of prescriptions, from January 1, 2010 to January 15, 2013, revealed that Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi partially filled prescriptions for controlled substances listed in Schedule II and then dispensed the balance of the prescription after the 72 hour period allowed for dispensing the balance of prescriptions. Specifically between January 1, 2010 to January 15, 2013, Respondents dispensed Prescription Nos. 329771, 331396, 332230, and 33265, then dispensed the balance of the prescriptions after 72 hours. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraph 74 as though set forth fully.

OTHER MATTERS

110. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 30911 issued to Peter Caldwell to do business as L M Caldwell Pharmacist, L M Caldwell Pharmacist shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 30911 is placed on probation or until Pharmacy Permit Number PHY 30911 is reinstated if it is revoked.

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111. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 530911 issued to Peter Caldwell to do business as L M Caldwell Pharmacist while Peter Caldwell has been an officer and owner and had knowledge of or knowingly participated in any conduct for which the licensee was disciplined, Peter Caldwell shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 30911 is placed on probation or until Pharmacy Permit Number PHY 30911 is reinstated if it is revoked.

112. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 30912 issued to L M Caldwell Pharmacist dba L M Caldwell Pharmacists, LM Caldwell Pharmacist shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 30912 is placed on probation or until Pharmacy Permit Number PHY 30912 is reinstated if it is revoked.

113. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 530912 issued to Peter Caldwell to do business as L M Caldwell Pharmacist while Peter Caldwell has been an officer and owner and had knowledge of or knowingly participated in any conduct for which the licensee was disciplined, Peter Caldwell shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 30912 is placed on probation or until Pharmacy Permit Number PHY 30912 is reinstated if it is revoked.

DISCIPLINE CONSIDERATIONS

114. To determine the degree of discipline, if any, to be imposed on Respondent L M Caldwell Pharmacists-Pueblo Street, Complainant alleges that on or about February 27, 2007, in a prior action, the Board of Pharmacy issued Citation Number CI 2006-32134 against Respondent L M Caldwell Pharmacist-Pueblo Street for violating California Code of Regulations, title 16, section 1716. A copy of the citation is attached as Exhibit A. That Citation is now final and is incorporated as if fully set forth. Complainant further alleges that on or about November 14, 2008, in a prior action, the Board of Pharmacy issued Citation Number CI 2007-35415 against Respondent L M Caldwell Pharmacists-Pueblo Street for violating California Code of

Regulations, title 16, section 1716. A copy of the citation is attached as Exhibit B. That Citation is now final and is incorporated as if fully set forth.

115. To determine the degree of discipline, if any, to be imposed on Respondent Yahyavi, Complainant alleges that on or about February 27, 2007, in a prior action, the Board of Pharmacy issued Citation Number CI 2006-32988 against Respondent Yahyavi and ordered him to pay fines in the amount of $ 250.00 for violating California Code of Regulations, title 16, section 1716. A copy of the citation is attached as Exhibit C. That Citation is now final and is incorporated as if fully set forth. Complainant further alleges that on or about November 14, 2008, in a prior action, the Board of Pharmacy issued Citation Number CI 2008-37974 against Respondent Yahyavi and ordered him to pay fines in the amount of $750.00 for violating California Code of Regulations, title 16, section 1716. A copy of the citation is attached as Exhibit D. That Citation is now final and is incorporated as if fully set forth.

116. To determine the degree of discipline, if any, to be imposed on Respondent L M. Caldwell Pharmacists- State Street, Complainant alleges that on or about July 23, 2013, in a prior action, the Board of Pharmacy issued Citation Number CI 2011 49544 against Respondent L M. Caldwell Pharmacists- State Street for violating California Code of Regulations, title 16, section 1716 and section 1711, subdivisions (d) and (e). A copy of the citation is attached as Exhibit E. That Citation is now final and is incorporated as if fully set forth herein.

117. To determine the degree of discipline, if any, to be imposed on Respondent Caldwell, Complainant alleges that on or about July 23, 2013, in a prior action, the Board of Pharmacy issued Citation Number CI 2013 57599 against Respondent Caldwell for violating California Code of Regulations, title 16, section 1716 and section 1711, subdivisions (d) and (e). A copy of the citation is attached as Exhibit F. That Citation is now final and is incorporated as if fully set forth herein. Respondent Caldwell, Complainant alleges that on or about February 29, 2012, in a prior action, the Board of Pharmacy issued Citation Number CI 2010 48187 against Respondent Caldwell for violating California Code of Regulations, title 16, section 1732.5 and Business and Professions Code 4231, subdivision (d) and 4301, subdivision (g). A copy of the citation is attached as Exhibit G. That Citation is now final and is incorporated as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Pharmacy Permit Number PHY 30911, issued to Peter Caldwell to do business as L M Caldwell Pharmacist;

2. Revoking or suspending Pharmacy Permit Number PHY 30912, issued to L M Caldwell Pharmacist to do business as L M Caldwell Pharmacist;

3. Revoking or suspending Pharmacist License Number 25356, issued to Peter Craig Caldwell;

4. Revoking or suspending Pharmacist License Number 30041, issued to Abdul Yahyavi;

5. Prohibiting LM Caldwell Pharmacist (PHY 30911) from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 30911 is placed on probation or until Pharmacy Permit Number PHY 30911 is reinstated if Pharmacy Permit Number 50434 issued to L M Caldwell Pharmacist is revoked;

6. Prohibiting Peter Caldwell from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 30911 is placed on probation or until Pharmacy Permit Number PHY 30911 is reinstated if Pharmacy Permit Number 30911 issued to L M Caldwell Pharmacist is revoked;

7. Prohibiting LM Caldwell Pharmacist (PHY 30912) from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 30912 is placed on probation or until Pharmacy Permit Number PHY 30912 is reinstated if Pharmacy Permit Number 30912 issued to L M Caldwell Pharmacist is revoked;

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8. Prohibiting Peter Caldwell from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 30912 is placed on probation or until Pharmacy Permit Number PHY 30912 is reinstated if Pharmacy Permit Number 30912 issued to L M Caldwell Pharmacist is revoked;

9. Ordering L M Caldwell Pharmacist (PHY 30911), L M Caldwell Pharmacist (PHY 30912), Peter Craig Caldwell, and Abdul Yahyavi to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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

DATED: 6/27/16

VIRGINIA HEROLD
Executive Officer
Board of Pharmacy
Department of Consumer Affairs
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 First Amended Accusation Against: **PETER CRAIG CALDWELL doing business as L M CALDWELL PHARMACIST** **1509 State St.** **Santa Barbara, CA 93101** **Pharmacy Permit No. PHY 30911** **PETER CRAIG CALDWELL doing business as L M CALDWELL PHARMACIST** **235 West Pueblo St.** **Santa Barbara, CA 93105** **Pharmacy Permit No. PHY 30912** **PETER CRAIG CALDWELL** **1509 State St.** **Santa Barbara, CA 93101** **Pharmacist License No. RPH 25356** **ABDUL YAHYAVI** **1624 La Coronilla Drive.** **Santa Barbara, CA 93109** **Pharmacist License No. RPH 30041** Respondent.	Case No. 4867 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about December 1, 1984, the Board of Pharmacy issued Pharmacy Permit Number PHY 30911 to Peter Caldwell to do business as L M Caldwell Pharmacist located at 1509 State Street, Santa Barbara, CA 93101 (Respondent L M Caldwell Pharmacist-State Street). The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on December 1, 2015, unless renewed. Peter C. Caldwell has been the individual licensed owner of Respondent State Street Pharmacy since December 13, 1984. Peter C. Caldwell has been the Pharmacist-In-Charge of Respondent State Street Pharmacy since December 13, 1984.

3. On or about December 1, 1984, the Board of Pharmacy issued Pharmacy Permit Number PHY 30912 to Peter Caldwell to do business as L M Caldwell Pharmacist located at 235 West Pueblo Street, Santa Barbara, CA 93105 (Respondent L M Caldwell Pharmacist- Pueblo Street). The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on December 1, 2015, unless renewed. Abdul Yahyavi was the Pharmacist-In-Charge of Respondent Pueblo Street Pharmacy from December 1, 1984 to October 1, 2014. Catherine Young Nance became the Pharmacist in Charge on October 1, 2014.

4. On or about January 9, 1968, the Board of Pharmacy issued Pharmacist Number 25356 to Peter Craig Caldwell (Respondent Caldwell). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2016, unless renewed.

5. On or about December 10, 1975, the Board of Pharmacy issued Pharmacist Number 30041 to Abdul Yahyavi (Respondent Yahyavi). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2014, unless renewed.

JURISDICTION

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

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

8. Section 4300 of the Code states:

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

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

(1) Suspending judgment.

(2) Placing him or her upon probation.

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

(4) Revoking his or her license.

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

. . .

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

9. Section 4300.1 of the Code states:

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

STATUTORY AUTHORITY

10. Section 4301 of the Code states:

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

(a) Gross immorality.

(b) Incompetence.

(c) Gross negligence.

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

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

. . .

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

. . .

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

. . .

11. Section 4022 of the Code states

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

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

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

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

12. Section 4059 of the Code states:

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

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

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

(d) Any records that are maintained electronically shall be maintained so that the pharmacist-in-charge, the pharmacist on duty if the pharmacist-in-charge is not on duty, or, in the case of a veterinary food-animal drug retailer or wholesaler, the designated representative on duty, shall, at all times during which the licensed premises are open for business, be able to produce a hard copy and electronic copy of all records of acquisition or disposition or other drug or dispensing-related records maintained electronically.

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

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

13. Section 4081 of the Code states:

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

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

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

14. Section 4105 of the Code states:

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

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

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

(d) Any records that are maintained electronically shall be maintained so that the pharmacist-in-charge, the pharmacist on duty if the pharmacist-in-charge is not on duty, or, in the case of a veterinary food-animal drug retailer or wholesaler, the designated representative on duty, shall, at all times during which the licensed premises are open for business, be able to produce a hard copy and electronic copy of all records of acquisition or disposition or other drug or dispensing-related records maintained electronically.

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

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

(f) When requested by an authorized officer of the law or by an authorized representative of the board, the owner, corporate officer, or manager of an entity licensed by the board shall provide the board with the requested records within three business days of the time the request was made. The entity may request in writing an extension of this timeframe for a period not to exceed 14 calendar days from the date the records were requested. A request for an extension of time is subject to the approval of the board. An extension shall be deemed approved if the board fails to deny the extension request within two business days of the time the extension request was made directly to the board.

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

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16. Health and Safety Code section 11153 states in pertinent part:

(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.

(b) Any person who knowingly violates this section shall be punished by imprisonment in the state prison or in the county jail not exceeding one year, or by a fine not exceeding twenty thousand dollars ($20,000), or by both a fine and imprisonment.

(c) No provision of the amendments to this section enacted during the second year of the 1981-82 Regular Session shall be construed as expanding the scope of practice of a pharmacist.

17. Health and Safety Code section 11200 states in pertinent part:

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

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

(c) No prescription for a Schedule II substance may be refilled.

STATE REGULATORY AUTHORITY

18. California Code of Regulations, title 16, section 1711, states:

(a) Each pharmacy shall establish or participate in an established quality assurance program which documents and assesses medication errors to determine cause and an appropriate response as part of a mission to improve the quality of pharmacy service and prevent errors.

. . .

(d) Each pharmacy shall use the findings of its quality assurance program to develop pharmacy systems and workflow processes designed to prevent medication errors. An investigation of each medication error shall commence as soon as is reasonably possible, but no later than 2 business days from the date the medication error is discovered. All medication errors discovered shall be subject to a quality assurance review.

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(e) The primary purpose of the quality assurance review shall be to advance error prevention by analyzing, individually and collectively, investigative and other pertinent data collected in response to a medication error to assess the cause and any contributing factors such as system or process failures. A record of the quality assurance review shall be immediately retrievable in the pharmacy. The record shall contain at least the following:

1. the date, location, and participants in the quality assurance review;

2. the pertinent data and other information relating to the medication error(s) reviewed and documentation of any patient contact required by subdivision (c);

3. the findings and determinations generated by the quality assurance review; and,

4. recommend changes to pharmacy policy, procedure, systems, or processes, if any. The pharmacy shall inform pharmacy personnel of changes to pharmacy policy, procedure, systems, or processes made as a result of recommendations generated in the quality assurance program.

. . .

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

. . .

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

. . .

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

. . .

20. California Code of Regulations, title 16, section 1716, states:

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. Nothing in this regulation is intended to prohibit a pharmacist from exercising commonly-accepted pharmaceutical practice in the compounding or dispensing of a prescription.

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21. California Code of Regulations, title 16, section 1745, states:

. . .

(b) A "partially filled" prescription is a prescription from which only a portion of the amount for which the prescription is written is filled at any one time; provided that regardless of how many times the prescription is partially filled, the total amount dispensed shall not exceed that written on the face of the prescription.

. . .

(d) A pharmacist may partially fill a prescription for a controlled substance listed in Schedule II, if the pharmacist is unable to supply the full quantity ordered by the prescriber. The pharmacist shall make a notation of the quantity supplied on the face of the written prescription. The remaining portion of the prescription may be filled within 72 hours of the first partial filling. If the remaining portion is not filled within the 72-hour period, the pharmacist shall notify the prescriber. The pharmacist may not supply the drug after 72 hour period has expired without a new prescription.

22. 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.

FEDERAL REGULATORY AUTHORITY

23. 21 Code of Federal Regulations, part 1306, section 13.06.13 states, in pertinent part:

(a) The partial filling of a prescription for a controlled substance listed in Schedule II is permissible if the pharmacist is unable to supply the full quantity called for in a written or emergency oral prescription and he makes a notation of the quantity supplied on the face of the written prescription, written record of the emergency oral prescription, or in the electronic prescription record. The remaining portion of the prescription may be filled within 72 hours of the first partial filling; however, if the remaining portion is not or cannot be filled within the 72-hour period, the pharmacist shall notify the prescribing individual practitioner. No further quantity may be supplied beyond 72 hours without a new prescription.

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COSTS

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

DRUGS

25. Acetaminophen is a Schedule III controlled substance as designated in Health and Safety Code section 11056(e)(2) and is categorized as a dangerous drug pursuant to section 4022 of the Code.

26. Alprazolam, sold under the brand name Xanax, is a Schedule IV controlled substance under Health and Safety Code section 11057 and a dangerous drug under Business and Professions Code Section 4022. Alprazolam is used to treat anxiety disorders and panic disorder. Alprazolam is in a class of medications called benzodiazepines. Alprazolam comes as a tablet, An extended-release tablet, and an orally disintegrating tablet. The tablet and orally disintegrating table usually are taken two to four times a day. The extended-release tablet is taken once daily, usually in the morning. Alprazolam may heighten the euphoric effect resulting from the use of an Oxycodone.

27. Diazepam, a generic for the brand name Valium, a Benzodiazepam derivative, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(9) and is categorized as a dangerous drug pursuant to section 4022 of the Code.

28. Dilaudid is a trade name for Hydromorphone, an Opium derivative, which is classified as a Schedule II Controlled Substance pursuant to Health and Safety Code section 11055, subdivision (b)(1), and is a dangerous drug within the meaning of Business and Professions Code section 4022.

29. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(c)(8) and is a dangerous drug pursuant to Business and Professions Code section 4022.

30. Hydrocodone is in Schedule II of the Controlled Substances Act. Lortab, Norco and Vicodin, brand/trade names of preparations containing hydrocodone in combination with other non-narcotic medicinal ingredients, are in Schedule III pursuant to Health and safety Code section 11056(e)(4), and are categorized as dangerous drugs pursuant to section 4022.

31. Morphine Sulfate, the narcotic substance is a preparation of Morphine, the principal alkaloid of Opium. It is classified as a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivisions (b)(1)(L) and (b)(2). It is categorized as a dangerous drug pursuant to Business and Professions Code section 4022.

32. Norco is the brand name for the combination narcotic, Hydrocodone and Acetaminophen, and is a Schedule III[1] controlled substance pursuant to Health and Safety Code section 11056(e) and is categorized as a dangerous drug pursuant to Business and Professions Code section 4022

33. Opana ER is an opioid and schedule II controlled substance.

34. Opiates are types of narcotic drugs that act as depressants in the central nervous system. They come from opium, which can be produced naturally form poppy plants or derived form semi-synthetic alkaloids. Some of the most common opiates include morphine, codeine, heroin, hydrocodone and oxyodone. Opiates are pain killers and can produce drowsiness, nausea, constipation and slow breathing.

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

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[1] Effective October 6, 2014, the Drug Enforcement Administration rescheduled Hydrocodone combination products from schedule III to schedule II of the Controlled Substances Act. (See 21 CFR Part 1308 § 1308.12; 21 U.S.C. 812 (c))

36. Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M) and is a dangerous drug pursuant to Business and Professions Code section 4022. Oxycodone is a narcotic analgesic used for moderate to severe pain and it has a high potential for abuse.

37. Suboxone, the brand name of buprenorphine and naloxone, is classified as a Schedule IV controlled substance pursuant to Health and Safety Code section 11058(d), and is a dangerous drug pursuant to Business and Professions Code section 4022. It is used for the treatment of opiate addiction.

38. Tranquilizers are central nervous system depressant drugs classified as sedative-hypnotics and are classified into two main categories: minor tranquilizers (anxiolytic, or anti-anxiety agents) and major tranquilizers (neuroleptics) drugs used to treat sever mental illnesses. Minor tranquilizers may include Valium (diazepam), Librium/Novopoxide (chlordiazepoxide), Halcion (triazolam), ProSom (estazolam), Xanax and Ativan.

FACTS

RESPONDENTS

39. Respondent L M Caldwell Pharmacist-State Street and Respondent L M Caldwell Pharmacist-Pueblo Street (collectively Respondents L M Caldwell Pharmacists) are pharmacies operating in the Santa Barbara area.

40. Respondent Caldwell is the Pharmacist in Charge at Respondent L M Caldwell Pharmacist-State Street, and Respondent Yahyani was the Pharmacist in Charge at Respondent L M Caldwell Pharmacist- Pueblo Street up to October 1, 2014.

41. Pharmacy Technician DLM[2] was employed at Respondent Caldwell Pharmacist-State Street in 2011.

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[2] Names are not being used to protect identities but individuals will be identified during the course of discovery.

LM CALDWELL PHARMACIST-STATE STREET AND RESPONDENT CALDWELL

Records of Acquisition, Disposition and Storage of Drugs

42. Drugs acquired by Respondents L M Caldwell Pharmacist were stored at Respondent L M Caldwell Pharmacists-State Street. Drugs were sent to Respondent L M Caldwell Pharmacist-Pueblo Street as needed. Drug recordkeeping included a transfer document which showed the bottles sent to Respondent L M Caldwell Pharmacist-Pueblo Street. Also, the records for Respondent L M Caldwell Pharmacist-Pueblo Street were located at Respondent L M Caldwell Pharmacist-State Street.

43. Between November 15, 2009 and July 13, 2011, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not account for an inventory overage (disposition greater than acquisition) of 55,370 tablets of Hydrocodone/Acetaminophen (HC/AP) 10/325 mg and 165 tablets of Oxycodone SR 80 mg. Between August 6, 2011 and January 15, 2013, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not account for an inventory overage of 78,746 tablets of HC/AP 10/325 mg.

44. Between January 5, 2010 and January 15, 2013, Respondent L M Caldwell Pharmacist -State Street and Respondent Caldwell could not account for prescription hardcopies for Prescriptions Nos. 793824, 793825, 793826, 789177, 789188, 793189, 793190, 805552, 782075, 792283, 793432, 793184, 791387, 797610, 787609, 790594, 790595, 790597, 795658, 804361, 792346, 793090, 795652, 776675, 773787, 779441, 780927, 790980, 792044, 792920, 792935 and 792928.

Operational Standards and Security

45. Respondent Caldwell was responsible for the security and record keeping at Respondents L M Caldwell Pharmacists. Between November 15, 2009 to July 13, 2011, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not account for the loss of 5,360 tablets of Hydromorphone 8 mg. Between August 6, 2011 to January 15, 2013, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not

account for the loss of 8,800 tablets of Hydromorphone 8 mg and for the loss of 605 tablets of Oxycodone 30 mg.

46. Respondents L M Caldwell Pharmacists and Respondent Caldwell failed to maintain an effective control of the security of the prescription department against theft or loss of controlled substances/ dangerous drugs.

Furnishing and Purchasing of Dangerous Drugs or Devices Without Adequate Sales and Purchase Records

47. Between July 23, 2010 and December 28, 2012, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell sold HC/AP 10/325 mg to Respondent L M Caldwell Pharmacist- Pueblo Street without adequate sales records.

Prescriptions Dispensed by L M Caldwell Pharmacist- State Street and Respondent Caldwell

48. Between January 1, 2011 and December 5, 2012, L M Caldwell Pharmacist-State Street and Respondent Caldwell, dispensed a total of 11,817 controlled substance prescriptions of which 1,492 were prescriptions written by Dr. Julio Gabriel Diaz, a family practice prescriber. The prescriptions were dispensed without regard to the following factors:

(1) Pattern of patients willing to drive long distance to obtain controlled substance prescriptions from Dr. Diaz and to fill the prescriptions at L M Caldwell Pharmacists and other pharmacies;

(2) Percentage of cash patients specific to listed prescribers and pattern of patients willing to pay cash for highly expensive prescriptions when insurance did not cover;

(3) Same or similar prescribing patterns for multiple patients, including at least three opiates and one to two tranquilizers;

(4) Irregular pattern of early refills/ patient returning too frequently.

49. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell failed in their corresponding responsibility to appropriately scrutinize patients' drug therapy with readily

available tools such as CURES [3] reports and its own pharmacy records. Respondents did not have a process to validate prescriptions. As a result, they repeatedly dispensed controlled substances early in certain instances to patients who habitually engaged in doctor shopping and multiple pharmacy activity. Questionable drug therapies were visible from Respondent L M Caldwell-State Street's own records and showed the prescribing pattern of Dr. Diaz was repetitive and redundant with respect to the same controlled substances prescribed repeatedly for the majority of his patients. His prescribing habits included numerous large quantities of opiates in combination with minor tranquilizers. Patients received on average three to four pain medications with one to two anti-anxiety drugs. The patients included, but were not limited to, VA, BA, KB, CD, LD, TF, JH, MM, AM, SM, SS, JS, NS, VS, and CW. A review of CURES and their own records would have been a red flag for Respondents. For example:

a. Patient VA went to 4 prescribers and 18 pharmacies from January 1, 2009 to April 8, 2013, including in Santa Maria, Arleta, Santa Barbara and Ventura. He lived in Oxnard and traveled approximately 37.34 miles to Santa Barbara to see prescriber Dr. Diaz. LM Caldwell-State Street was approximately 39.67 miles from Patient VA's home and 1.85 miles from Dr. Diaz's office. Patient VA paid cash for his prescriptions. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. He mainly went to Dr. Diaz while having prescriptions dispensed at LM Caldwell Pharmacist- State Street. Most pain medication was prescribed by Dr. Diaz, despite him not being a pain specialist. He received numerous prescriptions for HC/AP 10/325 mg and Methadone prescribed by Dr. Diaz on or around the same time he had them dispensed at different pharmacies. In the month of August 2010, for example, Patient VA received 960 tablets of HC/AP 10/325 mg within 30 days. He received 10,400 mg per day, well above the recommended dose of (Acetaminophen) per day of

[3] CURES is an acronym for "California Utilization Review and Evaluation System." It contains over 100 million entries of controlled substance drugs that were dispensed in California. Pharmacists and prescribers can register with the Department of Justice to obtain access to the CURES data through the California Prescription Drug Monitoring Program (PDMP). Patient Activity Reports (PARs) are provided and reflect all controlled substances dispensed to an individual. CURES herein refers to CURES in general and PARs. Pharmacies are required to report to the California Department of Justice every schedule II, II and IV drug prescription under Health and Safety Code section 1165, subdivision (d).

4,000 mg per day. In July of 2011, for example, Patient VA received 1,080 tablets of HC/AP 10/325 mg within 30 days. Patient VA received 13,000 mg per day. In January of 2011, for example, Patient VA received a 30 day supply of Methadone 10 mg from one pharmacy and then received another 30 day supply from another pharmacy, LM Pharmacist-State Street, ten days later on, January 25, 2011;

b. Patient BA only saw one prescriber, Dr. Diaz, and went to 12 pharmacies from January 1, 2009 to April 8, 2013. He lived in Ventura and traveled approximately 31.53 miles to Santa Barbara to see prescriber Dr. Diaz. LM Caldwell-State Street was approximately 33.86 miles from Patient BA's home and 1.85 miles from Dr. Diaz's office. Patient BA paid cash for his prescriptions. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Patient BA received numerous prescriptions for HC/AP 10/325 mg and Methadone prescribed by Dr. Diaz on or around the same time he had them dispensed at different pharmacies. Most pain medication was prescribed by Dr. Diaz, despite him not being a pain specialist. In March of 2010, for example, Patient BA received 1200 tablets of HC/AP 10/325 within 30 days. He received 13,000 mg per day of Acetaminophen, well above the recommended dose of 4,000 mg per day. In February of 2011, for example, Patient BA received 720 tablets of HC/AP 10/325. He received 7800 mg per day of Acetaminophen;

c. Patient KB saw 5 prescribers and went to 11 pharmacies from January 1, 2009 to April 8, 2013, including in Carpentaria, Hollywood, Lompoc, Santa Barbara and Solvang. He lived in Santa Inez and traveled approximately 31.99 miles to Santa Barbara to see prescriber Dr. Diaz. LM Caldwell-State Street was approximately 29.10 miles from Patient VA's home and 1.85 miles from Dr. Diaz's office. Patient VA paid cash for his prescriptions. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. He received most pain medication from Dr. Diaz, despite him not being a pain specialist. Patient KB was dispensed 595 tablets of Oxycodone 30 mg in one month in Prescriptions 788268, 788632 and 789490. Patient KB, for example, was dispensed Oxycodone 30 mg at both Respondent L M Caldwell- State Street and at Respondent L M Caldwell- Pueblo Street on June 18, 2010, October

5, 2010, November 2, 2010 and November 29, 2010. Patient KB was placed on Suboxone, used for the treatment of narcotic addiction, prior to going to LM Caldwell Pharmacists- State Street;

d. Patient LD saw 4 prescribers and went to 2 pharmacies from January 1, 2009 to April 8, 2013, including in Carpentaria, Hollywood, Lompoc, Santa Barbara and Solvang. Patient LD lived in Santa Barbara and paid cash for his prescriptions. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. He received most pain medication from Dr. Diaz, despite him not being a pain specialist. While going to LM Caldwell Pharmacist-State Street, Patient LD mainly saw Dr. Diaz but saw two prescribers after Dr. Diaz. Several questionable prescriptions were filled including: Prescription No. 773360(HC/AP) and 773361 (HC/ibuprofen) which were both dispensed on September 21, 2010 and both had hydrocodone; Prescription Nos. 789181 (HC/ Ibuprofen), 789182 (Oxycodone/Ibuprofen) and 789180 (Oxycodone) were all dispensed on August 23, 2011 and contained the same drugs; and Prescription Nos. 790459, 790460 and 790458 had dates that were not written in the prescriber's handwriting; Prescription No. 792432 (Lorazepam) was for a large quantity of 300 pills and Respondent dispensed 120 pills and did not verify with the prescribers;

e. Patient TF saw 1 prescriber, Dr. Diaz, and went to 8 pharmacies January 1, 2009 to April 8, 2013, including in Lompoc, Goleta, San Luis Obispo, Santa Maria and Orcutt. He lived in Santa Barbara and paid cash for his prescriptions Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed;

f. Patient JH saw 4 prescribers and went to 12 pharmacies from February 13, 2009 to April 8, 2013. He saw prescribers in Santa Barbara, Lompoc and Temecula and went to pharmacies in Santa Maria, Santa Barbara, Temecula, Buelton, and Lompoc. He lived in Santa Maria and traveled approximately 61.53 miles to Santa Barbara to see prescriber Dr. Diaz. LM Caldwell-State Street was approximately 58.68 miles from Patient JH's home and 1.85 miles from Dr. Diaz's office. Patient JH paid cash for his prescriptions. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. He received only pain medication from Dr. Diaz, despite him not being a pain specialist. He did not have significant pain history one month prior to February 2009 and had a history of Anxiety 8 months

prior to August 2009 and before seeing Dr. Diaz. Respondent LM Caldwell Pharmacist-State Street should have questioned the following prescriptions dispensed to Patient JH on November 25, 2011: Prescription Nos. 793748 (Morphine Sulfate 30 mg), 793749 (Methadone 10 mg),793750 (HC/AP 10/325 mg), 793751 (Oxycodone 30 mg), 793756 (Hydromorphone 8 mg), 793757 (Alprazolam 2 mg). Records also show that the quantity and therapy duplication combination was reduced from November 30, 2009 to September 22, 2010, during the period that JH did not go to Dr. Diaz. He again began to receive large quantities and therapy duplication combinations when he went back to Dr. Diaz on September 30, 2010.

g. Patient MM saw 19 prescribers and went to 20 pharmacies from January 1, 2009 to April 8, 2013. She went to prescribers in Santa Barbara, Lompoc, Stanford, Encinitas, Santa Maria, Solvang, San Luis Obispo and San Francisco and went to pharmacies in Santa Barbara, Lompoc, Orcutt, San Luis Obispo, Pismo Beach, Buelton, and Santa Maria. He lived in Lompoc and traveled approximately 56.30 miles to Santa Barbara to see prescriber Dr. Diaz. LM Caldwell-State Street was approximately 53.69 miles from Patient MM's home and 1.85 miles from Dr. Diaz's office. Patient MM paid cash and paid through insurance for his prescriptions. For example, he paid $2,585.80 for Oxycontin 60 mg (Prescription No. 319145). Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. MM received numerous prescriptions for Oxycontin prescribed by Dr. Diaz on or around the same time and went to different pharmacies to get dispensed, including LM Caldwell Pharmacist-Pueblo Street;

h. Patient SM saw 7 prescribers and went to 11 pharmacies from January 1, 2009 to April 8, 2013, including L M Caldwell- Pueblo Street. He lived in Santa Barbara and paid cash for his prescriptions. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. L M Caldwell- State Street dispensed questionable prescriptions for Oxycodone in which instructions for use seemed too high (including receiving 16-24 tablets per day), including Prescription Nos. 782797, 777041, 789979 and 786575. Patient SM was placed on Suboxone, used for the treatment of narcotic addition, after no longer seeing

Dr. Diaz. SM received only pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist;

i. Patient SS saw 2 prescribers and went to 4 pharmacies from January 1, 2009 to April 8, 2013. He lived in Santa Barbara and paid cash for his prescriptions when insurance did not cover the cost. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. He showed no significant pain or anxiety history prior to 11/23/2010. L M Caldwell- State Street dispensed the following questionable prescriptions: Prescription Nos. 780807 and 783547 for Fentanyl patches above the recommended dosing interval of 72 hours. The pharmacy dispensed it for every 48 hours; Prescription Nos. 79027, 790597, 782251, and 782250 in which the patient received Diazepam 10 mg and Alprazolam 2 mg at the same time. Patient SS received most pain medication from Dr. Diaz, despite him not being a pain specialist;

j. Patient JS saw 4 prescribers and went to 4 pharmacies from January 1, 2009 to April 8, 2013. He lived in Lompoc and traveled approximately 55.98 miles to Santa Barbara to see prescriber Dr. Diaz. LM Caldwell-State Street was approximately 53.37 miles from Patient JH's home and 1.85 miles from Dr. Diaz's office. Patient JS had the same address as Patient NS. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Prior to going to LM Caldwell Pharmacist-State Street, Patient JS went to multiple pharmacies for Dr. Diaz's prescriptions. There was no significant pain history 6 months prior to June 18, 2009 and Dr. Diaz. Patient JS received only pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist;

k. Patient NS saw 3 prescribers and went to 5 pharmacies from January 1, 2009 to April 8, 2013. He lived in Lompoc and traveled approximately 55.98 miles to Santa Barbara to see prescriber Dr. Diaz. LM Caldwell-State Street was approximately 53.37 miles from Patient NS's home and 1.85 miles from Dr. Diaz's office. Patient NS had the same address as Patient JS. Patient NS paid cash for his prescriptions when the cost was not covered by insurance. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Prior to going to LM Caldwell Pharmacist-State Street, Patient JS went to multiple pharmacies for

Dr. Diaz's prescriptions. While going to L M Caldwell Pharmacist- State Street, he continued to use other pharmacies. Patient NS received only pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist;

l. Patient VS saw 3 prescribers and went to 5 pharmacies from January 1, 2009 to April 8, 2013, including LM Caldwell Pharmacist-State Street. He lived in Lompoc a and traveled approximately 55.47 miles to Santa Barbara to see prescriber Dr. Diaz. LM Caldwell-State Street was approximately 52.86 miles from Patient VS's home and 1.85 miles from Dr. Diaz's office. Patient VS paid cash for his prescriptions when the cost was not covered by insurance. Patient VS paid over $200.00 for Oxycodone several times. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Patient VS went to multiple pharmacies for Dr. Diaz's prescriptions. L M Caldwell - State Street dispensed the following questionable prescriptions: Hydromorphone 8 mg and Hydromorphone 4 mg were dispensed on January 1, 2011, February 2, 2011, March 2, 2011, March 30, 2011 and April 27, 2011. Oxycodone 30 mg and Oxycodone 5 mg was dispensed on April 27, 2011. The different strength of the prescriptions should have been red flags. Patient VS received only pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist;

m. Patient CW saw 2 prescribers and went to 2 pharmacies from January 1, 2009 to April 8, 2013. Patient CW lived in Santa Barbara and paid cash when the cost was not covered by insurance. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Respondent L M Caldwell- State Street dispensed questionable prescriptions, including the following: Amphetamine 30 mg and Amphetamine 20 mg dispensed at same time in Prescription Nos. 772453, 772454, 773785, 773783, 775368, 775363, 776678, 776679, 780924, 780923, 779437, 779438, 771122 and 771123 and Suboxone was prescribed by Dr. Diaz for pain on numerous occasions. Patient CW received mostly pain, and anxiety medications prescribed by Dr. Diaz, despite him not being a pain specialist.

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50. L M Caldwell Pharmacist-State Street and Respondent Caldwell did not know the diagnosis for patients VA, BA, KB, CD, LD, TF, JH, MM, AM, SM, SS, JS, NS, VS, and CW, and knew that Dr. Diaz was a family practitioner and not a pain management physician. Also, L M Caldwell Pharmacist-State Street and Respondent Caldwell failed to maintain records or files on drug therapy for these patients.

51. When reviewing the records for patients VA, BA, KB, CD, LD, TF, JH, MM, AM, SM, SS, JS, NS, VS, and CW, it was noted that nine out of these fifteen patients lived outside Dr. Diaz's and LM Caldwell Pharmacist-State Street's normal trading area . Due to the number of readily accessible pharmacies throughout California, the common trading area is considered to be 5 miles. The range of distance travelled for the selected patients was between 3.7 miles for the shortest to 122.06 for the longest. The average distance traveled by the patient was 59.18 miles and the total distance these patients travelled to obtain controlled substances was excessive. Four of the fifteen patients' home addresses were not recognized by Mapquest. Two patients had the same address, NS and JS.

52. Respondent LM Caldwell Pharmacist-State Street dispensed a total of 11,817 controlled substances prescriptions from January 1, 2011 to December 5, 2012 and 1,492 were prescribed by Dr. Diaz. 31.64 % (407 out of 1,492) of Dr. Diaz' patients paid cash, including when the medication was not covered by their insurance or to get early refills. Some patients had insurance/Medicaid, however, were willing to pay a large sum of cash for controlled substances which were not covered by the plans, including those on Medicaid.

53. There was excessive furnishing of controlled substances prescribed by Dr. Diaz. The dispensing ratio of prescriptions by Dr. Diaz by L M Caldwell Pharmacists-State Street and Respondent Caldwell was greatly unbalanced when compared to other neighboring pharmacies, including the following three pharmacies: Federal Drugs PHY37078 (located 1.92 miles from L M Caldwell Pharmacist-State Street), Rite-Aid #5785 PHY 42255 (located 1.65 miles from L M Caldwell Pharmacist-State Street), and CVS#9392 PHY 494473 (located .41 miles from L M Caldwell Pharmacist-State Street). L M Caldwell Pharmacist-State Street filled tens of thousands more controlled substances prescribed by Dr. Diaz when compared to neighboring

pharmacies for the time period specified of January 1, 2011 through December 5, 2012. The CURES data for the L M Caldwell Pharmacists-State Street and three surrounding pharmacies, for example, was as follows:

Pharmacy	Total controlled substances dispensed between 1/1/2011-12/5/2012	Total Dr. Diaz's RX from 1/1/2011-12/5/2012	Total quantity for Dr. Diaz's RX from 1/1/2011-12/5/2012	% of total controlled substance RX dispensed for Dr. Diaz
Respondent LM Caldwell Pharmacist – State Street	**11, 817**	**1,492**	**195,041**	**12.62%**
Federal Drugs PHY 37078 (1.92 miles from LM Caldwell)	18, 282	0	0	0%
Rite-Aid #5785 PHY 42255 (.065 miles from LM Caldwell Pharmacist	3,584	0	0	0%
CVS # 9392 PHY 49473 (.41 miles from LM Caldwell)	13,365	44	6,599	.33%

Pattern of Early Refills and Duplicate Medications

54. Between January 1, 2010 and December 5, 2012, LM Caldwell- State Street engaged in a pattern of early refills, including for patients KB, CD, LD, TF, JH, AM, SM, NS, VS, and CW, including, for example, 23 days early for patient LD (prescription Nos. 764100 & 764468), 29 days early for patient AM (prescription Nos. 791702 & 793219), 21 days early for patient SM (prescription Nos. 786128 & 786573), and 14 days early for patient CW (prescription Nos. 782792 & 782792).

55. Also, the patient profile from 2010 to 2012 for patient SS,[4] for example, showed numerous therapy duplicate medications prescribed by Dr. Diaz and dispensed by L M Caldwell Pharmacists- State Street and Respondent Caldwell[5]. The profile showed the following:

a. On January 18, 2011, when L M Caldwell Pharmacists-State Street started dispensing Fentanyl 100 mcg/hr to Patient SS (Prescription No. 778213), the pharmacists should have questioned the high doses of Fentanyl and whether Patient SS was previously on Fentanyl 100 mcg/hr prior to getting his prescription from L M Caldwell Pharmacist-State Street;

b. Patient SS was prescribed Methadone 3 tablets every twelve (12) hours on July 19, 2011 and on August 17, 2011 (Prescription Nos. 787609 & 788989) and each month thereafter, his dose was increased, four (4) tablets every twelve (12) hours on September 22, 2011 (Prescription No. 790594), and five (5) tablets every 12 hours on October 27, 2011 (Prescription No. 792268);

c. On March 15, 2011, ten (10) patches of Fentanyl 100 mcg/hr were dispensed, each for a thirty (30) day supply (Prescription No. 780807). Seven days later, on March 22, 2011, another 10 patches of Fentanyl 100 mcg/hr were prescribed and entered as a file only as "FO" (Prescription No. 782067);

d. On March 22, 2011, Prescription No. 784841 for Morphine Sulfate 10 mg/5ml solution was written with no quantity written on the prescription, but the quantity box of "151 & over" was marked and 360 mls were dispensed by Respondent L M Caldwell-State Street and Respondent Caldwell. This prescription was incomplete and the prescriber, Dr. Diaz, should have been contacted and the quantity documented after clarification from the prescriber;

e. On May 20, 2011, Patient SS was prescribed three different narcotic pain medications: Hydromorphone 8 mg one tablet daily (Prescription No. 784840) with Fentanyl 100 mcg/hour patch every forty-eight (48) hours (Prescription No. 784839) and Morphine Sulfate 10

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[4] Patient SS died in May 2012 allegedly as a result of a drug overdose.

[5] No prescriptions were dispensed by Respondent L M Caldwell-State Street or Respondent Caldwell for Patient SS from January 10, 2010 to December 30, 2010.

mg, 5ml every two (2) to four (4) hours (Prescription No. 784841). Prescription No. 784839 was dispensed by Respondent L M Caldwell-State Street and Respondent Caldwell, for Fentanyl 100 mcg/hour with directions to apply every forty-eight (48) hours. However, the manufacturer's direction was to change the patch every seventy-two (72) hours;

f. On July 18, 2011, Prescription No. 787610 for Morphine 20 mg/ml solution was written for 400 mls, but 360 mls was dispensed. This was a variation from the quantity prescribed;

Exceeding the Day Supply For Controlled Substance Refills

56. The patient profile from 2010 to 2012 for patient SS, also showed that the day supply was exceeded for controlled substance refills, for example, as follows:

a. A review of SS patient profile revealed that alprazolam and diazepam, classified as benzodiazepines were also dispensed from December 2010 to September 2011. Prescription No. 782251 for Alprazolam, a Schedule IV controlled substance, was originally dispensed on March 25, 2011 for a 30 day supply. Prescription No. 782251 was then refilled five times, each for a 30 day supply, on April 22, 2011, May 18, 2011, June 16, 2011, July 18, 2011 and August 17, 2011 by Respondent L M Caldwell-State Street and Respondent Caldwell. A total of 150-day supply was dispensed, exceeding a 120-day supply as required by Health and Safety code section 11200;

b. Prescription No. 782250 for Diazepam, a schedule IV controlled substance, was originally dispensed on March 25, 2011 then refilled five times, each for a 30 day supply, on April 22, 2011, May 18, 2011, June 16, 2011, July 18, 2011 and August 17, 2011 by Respondent L M Caldwell-State Street and Respondent Caldwell. A total of 150-day supply was dispensed, exceeding a 120-day supply as required by Health and Safety code section 11200.

Patient JJ

57. On September 12, 2013, the Board received a report of settlement judgment or arbitration award, San Bernardino Superior Court, Case No. 2012-112565, regarding Patient JJ, from Liberty Insurance Underwriter, Inc. for Respondent Caldwell, without the admission of guilt. Improper Management and dispensing of controlled substance resulting in addiction and death was alleged in the civil suit. Patient JJ presented prescriptions from a medical doctor

which Respondent Caldwell dispensed. Patient JJ alleged that she became addicted to drugs because Respondent Caldwell dispensed the prescriptions to her.

58. A review of Respondent L M Caldwell Pharmacists-State Street's profile for Patient JJ revealed that she was mostly dispensed controlled substances by Respondent Caldwell which were prescribed by Dr. Diaz, who was not a pain specialist. A review of CURES revealed that Patient JJ went to multiple doctors at the same time and had prescriptions dispensed at multiple pharmacies during the same time period. Patient JJ received numerous refills and received above the recommended dose of 400 mg per day of Acetaminophen. On certain months, Patient JJ received over 600 tablets of Hydrocodone. If Respondent Caldwell would have checked CURES, he would been able to determine JJ was going to several pharmacies and several doctors. Respondent Caldwell knew that patient was getting drugs from Dr. Diaz, prior to being indicted, and then continued to dispense prescriptions from other doctors to this patient.

59. Patient JJ had a pattern of early refills on Oxycodone 30 mg, for the management of moderate to severe pain, and Morphine Sulfate 30 mg, for the management of severe pain. Both medications are for the immediate relief of pain. LM Caldwell Pharmacist-State Street and Respondent Caldwell failed to contact the prescriber to determine the logic of this combination. Also, Prescription Nos. 768630 and 768631 were dated July 1, 2010. LM Caldwell Pharmacist-State Street and Respondent Caldwell received and dispensed them on June 11, 2010.

60. From January 1, 2010 to January 1, 2013, Patient JJ had 145 prescriptions for controlled substances dispensed from various prescribers and pharmacies. 85 of the 145 prescriptions (58.96 %) were for cash.

61. From January 1, 2010 to January 1, 2013, LM Caldwell Pharmacist-State Street and Respondent Caldwell failed to assume their corresponding responsibility when they failed to appropriately scrutinize Patient JJ's drug therapy with readily available tools such as CURES reports and its own pharmacy records. Respondents should have looked at the repetitive prescribing pattern for highly abused controlled substances, the location of prescriber's practice in relation to the location of JJ's residence, and Patient's payment methods. As a result, Respondents dispensed controlled substances for Patient JJ who was habitually engaged in doctor

shopping and multiple pharmacy activity. Respondents should have questioned the legitimacy of Prescriptions, including Prescription Nos. 758920, 767530, 767531, 768630, 768631, 758920 (for 1/18/2010, 3/19/2010, 2/18/2011, 2/18/2011), 782598 (for 4/1/2011, 5/17/2011), 803536, 803537, 803963,803965, 803966, 805071, 805072, 805074, 806756, 806757, 807683, 807684, 807699 and 807700.

Patient AM

62. On February 3, 2014, the Board received a report of settlement judgment or arbitration award, Case No. 1414079, regarding Patient AM, from Chicago Insurance Company for Respondent Caldwell- State Street, without the admission of guilt. Patient AM, presented a prescriptions from a medical doctor which Respondent Caldwell dispensed. On November 25, 2011, Patient AM died from acute complications from narcotic abuse.

63. A review of Respondent L M Caldwell Pharmacist-State Street's profile for Patient AM revealed that Patient AM received the following controlled substances, that were prescribed by Dr. Diaz, at LM Caldwell Pharmacists-State Street, and had a pattern of being dispensed early:

RX Dispensed	RX #	QTY	Day Supply	Date dispensed	RX#	QTY	Day Supply	Days Early from Prior RX
10/24/11	792077	120	30	11/14/11	793124	120	30	9 days
11/14/11	793104	150	19	11/15/11	793216	90	30	19
11/15/11	793105	150	19	11/15/11	793218	90	30	19
11/15/11	791702	120	30	11/15/11	793219	60	20	29

64. The Board could not find the exact patient address on Mapquest in Solvang, California. Patient AM traveled 35.56 miles from Solvang to Santa Barbara where Dr. Diaz was located. Patient AM lived approximately 70.09 miles away from Respondent LM Caldwell-State Street. Patient AM paid cash for his medication and Dr. Diaz was the prescriber. Respondents did not have access to CURES during the time Dr. Diaz dispensed to AM so it was not accessed. The pharmacy did not have a process to validate the prescriptions. As long as the Dr. wrote the prescription, the pharmacy dispensed it.

65. A review of Respondent L M Caldwell Pharmacist-Pueblo Street's profile for Patient AM and CURES records also revealed that Patient AM saw 4 prescribers and went to 8 pharmacies from January 1, 2009 to April 8, 2013. Patient AM saw prescribers in Santa Barbara, Solvang, and Shell Beach. Patient AM received only pain medication form Dr. Diaz, despite him not being a pain specialist.

66. LM Caldwell Pharmacist-State Street and Respondent Caldwell would have been able to determine there were unusual prescribing patterns for Dr. Diaz and that Patient AM was going to multiple pharmacies. While going to L M Caldwell Pharmacist-State Street, Patient AM went to multiple pharmacies and received multiple prescriptions for Hydrocodone 8 mg on or around the same time form Dr. Diaz which AM dispensed at different pharmacies. For example:

a. On February 23, 2010, he received Hydrocodone (#60-5 day supply) dispensed at Sansum Clinic, Prescription No. 2272072, and Hydrocodone (#200-17 day supply) at The Medicine Shoppe Prescription No. 1142240;

b. On October 14, 2010, he received Hydrocodone (#60-4 day supply) dispensed at Sansum Clinic, Prescription No. 2277704, and Hydrocodone (#260-21 day supply) at LM Caldwell Pharmacists-Pueblo Street, Prescription No. 322231;

c. On January 5, 2011, he received Hydrocodone (#180-16 day supply) dispensed LM Caldwell Pharmacist-Pueblo Street, Prescription No. 324789, and on January 7, 2011, he received Hydrocodone (#180-30 day supply) at LM Caldwell Pharmacists-State Street, Prescription No. 778577;

d. On November 11, 2011, he received Hydrocodone (#120-15 day supply) dispensed LM Caldwell Pharmacist-Pueblo Street, Prescription No. 609846. On November 14, 2011, he received Hydrocodone (#150- 19 day supply) at LM Caldwell Pharmacists-State Street, Prescription No. 793104. On November 15, 2013, he received Hydrocodone (#90-30 day supply) dispensed at LM Pharmacist – State Street, Prescription No. 793216.

67. While going to L M Caldwell Pharmacist –State Street, Patient AM went to multiple pharmacies and received multiple prescriptions for Oxycodone 30 mg on or around the same time from Dr. Diaz which Patient AM had dispensed at different pharmacies. For example:

a. On July 21, 2010 he received Oxycodone (#60-15 day supply) dispensed at Sansum Clinic Pharmacy, Prescription No. 2275679 and on July 26, 2010 he received Oxycodone (#60-15 day supply) dispensed at L M Caldwell Pharmacist - State Street, Prescription No. 770660;

b. On January 5, 2011, he received Oxycodone (#180-15 day supply) dispensed at LM Caldwell Pharmacist-State Street, Prescription No. 324788, and on January 7, 2011, he received Oxycodone (#180-15 day supply) at LM Caldwell Pharmacists-State Street, Prescription No. 778578;

c. On November 11, 2011, he received Oxycodone (#97-12 day supply) dispensed at San Ysidro Pharmacy, Prescription No. 609848. On November 14, 2011, he received Oxycodone (#150- 19 day supply) at LM Caldwell Pharmacists-State Street, Prescription No. 793105. On November 15, 2013, he received Oxycodone (#90-30 day supply) dispensed at LM Pharmacist – State Street, Prescription No. 793218.

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LM CALDWELL PHARMACIST-PUEBLO STREET AND RESPONDENT YAHYAVI

Records of Acquisition, Disposition and Storage of Drugs

68. Between December 18, 2010 and December 17, 2012, Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyani could not account for an inventory overage of 53,811 tablets of HC/AP 10/325 mg.

69. On January 16, 2013, LM Caldwell Pharmacist - Pueblo Street and Respondent Yahyavi were unable to provide the original prescription documents for RX # 327435, 334405, 317892, 317893, 317894, 330297, 323526, 324203, 325803, 325881, 312027, 316180, 315861, 322717, 322718, 319209, 322715, 330610, 333178, 334336, 318220, 331648, 322460, 332461, 326892, 327949, 332102, and 336005.

Furnishing and Purchasing of Dangerous Drugs or Devices Without Adequate Sales and Purchase Records

70. Between July 23, 2010 and December 28, 2012, Respondent L M Caldwell Pharmacist-Pueblo Street purchased HC/AP 10/325 mg from Respondent L M Caldwell Pharmacist-State Street without adequate purchase records.

Variation from Prescription Without Prior Consent of Prescriber

71. Review of prescriptions from January 1, 2010 to January 15, 2013 revealed that Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi deviated from the requirements of a prescription without the prior consent of the prescriber. Specifically, between January 1, 2010 and January 15, 2013, they dispensed the following prescriptions incorrectly:

a. Prescription No. 321310, was for Oxycodone 30 mg 1-2 every 6 hour as needed for pain. Respondents dispensed it as 1 tablet four times daily as needed for pain;

b. Prescription No. 321312, was for Xanax mg 1-2 times daily for panic. Respondents dispensed it as 1 tablet four times daily;

c. Prescription No. 325038, was for 30 mg 1-2 HC/AP 7.5/750 mg. Prescriber wrote 1 tablet every 6 hours as needed for pain and Respondents dispensed it as 1 tablet every 4-6 hours as needed for pain;

d. Prescription No. 331728, was for Dilaudid 8 mg, 1 every 6 hours #120. Respondents dispensed Hydromorphone 8 mg, 1-2 tablets every 6 hours;

e. Prescription No. 332908, was for Methadone 10 mg 7 tablets every 12 hours #400. Respondents dispensed it as 6 tablets every 12 hours;

f. Prescription No. 335645, was for Oxycodone IR 30 mg 1 tablet every 4-6 hour. Respondents dispensed Oxycodone IR 30 mg 1 tablet every 6 hours.

Dispensing The Balance of Schedule II Prescriptions Beyond 72 hours

72. Review of prescriptions, from January 1, 2010 to January 15, 2013, revealed that Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi partially filled prescriptions for controlled substances listed in Schedule II and then dispensed the balance of the prescription after the 72 hour period allowed for dispensing the balance of prescriptions. Specifically between January 1, 2010 to January 15, 2013, Respondents dispensed Prescription Nos. 329771, 331396, 332230, and 33265, then dispensed the balance of the prescriptions after 72 hours.

Prescriptions Dispensed by L M Caldwell Pharmacist- Pueblo Street and Respondent Yahyavi

73. Between January 1, 2011 and December 5, 2012, L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi dispensed at total of 11,215 controlled substance prescriptions of which 1,418 prescriptions were written by Dr. Diaz. The prescriptions were dispensed without regard to the following factors:

(1) Pattern of patients willing to drive long distance to obtain controlled substance prescriptions from Dr. Diaz and to fill the prescriptions at L M Caldwell Pharmacists and other pharmacies;

(2) Percentage of cash patients specific to listed prescribers and pattern of patients willing to pay cash for highly expensive prescriptions when insurance did not cover;

(3) Same or similar prescribing patterns for multiple patients, including at least three opiates and one to two tranquilizers;

(4) Irregular pattern of early refills/ patient returning too frequently.

74. Respondent L M Caldwell Pharmacists- Pueblo Street and Respondent Yahyavi failed to appropriately scrutinize patients' drug therapy with readily available tools such as CURES[6] reports and its own pharmacy records. Respondents did not have a process to validate prescriptions. As a result, they repeatedly dispensed controlled substances early in certain instances to patients who habitually engaged in doctor shopping and multiple pharmacy activity. Questionable drug therapies were visible from Respondent L M Caldwell- Pueblo Street's own records and showed the prescribing pattern of Dr. Diaz was repetitive and redundant with respect to the same controlled substances prescribed repeatedly for the majority of his patients. His prescribing habits included numerous large quantities of opiates in combination with minor tranquilizers. Patients received on average three to four pain medications with one to two anti-anxiety drugs. The patients included, but were not limited to GA, RB, CB, CC, JF, CG, GJ, IJ, ML, KM, MM, SP, VS, MS, and RS. Four of these patients were on Suboxone/Subtex, used for treating opiate addiction, prior to, during and/or after treatment by Dr. Diaz. A review of CURES and their own records would have been a red flag for Respondents. For example:

a. Patient GA went to 4 prescribers, in Goleta and Santa Barbara, and 3 pharmacies in Santa Barbara from January 1, 2009 to April 9, 2013. Patient GA had no anxiety history prior to April 21, 2011 and prior to seeing Dr. Diaz. However, Dr. Diaz started him with a high dose of Alprazolam 2 mg. Patient VA paid cash for his prescriptions when insurance did not cover the cost. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. He mainly went to Dr. Diaz while having prescriptions dispensed at LM Caldwell Pharmacist- Pueblo Street. Most pain medication was prescribed by Dr. Diaz, despite him not being a pain specialist. He received numerous prescriptions for HC/AP 10/325 mg and Methadone prescribed by Dr. Diaz on or around the same time he had them dispensed at different pharmacies. In the month of August 2010, for example, Patient VA received 960 tablets of HC/AP 10/325 mg within 30 days and received 10,400 mg per day, well above the recommended dose (of Acetaminophen) of 4,000 mg per day. In July of 2011, for example, Patient VA

[6] Respondent Yahyavi advised the Board that he obtained access to CURES at the end of 2011.

received 1,080 tablets of HC/AP 10/325 mg within 30 days. Patient VA received 13,000 mg per day. In January of 2011, for example, Patient VA received a 30 day supply of Methadone 10 mg from one pharmacy and then received another 30 day supply from another pharmacy, LM Pharmacist- Pueblo Street, ten days later on, January 25, 2011;

b. Patient RB went to 3 prescribers in Santa Barbara and 4 pharmacies, in Ojai and Santa Barbara from January 1, 2009 to April 9, 2013. He lived in OakView and traveled approximately 30.33 miles to Santa Barbara to see prescriber Dr. Diaz. LM Caldwell-Pueblo Street was approximately 33.17 miles from Patient RB's home and 2.88 miles from Dr. Diaz's office. Patient RB paid cash for his prescriptions and paid over $200.00 for Oxycodone and Hydromorphone. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. He mainly went to Dr. Diaz while having prescriptions dispensed at LM Caldwell Pharmacist- Pueblo Street. Most pain medication was prescribed by Dr. Diaz, despite him not being a pain specialist. The following prescriptions dispensed by LM Caldwell Pharmacists-Pueblo Street for Oxycodone were questionable: Prescription Nos. 347843, 347918, and 338143 were written by Dentist Jeff Peppard;

c. Patient CB went to 4 prescribers in Santa Barbara and 11 pharmacies, in Ojai and Santa Barbara, Port Hueneme, Sacramento and St. Louis Missouri from January 1, 2009 to April 9, 2013. He lived in Santa Barbara (although the exact address he listed could not be found through mapquest) and paid cash for his prescriptions. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. He mainly went to Dr. Diaz while having prescriptions dispensed at LM Caldwell Pharmacist- Pueblo Street. Most pain and anxiety medication was prescribed by Dr. Diaz, despite him not being a pain specialist. CB received multiple prescriptions for HC/AP 10/325 mg and Alprazolam @mg on or around the same time by Dr. Diaz which he had dispensed at different pharmacies, including for example: On March 26, 2010 Patient CB received HC/AP 10/325 #200 (25 day supply) dispensed at Rite Aid #5782 (Prescription No. 676053) and on April 9, 2010 he received HC/AP 10/325#240(30 day supply) dispensed at LM Caldwell Pharmacists-Pueblo Street (Prescription No. 316460). The prescriptions were refilled again at Ride Aid on April 29, 2010, May 29, 2010, June 14, 2010,

July 10, 2010 and at L M Caldwell- Pueblo Street on May 24, 2010 and July 15, 2010. Patient CB received 440 tablets of HC/AP in 30 days, 5200 mg per day of Acetaminophen, well above the recommended 4,000 mg dose per day. In addition, September 27, 2010, L M Caldwell Pharmacists- Pueblo Street received 2 different prescriptions for Oxycodone 30 mg form Dr. Diaz's office for Patient CB. After Dr. Diaz was investigated, Patient CB did not get any prescriptions dispensed at L M Caldwell Pharmacist-Pueblo Street nor did patient CB have any significant history of pain or anxiety drug treatment.

d. Patient CC went to 22 prescribers and 13 pharmacies from January 1, 2009 to April 9, 2013. He went to prescribers in Bakersfield, Goleta, Isla Vista, Long Beach, Santa Barbara and Santa Maria. He went to pharmacies in Goleta, Santa Barbara, Torrance and Wilmington. Prior to and while going to L M Caldwell Pharmacist-Pueblo Street, Patient CC went to numerous prescribers and pharmacies. He lived in Goleta (although the exact two addresses he listed could not be found through mapquest) and paid cash for his prescriptions of HC/AP, Carisoprodol, Oxycodone/AP and Hydromorphine. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. He mainly went to Dr. Diaz while having prescriptions dispensed at LM Caldwell Pharmacist-Pueblo Street. Most pain medication was prescribed by Dr. Diaz, despite him not being a pain specialist. For example, Patient CC received 5,200 mg of Acetaminophen, an amount above the recommended dose of Acetaminophen of 4,000 mg in October and November of 2011 through the following prescriptions dispensed at L M Caldwell Pharmacists- Pueblo Street: Prescription No. 334473 for AP/Oxycodone 10/325 mg #240 (30 day supply) on October 20, 2011, Prescription No. 333957 for HC/AP 10/325 mg #240 (30 day supply) on October 31, 2011, Prescription No. 335134 for AP/Oxycodone 10/325 mg #240 (30 day supply) on November 14, 2011, Prescription No. 333957 for AP/HC 10/325 mg #240 (30 day supply) on November 23, 2011. On August 2, 2010, L M Caldwell Pharmacist – Pueblo Street dispensed 2 prescriptions for Alprazolam 2 mg, Prescription No. 318318 and 319040 on the same day. Patient CC continued to have most of his prescriptions dispensed at L M Caldwell Pharmacist- Pueblo Street after Dr. Diaz. The number of pain medications and quantities were reduced.

e. Patient JF went to 1 prescriber, Dr. Diaz in Santa Barbara, and 4 pharmacies, in Ojai, Goleta, and Santa Barbara from January 1, 2009 to April 9, 2013. He lived Santa Barbara and paid for his prescriptions through insurance. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Patient JF had no significant pain history one year prior to January 20, 2010 and obtaining prescriptions from Dr. Diaz. However, Dr. Diaz began his treatment with Oxycontin 80 mg, Morphine Sulfate 100 mg and Oxycodone 30 mg. Also, Patient JF did not have a history of anxiety nine months prior to obtaining prescriptions from Dr. Diaz. However Dr. Diaz began treatment with Lorazepam 2 mg. Most pain medication was prescribed by Dr. Diaz, despite him not being a pain specialist. JF was prescribed the long acting opiates, Opana ER, Oxycontine, and MS Contin by Dr. Diaz at the same time and were dispensed by L M Caldwell Pharmacist-Pueblo Street. These long acting drugs are usually not prescribed together. Patient JF did not get any prescriptions dispensed at LM Caldwell Pharmacist- Pueblo Street after Dr. Diaz;

f. Patient CG went to 10 prescribers and 5 pharmacies in Santa Barbara from January 1, 2009 to April 9, 2013. She went to prescribers in Lompoc, Santa Barbara, Carpentaria and Sacramento. She lived in Carpentaria and traveled 10.63 miles to get to Dr. Diaz's Office in Santa Barbara and Respondent L M Caldwell Pharmacist- Pueblo Street was located 13.63 miles away from Patient CG's home. Patient CG paid for her prescriptions through insurance. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Patient CG mostly went to Respondent L M Caldwell Pharmacist-Pueblo Street while going to Dr. Diaz. Most pain medication was prescribed by Dr. Diaz, despite him not being a pain specialist. Respondent L M Caldwell Pharmacist- Pueblo Street dispensed prescriptions in November 2009 through February 2010 above the 4,000 mg recommended dose of Acetaminophen. Respondent L M Caldwell Pharmacist- Pueblo Street also dispensed numerous prescriptions for Suboxone, used for treatment of opioid addiction, from Dr. Diaz while prescribing other narcotics. Respondent L M Caldwell Pharmacist- Pueblo Street also dispensed Prescription Nos. 312135, 312136, 333177, 333178, 335385, 33586 for the long action opiates, Opana ER and Oxycontine. Patient CG continued to get most pain and anxiety prescriptions

dispensed at Respondent L M Caldwell Pharmacist-Pueblo Street after Dr. Diaz, but the quantity and therapy duplication was reduced by other prescribers. Respondent L M Caldwell Pharmacist-Pueblo Street dispensed Prescription Nos. 319209, 319172, 319173 which were telephoned by the prescriber's office but did not note the name of the agent of the prescriber nor the pharmacist who transcribed it;

g. Respondent L M Caldwell Pharmacist-Pueblo Street dispensed Prescription Nos. 337054, 337055 and 337056 with no prescriber signature and date to Patient IJ on January 3, 2012;

h. Patient ML went to 2 prescribers and 3 pharmacies, in Ojai, Goleta, and Santa Barbara from January 1, 2009 to April 9, 2013. She lived in Santa Barbara (same address as Patient IJ and Patient GJ) and paid cash for her prescriptions when not covered by insurance. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. While going to Respondent L M Caldwell Pharmacist-Pueblo Street, she mainly went to Dr. Diaz. Patient ML received various HC/AP drugs prescribed by Dr. Diaz on or around the same time which she had dispensed at multiple pharmacies, including Respondent L M Caldwell Pharmacist- Pueblo Street. ML Received 5,166 mg per day of Acetaminophen, for example in September of 2009, an amount over the recommended dose of Acetaminophen of 4,000 mg per day. She received 7,100 mg per day of Acetaminophen in November, 2010 from Respondent L M Caldwell Pharmacist- Pueblo Street and January 2011. Patient ML only had one pain prescription dispensed at Respondent L M Caldwell Pharmacist-Pueblo Street after Dr. Diaz. A review of Patient ML's Profile revealed she received mostly pain medication from Dr. Diaz, who was not a pain specialist;

i. Patient KM went to 4 prescribers in Santa Barbara and Lompoc and 13 pharmacies from January 1, 2009 to April 9, 2013. She went to pharmacies in Lompoc, Santa Barbara, Santa Maria, Orcutt and San Luis Obispo. She lived in Lompoc (same address as Patient MM) and traveled 55. 81 miles to Dr. Diaz's office and lived 53.28 miles from Respondent L M Caldwell Pharmacist- Pueblo Street. Patient KM paid cash for her prescriptions and paid over $350.00 for Oxycodone and Hydromorphone. Review of CURES showed therapy duplication based on the

number of opiates and tranquilizers dispensed. She received only pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist. On January 12, 2011, Patient KM received Oxycodone #180 and January 19, 2011 received Oxycodone #60. On February 11, 2011 he received #180 and on February 15, 2011, he received #60. KM should have had enough tablets and the unusual dosage changes should have been questioned by Respondent L M Caldwell Pharmacist- Pueblo Street. Patient KM did not get any pain or anxiety prescriptions dispensed at Respondent L M Caldwell Pharmacist- Pueblo Street after Dr. Diaz;

j. Patient MM went to 17 prescribers and 20 pharmacies from January 1, 2009 to April 8, 2013. She went to prescribers in Santa Barbara, Lompoc, Lodi, Encinitas, San Luis Obispo, Santa Maria, Solvang and Stanford and went to pharmacies in Lompoc, Santa Barbara, Santa Maria, Orcutt, Buellton, San Luis Obispo and Pismo Beach. Prior to going to Respondent L M Caldwell –Pueblo Street, she went to multiple pharmacies and prescribers. She lived in Lompoc (same address as Patient KM) and traveled 55. 81 miles to Dr. Diaz's office and lived 53.28 miles from Respondent L M Caldwell Pharmacist-Pueblo Street. Patient KM paid cash when early refills were obtained and/or when medication was not covered by insurance. Patient KM paid $327.00 for Oxycodone and $1,585.00 for Oxycontin. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. She received only pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist. Patient MM received multiple Oxycodone 30 mg prescriptions on or around the same time from Dr. Diaz which she had dispensed at multiple pharmacies. She also received multiple Oxycontin 80 mg prescriptions on or around the same time from Dr. Diaz which she had dispensed at multiple pharmacies, including at Respondent L M Caldwell Pharmacist-Pueblo Street. Patient MM also received Suboxone, prior to and while going to Respondent L M Caldwell Pharmacist-Pueblo Street. Patient MM did not get any pain or anxiety prescriptions dispensed at LM Caldwell Pharmacist- Pueblo Street after Dr. Diaz. Patient MM received only pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist. Patient MM paid $1,585.80 cash for Oxycontin 60 mg on July 4, 2010;

k. Patient SP went to 6 prescribers in Santa Barbara and 7 pharmacies from January 1, 2009 to April 9, 2013. She went to pharmacies in Lompoc, Santa Barbara, and Goleta. She lived in Santa Barbara and paid for her medication through insurance. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Patient SP received mostly pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist. Respondent L M Caldwell Pharmacist-Pueblo Street dispensed Prescription No. 33143 for Oxycodone IR (1 Tablet, twice daily #60) for a 30 day supply on July 18, 2011 and then again on July 28, 2011 (Prescription No. 33176, 1-3 tablets every 4-6 hours #240.) Patient SP also received therapy duplication in the form of Diazepam and Alprazolam and HC/AP and HC/Ibuprofen from Respondent L M Caldwell Pharmacist- Pueblo Street. Patient SP continued to get one pain medication dispensed at Respondent L M Caldwell Pharmacist- Pueblo Street after Dr. Diaz. The number of pain drugs prescribed by other prescribers was reduced. Patient SP was placed on Suboxone and did not have significant pain or anxiety after Dr. Diaz;

l. Patient VS went to 3 prescribers and 6 pharmacies from January 1, 2009 to April 8, 2013. She went to prescribers in Santa Barbara, Lompoc and Goleta and went to pharmacies in Lompoc, Santa Barbara, and Santa Maria. She lived in Lompoc (same address as Patient MM) and traveled 55. 81 miles to Dr. Diaz's office and lived 53.28 miles from Respondent L M Caldwell Pharmacist- Pueblo Street. Patient VS paid cash for her prescriptions when insurance did not cover the cost of medication. Patient VS paid over $250.00 for Oxycodone and $220.00 Hydromorphone. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Patient VS received mostly pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist. Respondent L M Caldwell Pharmacist- Pueblo Street dispensed Prescription Nos. 33225, 033221, 33220, 33223 and 33222 with a written date that was not in the prescriber's handwriting. Patient VS received Hydromorphone 4 mg and 8 mg at or around the same time prescribed by Dr. Diaz which he had dispensed sometimes at the same pharmacy, including Respondent L M Caldwell Pharmacist- Pueblo Street. Patient VS did not get any pain or anxiety medication dispensed at LM Caldwell Pharmacist- Pueblo Street after

September 14, 2011 and did not have any significant pain or anxiety history after Dr. Diaz was investigated.

m. Patient MS went to 7 prescribers and 12 pharmacies from January 1, 2009 to April 9, 2013. She went to prescribers in Santa Barbara, Solvang, and Goleta and to pharmacies in Lompoc, Santa Barbara, Oxnard, Santa Ynez Santa Maria and Goleta. She lived in Santa Barbara and paid cash for her medication. She paid approximately $350.00 for Hydromorphone, $103 for Methadone, $130.00 for Alprazolam, $218.00 for HC/AP, and $200.00 for Oxycodone. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Patient MS went to multiple pharmacies and mainly went to Dr. Diaz. Patient MS received mostly pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist. Patient MS received multiple prescriptions for AC/AP 10/325 mg from Dr. Diaz which she dispensed at multiple pharmacies. She received 600-840 tablets of HC/AP within 30 days and received 7,800 mg per day to 9,750 mg per day of Acetaminophen. The practice of Patient MS receiving multiple prescriptions dispensed at multiple pharmacies began in March of 2010 and continued monthly until November of 2011. Patient MS received multiple prescriptions for Alprazolam 2 mg from Dr. Diaz which she dispensed at multiple pharmacies. MS received 240-360 tablets of Alprazolam within 30 days. Patient MS had a couple of pain prescriptions dispensed at L M Caldwell Pharmacist-Pueblo Street after Dr. Diaz and the quantities and therapy duplications prescribed by other prescribers were reduced;

n. Patient RS went to 2 prescribers in Santa Barbara and 6 pharmacies in Santa Barbara and Goleta from January 1, 2009 to April 9, 2013. She lived in Santa Barbara and paid cash for her medication. She paid approximately $225.00 for Hydromorphone, $175.00 for HC/AP, and $107 for Alprazolam. Review of CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed. Patient MS went to multiple pharmacies and mainly went to Dr. Diaz. Patient MS received mostly pain and anxiety medication from Dr. Diaz, despite him not being a pain specialist. Patient RS had no significant pain or anxiety history prior to going to Dr. Diaz. However, Dr. Diaz began by prescribing him Methadone 10 mg, Hydromorphone 8 mg, HC/AP 10/325 mg and Alprazolam 2 mg. Patient RS received multiple prescriptions for HC/AP

10/325 mg from Dr. Diaz which he dispensed at multiple pharmacies. Patient RS received 480 tablets of HC/AP within 30 days and received 5,200 mg per day of Acetaminophen. The practice of Patient RS getting multiple prescriptions dispensed at multiple pharmacies began in August of 2011 and continued monthly until December of 2011. Patient RS did not get any pain or anxiety prescriptions dispensed at LM Caldwell Pharmacist – Pueblo Street after Dr. Diaz. Respondent L M Caldwell Pharmacist- Pueblo Street dispensed Prescription No. 336005 for Buprenorphine, used for treatment of narcotic addiction on December 1, 2011, prescribed by Dr. Diaz.

75. L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi did not know the diagnosis for patients GA, RB, CB, CC, JF, CG, GJ, IJ, ML, KM, MM, SP, VS, MS, RS, and knew that Dr. Diaz was a family practitioner and not a pain management physician. Also, L M Caldwell Pharmacist-Pueblo Street and Respondent Caldwell failed to maintain records or files on drug therapy for these patients, and failed to check data in CURES.

76. When reviewing the records for patients GA, RB, CB, CC, JF, CG, GJ, IJ, ML, KM, MM, SP, VS, MS, and RS, it was noted that eight out of these fifteen patients lived outside Dr. Diaz's trading area and five out of nine lived outside of LM Caldwell Pharmacist-Pueblo Street normal trading area. The range of distance travelled for the selected patients was between 6.97 miles for the shortest to 111.97 for the longest. The average distance traveled by the patient was 35.26 miles and the total distance these patients travelled to obtain controlled substances was excessive. Five of the fifteen patient home addresses were not recognized by Mapquest. In addition seven of the fifteen patients had the same address. Eight of the fifteen patients reviewed lived outside of Dr. Diaz's normal trading area and five of fifteen lived outside of L M Caldwell Pharmacist-Pueblo Street normal trading area.

77. Most of the patients paid cash, including when the medication was not covered by their insurance or to get early refills. Some patients had insurance/Medicaid, however, were willing to pay a large sum of cash for controlled substances which were not covered by the plans, including those on Medicaid.

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78. There was excessive furnishing of controlled substances prescribed by Dr. Diaz. The dispensing ratio of prescriptions by Dr. Diaz by L M Caldwell Pharmacist -Pueblo Street and Respondent Yahyavi was greatly unbalanced when compared to other neighboring pharmacies, including the following three pharmacies: Federal Drugs PHY37078 (located 1.83 miles from L M Caldwell Pharmacist-Pueblo Street), Rite-Aid #5785 PHY 42255 (located 1.72 miles from L M Caldwell Pharmacist-Pueblo Street), and CVS#9392 PHY 494473 (located 1.46 miles from L M Caldwell Pharmacist-Pueblo Street). L M Caldwell Pharmacist-Pueblo Street filled tens of thousands more controlled substances prescribed by Dr. Diaz when compared to neighboring pharmacies for the time period specified of January 1, 2011 through December 5, 2012. The CURES data for the L M Caldwell Pharmacist- Pueblo Street and three surrounding pharmacies, for example, was as follows:

Pharmacy	Total controlled substances dispensed between 1/1/2011-12/5/2012	Total Dr. Diaz's RX from 1/1/2011-12/5/2012	Total quantity for Dr. Diaz's RX from 1/1/2011-12/5/2012	% of total controlled substance RX dispensed for Dr. Diaz
Respondent LM Caldwell Pharmacist – Pueblo Street	**11,215**	**1,418**	**215,186**	**12.64%**
Federal Drugs PHY 37078 (1.92 miles from LM Caldwell)	18, 282	0	0	0%
Rite-Aid #5785 PHY 42255 (.065 miles from LM Caldwell Pharmacist	3,584	0	0	0%
CVS # 9392 PHY 49473 (.41 miles from LM Caldwell)	13,365	44	6,599	.33%

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Pattern of Early Refills and Duplicate Medications

79. Between January 1, 2010 and December 7, 2012, LM Caldwell-Pueblo Street engaged in a pattern of early refills, including for Patients GA, RB, CB, CC, JF, CG, GJ, IJ, ML, KM, MM, SP, VS, MS and RS, including, for example, 22 days early for Patient RB (Prescription Nos. 335933 & 336232), 24 days early for Patient CB (Prescription Nos. 328602 & 328602) 25 days for Patient CC (Prescription Nos. 325881 & 326067), 16 days early for Patient CG (Prescription Nos. 312824 & 312824), 25 days early for Patient GJ (Prescription Nos. 329632 & 329632), 18 days early for Patient IJ (Prescription Nos. 328627 & 328627) 27 days early for Patient ML (Prescription Nos. 317889 & 31789), 29 days early for Patient MM (Prescription Nos. 326892 & 326705), and 16 days early for Patient MS (Prescription Nos. 331092 & 331728).

Patient AM

80. On December 10, 2013, the Board received a medical malpractice payment report, Santa Barbara Superior Court, Case No. 1414079, from American Casualty Co. of Reading PA for Respondent Yahyavi, without admission of negligence or liability. On February 3, 2014, the Board received a report of settlement judgment or arbitration award, Case No. 1414079, from Chicago Insurance Company for Respondent Yahyavi, without the admission of guilt. Prescribing of narcotic medication which led to death was alleged in the civil suit. The Board confirmed that both settlement reports were regarding Patient AM and the insurance companies split the costs of settlement. Patient AM, presented prescriptions from a medical doctor which Respondent Yahyavi dispensed. On November 25, 2011, Patient AM died from acute complications from narcotic abuse. At the time of his death, Patient AM had multiple controlled substances in his system.

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81. A review of Respondent L M Caldwell Pharmacists- Pueblo Street's profile for Patient AM revealed that Patient AM received the following controlled substances at LM Caldwell Pharmacists-Pueblo Street:

RX Date	RX #	Drug	Prescriber
8/23/2010	320263	Hydromorphone 8 mg 2 tablets every 6 hours as needed for pain #240	Dr. Diaz
	230234	Oxycodone 30 mg 2 tablet every 6 hours as needed for pain. #240	
9/20/2010	321036	Hydromorphone 8 mg 2 tablets every 4-6 hours as needed for pain #240	Dr. Diaz
		Oxycodone 30 mg 2 tablet every 4-6 hours as needed for pain. #240	
10/14/2010	322230	Oxycodone 30 mg 2 tablet every 2-4 hours #260	Dr. Diaz
	322231	Hydromorphone 8 mg 2 tablets every 2-4 hours #260	
	322232	Methadone 10 mg 2 pills every 12 hours #120	
11/11/2010	323197	Hydromorphone 8 mg 2 tablets every 4-6 hours #260	Dr. Diaz
	323198	Oxycodone 30 mg 2 tablet every 4-6 hours #260	

82. A review of Respondent L M Caldwell Pharmacists- Pueblo Street's profile for Patient AM and CURES records also revealed that Patient AM saw 4 prescribers and went to 8 pharmacies from January 1, 2009 to April 8, 2013. Patient AM saw prescribers in Santa Barbara, Solvang, and Shell Beach. Patient AM received only pain medication from Dr. Diaz, despite him not being a pain specialist. Patient AM traveled over 70 miles from home in Solvang to obtain the prescriptions from Dr. Diaz and then to LM Caldwell Pharmacists-Pueblo Street to have the prescriptions dispensed. Patient AM paid cash for his medication.

83. LM Caldwell Pharmacists-Pueblo Street and Respondent Yahyavi dispensed 9 prescriptions for AM. However, if they would have checked CURES data, they would have been able to determine there was unusual prescribing patterns for Dr. Diaz and that Patient AM was going to multiple pharmacies. Patient AM, for example, went to 2 separate pharmacies on the same day to get Oxycodone and Hydromorphone. Since Respondent Yahyavi knew Dr. Diaz as the "Candy Man," he should have questioned the legitimacy of his prescriptions.

84. From January 1, 2010 to January 1, 2014, Respondent Yahyavi, failed to exercise best professional judgment while dispensing controlled substance prescriptions for Patient AM prescribed by Dr. Diaz. Looking at the totality of the factors such as repetitive prescribing patterns for highly abused controlled substances, the location of prescriber's practice in relation to the location of AM's residence, and patient's payment methods. Respondent Yahyavi also failed to appropriately scrutinize patients' drug therapy with readily available tools such as CURES reports and its own pharmacy records. The result of this negligence was the dispensing of controlled substances for AM who habitually engaged in doctor shopping and multiple pharmacy activity. Respondent Yahyavi should have questioned the legitimacy of the prescriptions it and Respondent L M Caldwell Pharmacists-Pueblo Street dispensed to Patient AM.

Conviction and Medical Board Disciplinary Action

85. On April 29, 2011, the Board received an arrest report from the California Department of Justice for Pharmacy Technician DLM who had been arrested on allegations that he stole Oxycontin from his employer Respondent L M Caldwell Pharmacist-State Street and sold the drugs to an undercover detective. In May of 2011, Pharmacy Technician DLM, following a plea, was convicted of the sale of a controlled substance Oxycontin under Health and Safety Code section 11352, subdivision (a).

86. On January 5, 2012, the Board received notification that Dr. Diaz was allegedly linked to a string of deaths involving prescriptions drugs and had been arrested for allegedly prescribing an excessive amount of painkillers to his patients. On May 13, 2014, the California Medical Board revoked Dr. Diaz's license as a general practitioner and his specialty in Geriatrics

and Pathology for gross negligence in the care and treatment of a patient, prescribing excessive narcotic medications to patients, and failing to maintain adequate and accurate records.

Board Inspections and Audits

87. On July 13, 2011, January 1, 2013, and January 15, 2013, the Board inspected Respondent L M Caldwell Pharmacist-State Street. The Board also conducted audits of Respondent L M Caldwell Pharmacist-State Street from 2009 to January 2013.

88. On January 16, 2013, the Board inspected Respondent L M Caldwell Pharmacist-Pueblo Street. During the inspection, Respondent Yahyavi admitted to the inspector that he knew Dr. Diaz as the "Candy Man." The Board also conducted audits of Respondent L M Caldwell Pharmacist-Pueblo Street from 2009 to January 2013.

89. On April 8, 2013, the Board issued a written Notice of Noncompliance to Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell. The Board also issued a written Notice of Noncompliance to Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyani.

90. On July 31, 2013, the Board issued a written Notice of Noncompliance to Respondent L M Caldwell Pharmacists-Pueblo Street and Respondent Yahyavi.

91. On August 7, 2013, the Board issued another written Notice of Noncompliance to Respondent L M Caldwell Pharmacists-State Street and Respondent Caldwell.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Lack of Operational Standards and Security- Pharmacy)

(Against Respondent L M Caldwell Pharmacist -State Street)

92. Respondent L M Caldwell Pharmacist-State Street is subject to discipline under section 4301, subsection (o) of the Code, and/or California Code of Regulations, title 16, section 1714, subsection (b), for failure to maintain its facilities, space, fixtures, and equipment so that drugs are safely and properly prepared, maintained, secured and distributed. The circumstances are that between November 15, 2009 to July 13, 2011, Respondent L M Caldwell Pharmacist-State Street could not account for the loss of 5,360 tablets of Hydromorphone 8 mg. Between August 6, 2011 to January 15, 2013, Respondent L M Caldwell Pharmacist-State Street could not

account for the loss of 8,800 tablets of Hydromorphone 8 mg and the loss of 605 tablets of Oxycodone 30 mg. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraphs 45 through 46, as though set forth fully.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Lack of Operational Standards and Security- Pharmacist)

(Against Respondent Caldwell)

93. Respondent Caldwell is subject to discipline under section 4301, subdivision (o), of the Code, and California Code of Regulations, title 16, section 1714, subdivision (d), for failure to maintain the security of the prescription department, including provisions for effective control against theft or diversion of dangerous drugs and devices, and records for such drugs and devices and to ensure that possession of a key to the pharmacy where dangerous drugs and controlled substances are stored is restricted to pharmacists. The circumstances are that between November 15, 2009 to July 13, 2011, Respondent Caldwell could not account for the loss of 5,360 tablets of Hydromorphone 8 mg. Between August 6, 2011 to January 15, 2013, Respondent Caldwell could not account for the loss of 8,800 tablets of Hydromorphone 8 mg and the loss of 605 tablets of Oxycodone 30 mg. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraphs 45 through 46, as though set forth fully.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Records of Acquisition and Disposition of Dangerous Drugs)

(Against L M Caldwell Pharmacist- State Street, Respondent L M Caldwell Pharmacist-Pueblo Street, Respondent Caldwell, and Respondent Yahyavi)

94. Respondent L M Caldwell Pharmacist-State Street, Respondent L M Caldwell Pharmacist-Pueblo Street, Respondent Caldwell and Respondent Yahyavi, are each and severally subject to disciplinary action under section 4081, subdivision (a), and section 4105, subdivision (a) of the Code, for failure to maintain all records of sale, acquisition or disposition of dangerous drugs at all times open to inspection and preserved for at least three years from the date of making. The circumstances are as follows:

a. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not account for the records of acquisition and disposition and the current inventory. Between November 15, 2009 and July 13, 2011, Respondent L M Caldwell Pharmacist- State Street and Respondent Caldwell could not account for an inventory overage (disposition greater than acquisition) of 55,370 tablets of HC/AP 10/325 mg and 165 tablets of Oxycodone SR 80 mg. Between August 6, 2011 and January 15, 2013, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not account for an inventory overage of 78,746 tablets of HC/AP 10/325 mg. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraphs 42 through 43, as though set forth fully.

b. Between January 5, 2010 and January 15, 2013, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not account for prescription hardcopies for Prescriptions Nos. 793824, 793825, 793826, 789177, 789188, 793189, 793190, 805552, 782075, 792283, 793432, 793184, 791387, 797610, 787609, 790594, 790595, 790597, 795658, 804361, 792346, 793090, 795652, 776675, 773787, 779441, 780927, 790980, 792044, 792920, 792935 and 792928. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraphs 44, as though set forth fully.

c. Between December 18, 2010 and December 17, 2012, Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi could not account for an inventory overage of 53,811 tablets of HC/AP 10/325 mg. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraph 68, as though set forth fully.

c. On January 16, 2013, LM Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi were unable to provide the original prescription documents for RX # 327435, 334405, , 317892, 317893, 317894, 330297, 323526, 324203, 325803, 325881, 312027, 316180, 315861, 322717, 322718, 319209, 322715, 330610, 333178, 334336, 318220, 331648, 322460, 332461, 326892, 327949, 332102, and 336005. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraph 69, as though set forth fully.

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FOURTH CAUSE FOR DISCIPLINE

(Failure to Provide Drug Sales and Purchase Records After Furnishing Dangerous Drugs)

(Against L M Caldwell Pharmacist-State Street, Respondent L M Caldwell Pharmacist-Pueblo Street, Respondent Caldwell and Respondent Yahyavi)

95. Respondent L M Caldwell Pharmacist-State Street, Respondent L M Caldwell Pharmacist-Pueblo Street, Respondent Caldwell and Respondent Yahyavi, are each and severally subject to disciplinary action under section 4059, subdivision (b), of the Code, for furnishing a dangerous drug or dangerous device to each other without sales and purchase records that correctly give the date, names and addresses of the supplier and buyer, the drug or device and the quantity. The circumstances are as follows:

a. Between July 23, 2010 and December 28, 2012, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell sold HC/AP 10/325 mg to Respondent Caldwell Pharmacist- Pueblo Street without adequate sales records. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraph 47, as though set forth fully.

b. Between July 23, 2010 and December 28, 2012, L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi purchased HC/AP 10/325 mg from Caldwell Pharmacist-State Street without adequate purchase records. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraph 70, as though set forth fully.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Failure to Exercise Corresponding Responsibility)

(Against L M Caldwell Pharmacist- State Street, Respondent L M Caldwell Pharmacist-Pueblo Street, Respondent Caldwell and Respondent Yahyavi)

96. Respondent L M Caldwell Pharmacist-State Street, Respondent L M Caldwell Pharmacist- Pueblo Street, Respondent Caldwell and Respondent Yahyavi are each and severally subject to disciplinary action under section 4301, subdivisions (d) and (j), of the Code, Health and Safety code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, subdivisions (a) and (b), for excessive furnishing of controlled substances with an

established history of a high potential for abuse despite multiple cues of irregularity and uncertainty related to patient and prescriber factors, and in failing to comply with their corresponding responsibility to ensure that controlled substances are dispensed for a legitimate medical purpose:

a. Specifically, between January 1, 2011 and December 5, 2012, Respondent L M Caldwell Pharmacist- State Street, and Respondent Caldwell dispensed 1,492 controlled substance prescriptions written by Dr. Julio Diaz with disregard to the following factors: distance from the pharmacy to Dr. Diaz's office, distance from the pharmacy to each patient's home, percentage of cash patients specific to listed prescribers, pattern of patients willing to pay cash for highly expensive prescriptions, and same or similar prescribing patterns for individual patients from alleged pain specialists. Respondent L M Caldwell Pharmacist-State Street, and Respondent Caldwell failed to appropriately scrutinize patients' drug therapy with readily available tools such as CURES reports and its own pharmacy records, including to Patients VA, BA, KB, CD, LD, TF, JH, MM, AM, SM, SS, JS, NS, VS and CW. From January 1, 2010 to January 1, 2013, LM Caldwell Pharmacist-State Street and Respondent Caldwell failed to exercise their corresponding responsibility with regard to Patient JJ. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraphs 48 through 66 as though set forth fully.

b. Specifically, between January 1, 2011 and December 7, 2012, Respondent L M Caldwell Pharmacist- Pueblo Street, and Respondent Yahyavi dispensed 1,418 controlled substance prescriptions written by Dr. Julio Diaz with disregard to the following factors: distance from the pharmacy to Dr. Diaz's office, distance from the pharmacy to each patient's home, percentage of cash patients specific to listed prescribers, pattern of patients willing to pay cash for highly expensive prescriptions, and same or similar prescribing patterns for individual patients from alleged pain specialists. Respondent L M Caldwell Pharmacist-Pueblo Street, and Respondent Yahyavi failed to appropriately scrutinize patients' drug therapy with readily available tools such as CURES reports and its own pharmacy records, including to Patients GA, RB, CB, CC, JF, CG, IJ, ML, KM, MM, SP, VS, MS and RS. From January 1, 2010 to January 1, 2014, LM Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi failed to exercise their

corresponding responsibility with regard to Patient AM. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraphs 73 through 84, as though set forth fully.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Dispensing Prescriptions Which Contains Significant Error, Omission, Irregularity, Uncertainty, Ambiguity or Alteration)

(Against L M Caldwell Pharmacist-State Street and Respondent Caldwell)

97. Respondent L M Caldwell Pharmacist- State Street, and Respondent Caldwell are each and severally subject to disciplinary action under section 4301, subdivision (o), of the Code, and California Code of Regulations section 1761, subdivisions (a) and (b), for dispensing a prescription which contained a significant error, omission, irregularity, uncertainty, ambiguity, or alteration, for failing to contact the prescriber to obtain information to validate the prescription, and/or for dispensing a controlled substance knowing or having the objective reason to know that the prescription was not issued for a legitimate purpose, even after conferring with the prescriber. The circumstances are as follows:

a. On March 22, 2011, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell dispensed Prescription No. 784841 for Morphine Sulfate 10 mg/ml solution that was written with no quantity on the prescription with the quantity box for "151 & over" marked. Respondent L M Caldwell Pharmacist- State Street and Respondent Caldwell dispensed 360 mls of Morphine Sulfate solutions with no documentation on the prescription indicating that the prescribing physician, Dr. Diaz, was contacted to clarify the quantity. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraph 55, subparagraph (d), as though set forth fully.

b. On May 20, 2011, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell dispensed Prescription No. 784839 for Fentanyl 100 mcg/hour with directions to apply every 48 hours. The manufacturer's direction was to change the patch every 72 hours. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraph 55, subparagraph (e), as though set forth fully.

SEVENTH CAUSE FOR DISCIPLINE

(Exceeding the Day Supply for Controlled Substance Refills)

(Against L M Caldwell Pharmacist-State Street and Respondent Caldwell)

98. Respondent L M Caldwell Pharmacist-State Street, and Respondent Caldwell are each and severally subject to disciplinary action under Health and Safety Code section 11200, subdivision (b) for refilling a prescription for Schedule II or IV substance more than five times and/or in an amount, for all refills of that prescription taken together, exceeding a 120-day supply. The circumstances are as follows:

a. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell dispensed Prescription No. 782251 for Alprazolam, a Schedule IV controlled substance, on March 25, 2011 for a 30 day supply. They then refilled Prescription No. 782251 five times on April 22, 2011, May 18, 2011, June 16, 2011, July 18, 2011 and August 17, 2011, for a total of five (5) refills for a total of a 150-day supply. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraph 56, subparagraph (a), as though set forth fully.

b. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell dispensed Prescription No. 782250 for Diazepam, a Schedule IV controlled substance, on March 25, 2011 for a 30 day supply. They then refilled Prescription No. 782250 on April 22, 2011, May 18, 2011, June 16, 2011, July 18, 2011 and August 17, 2011, for a total of five (5) refills for a total of a 150-day supply. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraph 56, subparagraph (b), as though set forth fully.

EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Variation from Prescription)

(Against L M Caldwell Pharmacist–Pueblo Street and Respondent Yahyavi)

99. Respondent L M Caldwell Pharmacist-Pueblo Street, and Respondent Yahyavi are each and severally subject to disciplinary action under section 4301, subdivision (o), of the Code, and California Code of Regulations section 1716, when they deviated from the requirements of a

prescription without the prior consent of the prescriber. Specifically, between January 1, 2010 and January 15, 2013, they dispensed the following prescriptions incorrectly:

(1) Prescription No. 321310, was for Oxycodone 30 mg 1-2 every 6 hour as needed for pain. Respondents dispensed it as 1 tablet four times daily as needed for pain;

(2) Prescription No. 321312, was for Xanax mg 1-2 times daily for panic. Respondents dispensed it as 1 tablet four times daily;

(3) Prescription No. 325038, was for 30 mg 1-2 HC/AP 7.5/750 mg. Prescriber wrote 1 tablet every 6 hours as needed for pain and Respondents dispensed it as 1 tablet every 4-6 hours as needed for pain;

(4) Prescription No. 331728, was for Dilaudid 8 mg, 1 every 6 hours #120. Respondents dispensed Hydromorphone 8 mg, 1-2 tablets every 6 hours;

(5) Prescription No. 332908, was for Methadone 10 mg 7 tablets every 12 hours #400. Respondents dispensed it as 6 tablets every 12 hours;

(6) Prescription No. 335645, was for Oxycodone IR 30 mg 1 tablet every 4-6 hour. Respondents dispensed Oxycodone IR 30 mg 1 tablet every 6 hours.

Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraph 71, subdivisions (a) through (f) as though set forth fully.

NINTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Dispensing Balance of Schedule II Prescriptions Beyond 72 hours)

(Against L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi)

100. Respondent L M Caldwell Pharmacist-Pueblo Street, and Respondent Yahyavi are each and severally liable to disciplinary action under section 4301, subdivision (o), of the Code, and California Code of Regulations section 1745, subdivision (d), as it related to Code of Federal Regulations 1306.13, subdivision (a) as follows:

a. Review of prescriptions, from January 1, 2010 to January 15, 2013, revealed that Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi partially filled prescriptions for controlled substances listed in Schedule II and then dispensed the balance of the

prescription after the 72 hour period allowed for dispensing the balance of prescriptions. Specifically between January 1, 2010 to January 15, 2013, Respondents dispensed Prescription Nos. 329771, 331396, 332230, and 33265, then dispensed the balance of the prescriptions after 72 hours. Complainant refers to, and by this reference, incorporates the allegations set forth above in paragraph 72 as though set forth fully.

DISCIPLINE CONSIDERATIONS

101. To determine the degree of discipline, if any, to be imposed on Respondent L M Caldwell Pharmacists-Pueblo Street, Complainant alleges that on or about February 27, 2007, in a prior action, the Board of Pharmacy issued Citation Number CI 2006-32134 against Respondent L M Caldwell Pharmacist-Pueblo Street for violating California Code of Regulations, title 16, section 1716. A copy of the citation is attached as Exhibit A. That Citation is now final and is incorporated as if fully set forth. Complainant further alleges that on or about November 14, 2008, in a prior action, the Board of Pharmacy issued Citation Number CI 2007-35415 against Respondent L M Caldwell Pharmacists-Pueblo Street for violating California Code of Regulations, title 16, section 1716. A copy of the citation is attached as Exhibit B. That Citation is now final and is incorporated as if fully set forth.

102. To determine the degree of discipline, if any, to be imposed on Respondent Yahyavi, Complainant alleges that on or about February 27, 2007, in a prior action, the Board of Pharmacy issued Citation Number CI 2006-32988 against Respondent Yahyavi and ordered him to pay fines in the amount of $ 250.00 for violating California Code of Regulations, title 16, section 1716. A copy of the citation is attached as Exhibit C. That Citation is now final and is incorporated as if fully set forth. Complainant further alleges that on or about November 14, 2008, in a prior action, the Board of Pharmacy issued Citation Number CI 2008-37974 against Respondent Yahyavi and ordered him to pay fines in the amount of $750.00 for violating California Code of Regulations, title 16, section 1716. A copy of the citation is attached as Exhibit D. That Citation is now final and is incorporated as if fully set forth.

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103. To determine the degree of discipline, if any, to be imposed on Respondent L M. Caldwell Pharmacists- State Street, Complainant alleges that on or about July 23, 2013, in a prior action, the Board of Pharmacy issued Citation Number CI 2011 49544 against Respondent L M. Caldwell Pharmacists- State Street for violating California Code of Regulations, title 16, section 1716 and section 1711, subdivisions (d) and (e). A copy of the citation is attached as Exhibit E. That Citation is now final and is incorporated as if fully set forth herein.

104. To determine the degree of discipline, if any, to be imposed on Respondent Caldwell, Complainant alleges that on or about July 23, 2013, in a prior action, the Board of Pharmacy issued Citation Number CI 2013 57599 against Respondent Caldwell for violating California Code of Regulations, title 16, section 1716 and section 1711, subdivisions (d) and (e). A copy of the citation is attached as Exhibit F. That Citation is now final and is incorporated as if fully set forth herein. Respondent Caldwell, Complainant alleges that on or about February 29, 2012, in a prior action, the Board of Pharmacy issued Citation Number CI 2010 48187 against Respondent Caldwell for violating California Code of Regulations, title 16, section 1732.5 and Business and Professions Code 4231, subdivision (d) and 4301, subdivision (g). A copy of the citation is attached as Exhibit G. That Citation is now final and is incorporated as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Pharmacy Permit Number PHY 30911, issued to Peter Caldwell to do business as L M Caldwell Pharmacist;

2. Revoking or suspending Pharmacy Permit Number PHY 30912, issued to Peter Caldwell to do business as L M Caldwell Pharmacist;

3. Revoking or suspending Pharmacist License Number 25356, issued to Peter Craig Caldwell;

4. Revoking or suspending Pharmacist License Number 30041, issued to Abdul Yahyavi;

6. Ordering L M Caldwell Pharmacist (PHY 30911), L M Caldwell Pharmacist (PHY 30912), Peter Craig Caldwell, and Abdul Yahyavi to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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

DATED: 8/13/15

VIRGINIA HEROLD
Executive Officer
Board of Pharmacy
Department of Consumer Affairs
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: **PETER CRAIG CALDWELL doing business as L M CALDWELL PHARMACIST** **1509 State St.** **Santa Barbara, CA 93101** **Pharmacy Permit No. PHY 30911** **PETER CRAIG CALDWELL doing business as L M CALDWELL PHARMACIST** **235 West Pueblo St.** **Santa Barbara, CA 93105** **Pharmacy Permit No. PHY 30912** **PETER CRAIG CALDWELL** **1509 State St.** **Santa Barbara, CA 93101** **Pharmacist License No. RPH 25356** **ABDUL YAHYAVI** **1624 La Coronilla Drive.** **Santa Barbara, CA 93109** **Pharmacist License No. RPH 30041** Respondent.	Case No. 4867 **A C C U S A T I O N**

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Complainant alleges:

PARTIES

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

2. On or about December 1, 1984, the Board of Pharmacy issued Pharmacy Permit Number PHY 30911 to Peter Caldwell to do business as L M Caldwell Pharmacist located at 1509 State Street, Santa Barbara, CA 93101 (Respondent L M Caldwell Pharmacist-State Street). The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on December 1, 2013, unless renewed. Peter C. Caldwell has been the individual licensed owner of Respondent State Street Pharmacy since December 13, 1984. Peter C. Caldwell has been the Pharmacist-In-Charge of Respondent Pueblo Street Pharmacy since December 1, 1984.

3. On or about December 1, 1984, the Board of Pharmacy issued Pharmacy Permit Number PHY 30912 to Peter Caldwell to do business as L M Caldwell Pharmacist located at 235 West Pueblo Street, Santa Barbara, CA 93105 (Respondent L M Caldwell Pharmacist- Pueblo Street). The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on December 1, 2013, unless renewed. Abdul Yahyavi has been the Pharmacist-In-Charge of Respondent Pueblo Street Pharmacy since December 1, 1984.

4. On or about January 6, 1968, the Board of Pharmacy issued Pharmacist Number 25356 to Peter Craig Caldwell (Respondent Caldwell). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2015, unless renewed.

5. On or about December 10, 1975, the Board of Pharmacy issued Pharmacist Number 30041 to Abdul Yahyavi (Respondent Yahyavi). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2014, unless renewed.

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JURISDICTION

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

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

8. Section 4300 of the Code states:

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

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

(1) Suspending judgment.

(2) Placing him or her upon probation.

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

(4) Revoking his or her license.

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

. . .

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

9. Section 4300.1 of the Code states:

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

STATUTORY AUTHORITY

10. Section 3640.7 of the Code states:

Notwithstanding the requirements of Section 3640.5 or any other provision of this chapter, a naturopathic doctor may independently prescribe and administer the following:

(a) Epinephrine to treat anaphylaxis.

(b) Natural and synthetic hormones.

(c) Vitamins, minerals, amino acids, glutathione, botanicals and their extracts, homeopathic medicines, electrolytes, sugars, and diluents that may be administered utilizing routes of administration, pursuant to subdivision (d) of Section 3640, only when such substances are chemically identical to those for sale without a prescription.

11. Section 4301 of the Code states:

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

(a) Gross immorality.

(b) Incompetence.

(c) Gross negligence.

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

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

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

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

. . .

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

. . .

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

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

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

. . .

12. Section 4022 of the Code states

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

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

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

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

13. Section 4051 of the Code states:

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

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

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

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

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

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

15. Section 4081 of the Code states:

> (a) All records of manufacture and of sale, acquisition, or disposition of dangerous drugs or dangerous devices shall be at all times during business hours open to inspection by authorized officers of the law, and shall be preserved for at least three years from the date of making. A current inventory shall be kept by every manufacturer, wholesaler, pharmacy, veterinary food-animal drug retailer, physician, dentist, podiatrist, veterinarian, laboratory, clinic, hospital, institution, or establishment holding a currently valid and unrevoked certificate, license, permit, registration, or exemption under Division 2 (commencing with Section 1200) of the Health and Safety Code or under Part 4 (commencing with Section 16000) of Division 9 of the Welfare and Institutions Code who maintains a stock of dangerous drugs or dangerous devices.
>
> (b) The owner, officer, and partner of any pharmacy, wholesaler, or veterinary food-animal drug retailer shall be jointly responsible, with the pharmacist-in-charge or representative-in-charge, for maintaining the records and inventory described in this section.
>
> (c) The pharmacist-in-charge or representative-in-charge shall not be criminally responsible for acts of the owner, officer, partner, or employee that violate this section and of which the pharmacist-in-charge or representative-in-charge had no knowledge, or in which he or she did not knowingly participate.

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

> (a) A pharmacy may furnish dangerous drugs only to the following:
>
> . . .
>
> (4) Another pharmacy or wholesaler to alleviate a temporary shortage of a dangerous drug that could result in the denial of health care. A pharmacy furnishing dangerous drugs pursuant to this paragraph may only furnish a quantity sufficient to alleviate the temporary shortage.
>
> (5) A patient or to another pharmacy pursuant to a prescription or as otherwise authorized by law.
>
> . . .
>
> (7) To another pharmacy under common control.

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17. Section 4328 of the Code states:

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

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

19. Section 4059 of the Code states:

> (a) All records or other documentation of the acquisition and disposition of dangerous drugs and dangerous devices by any entity licensed by the board shall be retained on the licensed premises in a readily retrievable form.
>
> (b) The licensee may remove the original records or documentation from the licensed premises on a temporary basis for license-related purposes. However, a duplicate set of those records or other documentation shall be retained on the licensed premises.
>
> (c) The records required by this section shall be retained on the licensed premises for a period of three years from the date of making.
>
> (d) Any records that are maintained electronically shall be maintained so that the pharmacist-in-charge, the pharmacist on duty if the pharmacist-in-charge is not on duty, or, in the case of a veterinary food-animal drug retailer or wholesaler, the designated representative on duty, shall, at all times during which the licensed premises are open for business, be able to produce a hard copy and electronic copy of all records of acquisition or disposition or other drug or dispensing-related records maintained electronically.
>
> (e)(1) Notwithstanding subdivisions (a), (b), and (c), the board, may upon written request, grant to a licensee a waiver of the requirements that the records described in subdivisions (a), (b), and (c) be kept on the licensed premises.
>
> (2) A waiver granted pursuant to this subdivision shall not affect the board's authority under this section or any other provision of this chapter.

STATE REGULATORY AUTHORITY

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

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

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

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

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

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

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

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

COSTS

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

DRUGS

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

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23. Dilaudid is a trade name for Hydromorphone, an Opium derivative, which is classified as a Schedule II Controlled Substance pursuant to Health and Safety Code section 11055, subdivision (b)(1), and is a dangerous drug within the meaning of Business and Professions Code section 4022.

24. Hydrocodone is in Schedule II of the Controlled Substances Act. Lortab, Norco and Vicodin, brand/trade names of preparations containing hydrocodone in combination with other non-narcotic medicinal ingredients, are in Schedule III pursuant to Health and safety Code section 11056(e)(4), and are categorized as dangerous drugs pursuant to section 4022.

FACTS

Respondent L M Caldwell Pharmacist- Pueblo Street, Respondent L M Caldwell Pharmacist- State Street, Respondent Caldwell, and Respondent Yahyavi.

25. Respondent L M Caldwell Pharmacist- State Street and Respondent L M Caldwell Pharmacist- Pueblo Street (collectively Respondents L M Caldwell Pharmacists) are pharmacies operating in the Santa Barbara area.

26. Respondent Caldwell is the Pharmacists in Charge at Respondent L M Caldwell Pharmacist- State Street and Respondent Yahyani is the Pharmacists in Charge at Respondent L M Caldwell Pharmacist- Pueblo Street.

27. Pharmacy Technician DLM[1] was employed at Respondent Caldwell Pharmacists-State Street.

Acquisition, Disposition and Storage of Drugs

28. Drugs acquired by Respondents L M Caldwell Pharmacists were stored at Respondent L M Caldwell Pharmacists-State Street. Drugs were sent to Respondent L M Caldwell Pharmacist-Pueblo Street as needed. Drug recordkeeping included a transfer document which showed the bottles sent to Respondent L M Caldwell Pharmacist-Pueblo Street. However, the documentation did not include whether the drugs were initially received at Respondent L M Caldwell Pharmacist-Pueblo Street and then sent to Respondent L M Caldwell Pharmacist-State

[1] Initials are used to protect confidentiality. Identities will be revealed during discovery.

Street before being transferred back. Also the records for Respondent L M Caldwell Pharmacist-Pueblo Street were located at Respondent L M Caldwell Pharmacist-State Street.

29. Between November 15, 2009 and July 13, 2011, Respondent L M Caldwell Pharmacist- State Street and Respondent Caldwell could not account for an inventory overage (disposition greater than acquisition) of 55,370 tablets of Hydrocodone/acetaminophen 10/325 mg and 165 tablets of Oxycodone SR 80 mg. Between August 6, 2011 and January 15, 2013, Respondent L M Caldwell Pharmacist- State Street could not account for an inventory overage of 78,746 tablets of Hydrocodone/Acetaminophen 10/325 mg.

30. Between December 18, 2010 and December 17, 2012, Respondent L M Caldwell Pharmacist- Pueblo Street and Respondent Yahyani could not account for an inventory overage of 53,811 tablets of Hydrocodone/Acetaminophen 10/325 mg.

Operational Standards and Security

31. Respondent Caldwell was responsible for the security and record keeping at Respondents L M Caldwell Pharmacists. Between November 15, 2009 to July 13, 2011, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not account for 5,360 tablets of Hydromorphone 8 mg. Between August 6, 2011 to January 15, 2013, Respondent L M Caldwell Pharmacist-State Street could not account for 8,800 tablets of Hydromorphone 8 mg and 605 tablets of Oxycodone 30 mg.

32. Respondents L M Caldwell Pharmacists failed to maintain an effective control on the security of the prescription department against theft or loss of controlled substance/ dangerous drugs.

Furnishing of Dangerous Drugs or Devices

33. Between July 23, 2010 and December 28, 2012, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell sold Hydrocodone/Acetaminophen 10/325 mg to Respondent L M Caldwell Pharmacists- Pueblo Street without adequate sales records.

34. Between July 23, 2010 and December 28, 2012, Respondent L M Caldwell Pharmacist-Pueblo Street purchased Hydrocodone/Acetaminophen10/325 mg from Respondent L M Caldwell Pharmacist-State Street without adequate purchase records.

Arrest and Conviction

35. On April 29, 2011, the Board received an arrest report from the California Department of Justice for Pharmacy Technician DLM who had been arrested on allegations that he stole Oxycontin from his employer Respondent L M Caldwell Pharmacist and sold the drugs to an undercover detective. In May of 2011, Pharmacy Technician DL M, following a plea, was convicted of the sale of a controlled substance Oxycontin under Health and Safety Code section 11352, subdivision (a).

Board Inspections and Audits

36. On July 13, 2011 and January 1, 2013, the Board inspected Respondents Caldwell Pharmacists. The Board also conducted audits of Respondents Caldwell Pharmacists for the following time periods: November 15, 2009 to July 13, 2011 and August 6, 2011 to January 15, 2013.

37. On April 8, 2013, the Board issued a written Notice of Noncompliance to Respondent L M Caldwell Pharmacists-State Street and Respondent Caldwell. The Board also issued a written Notice of Noncompliance to Respondent L M Caldwell Pharmacists-Pueblo Street and Respondent Yahyani.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Lack of Operational Standards and Security- Pharmacy)

(Against Respondent L M Caldwell Pharmacist -State Street)

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

a. Between November 15, 2009 to July 13, 2011, Respondent L M Caldwell Pharmacist-State Street could not account for 5,360 tablets of Hydromorphone 8 mg. Between August 6, 2011 to January 15, 2013, Respondent L M Caldwell Pharmacist-State Street could not account for 8,800 tablets of Hydromorphone 8 mg and 605 tablets of Oxycodone 30 mg.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Lack of Operational Standards and Security- Pharmacist)

(Against Respondent Caldwell)

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

a. Between November 15, 2009 to July 13, 2011, Respondent Caldwell could not account for 5,360 tablets of Hydromorphone 8 mg. Between August 6, 2011 to January 15, 2013, Respondent Caldwell could not account for 8,800 tablets of Hydromorphone 8 mg and 605 tablets of Oxycodone 30 mg.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Records of Acquisition and Disposition of Dangerous Drugs)

(Against L M Caldwell Pharmacist- State Street, Respondent L M Caldwell Pharmacist- Pueblo Street, Respondent Caldwell, and Respondent Yahyani)

40. Respondent L M Caldwell Pharmacist- State Street, Respondent L M Caldwell Pharmacist- Pueblo Street, Respondent Caldwell and Respondent Yahyani, are each and severally subject to disciplinary action under section 4081, subdivision (a), and section 4105, of the Code, for failure to maintain all records of acquisition or disposition of dangerous drugs at all times open to inspection and preserved for at least three years from the date of making. The circumstances are as follows:

a. Respondent L M Caldwell Pharmacist- State Street and Respondent Caldwell could not account for the records of acquisition and disposition and the current inventory. Between November 15, 2009 and July 13, 2011, Respondent L M Caldwell Pharmacist- State Street could not account for an inventory overage (disposition greater than acquisition) of 55,370 tablets of Hydrocodone/acetaminophen 10/325 mg and 165 tablets of Oxycodone SR 80 mg. Between

August 6, 2011 and January 15, 2013, Respondent L M Caldwell Pharmacist- State Street could not account for an inventory overage of 78,746 tablets of Hydrocodone/acetaminophen 10/325 mg.

b. Between December 18, 2010 and December 17, 2012, Respondent L M Caldwell Pharmacist- Pueblo Street and Respondent Yahyani could not account for an inventory overage of 53,811 tablets of Hydrocodone/Acetaminophen 10/325 mg.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Provide Drugs Sales and Purchase Records After Furnishing Dangerous Drugs) (Against L M Caldwell Pharmacist- State Street, Respondent L M Caldwell Pharmacist- Pueblo Street, Respondent Caldwell and Respondent Yahyani)

41. Respondent L M Caldwell Pharmacist- State Street, Respondent L M Caldwell Pharmacist- Pueblo Street, Respondent Caldwell and Respondent Yahyani, are each and severally subject to disciplinary action under section 4081, subdivision (a), and section 4105, of the Code, for failure to maintain all records of acquisition or disposition of dangerous drugs at all times open to inspection and preserved for at least three years from the date of making. The circumstances are as follows:

a. Between July 23, 2010 and December 28, 2012, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell sold Hydrocodone/Acetaminophen 10/325 mg to Respondent Caldwell Pharmacists- Pueblo Street without adequate sales records.

b. Between July 23, 2010 and December 28, 2012, L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyani purchased Hydrocodone/Acetaminophen10/325 mg from Caldwell Pharmacist-State Street without adequate purchase records.

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DISCIPLINE CONSIDERATIONS

42. To determine the degree of discipline, if any, to be imposed on Respondent L M Caldwell Pharmacists-Pueblo Street, Complainant alleges that on or about February 27, 2007, in a prior action, the Board of Pharmacy issued Citation Number CI 2006-32134 against Respondent L M Caldwell Pharmacist-Pueblo Street for violating California Code of Regulations, title 16, section 1716. A copy of the citation is attached as Exhibit A. That Citation is now final and is incorporated as if fully set forth. Complainant further alleges that on or about November 14, 2008, in a prior action, the Board of Pharmacy issued Citation Number CI 2007-35415 against Respondent L M Caldwell Pharmacists-Pueblo Street for violating California Code of Regulations, title 16, section 1716. A copy of the citation is attached as Exhibit B. That Citation is now final and is incorporated as if fully set forth.

43. To determine the degree of discipline, if any, to be imposed on Respondent Yahyavi, Complainant alleges that on or about February 27, 2007, in a prior action, the Board of Pharmacy issued Citation Number CI 2006-32988 against Respondent Yahyavi and ordered him to pay fines in the amount of $ 250.00 for violating California Code of Regulations, title 16, section 1716. A copy of the citation is attached as Exhibit C. That Citation is now final and is incorporated as if fully set forth. Complainant further alleges that on or about November 14, 2008, in a prior action, the Board of Pharmacy issued Citation Number CI 2008-37974 against Respondent Yahyavi and ordered him to pay fines in the amount of $750.00 for violating California Code of Regulations, title 16, section 1716. A copy of the citation is attached as Exhibit D. That Citation is now final and is incorporated as if fully set forth.

PRAYER

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

1. Revoking or suspending Pharmacy Permit Number PHY 30911, issued to Peter Caldwell to do business as L M Caldwell Pharmacist;

2. Revoking or suspending Pharmacy Permit Number PHY 30912, issued to Peter Caldwell to do business as L M Caldwell Pharmacist;

3. Revoking or suspending Pharmacist License Number 25356, issued to Peter Craig Caldwell;

4. Revoking or suspending Pharmacist License Number 30041, issued to Abdul Yahyavi;

6. Ordering L M Caldwell Pharmacist (PHY 30911), L M Caldwell Pharmacist (PHY 30912), Peter Craig Caldwell, and Abdul Yahyavi to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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

DATED: 1/8/14

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

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