

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

In the Matter of the Accusation Against:

KENT LA DELL MILES,  
Pharmacist License Number RPH 30244,

and

HOME CARE PHARMACY,  
Original Permit Number PHY 32722,

Respondents.

Case No. 5005

OAH No. 2015040850

**DECISION**

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Pharmacy as the decision in the above-entitled matter, except that, pursuant to the provisions of Government Code section 11517, subdivision (c)(2)(C), the following technical changes are made to page one of the caption box:

“Kent La Dell Miles, Pharmacist License Number RPH 30244 “  
“Home Care Pharmacy, Original Permit Number PHY 32722 “

Also, the following technical change is made to page two, under Findings of Fact, #2:

“The Board issued Original Permit Number PHY 32722 to Home Care on August 8, 1986,  
with Respondent designated as the Pharmacist-in-Charge.”

In addition, the following technical change is made to page eight of the Order, #1:

Pharmacy license number RPH 30244 issued to Kent La Dell Miles, together with all  
licensing rights appurtenant thereto, are revoked.

The technical changes made above do not affect the factual or legal basis of the Proposed Decision, which shall become effective on December 30, 2015.

IT IS SO ORDERED this 30th day of November, 2015.

BOARD OF PHARMACY  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA



By

Amy Gutierrez, Pharm.D.  
Board President

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

In the Matter of the Accusation Against:

KENT LA DELL MILES,  
Pharmacist License Number 30244,

and

HOME CARE PHARMACY,  
Original Permit Number 32722,

Respondents.

Case No. 5005

OAH No. 2015040850

**PROPOSED DECISION**

Administrative Law Judge Ralph B. Dash heard this matter in Los Angeles, California on October 25, 2015.

Zachary T. Fanselow, Deputy Attorney General, represented Complainant.

Kent La Dell Miles (Respondent) represented himself and Home Care Pharmacy, Inc., doing business as Home Care Pharmacy (Home Care).

The record was held open until October 21, 2015, to permit Complainant to apply for a protective order sealing certain exhibits and for Respondent to submit reference letters. The application for protective order was timely received and a protective order issued sealing Exhibits 5, 7, 10, 12, 13, 14, and 15. Respondent's reference letters were timely received and collectively marked Exhibit B for identification. Respondent failed to attach a proof of service to Exhibit B but the Office of Administrative Hearings sent Mr. Fanselow a courtesy copy. Exhibit B was admitted as administrative hearsay.<sup>1</sup>

Oral and documentary evidence having been received and the matter having been submitted, the Administrative Law Judge makes the following Proposed Decision.

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<sup>1</sup> The term "administrative hearsay" is a shorthand reference to the provisions of Government Code section 11513, subdivision (d), to the effect that hearsay evidence that is objected to, and is not otherwise admissible, may be used to supplement or explain other evidence but may not, by itself, support a factual finding.

## FINDINGS OF FACT

1. Virginia Herold made the Accusation in her official capacity as the Executive Director of the Board of Pharmacy (Board), State of California.

2. The Board issued Pharmacist License Number RPH 30244 to Respondent on June 8, 1976. The license is in full force and effect and is due to expire on January 31, 2017. The Board issued Original Permit Number PHY 32772 to Home Care on August 8, 1986, with Respondent designated as the Pharmacist-in-Charge. The Board cancelled the permit on October 16, 2013. The permit expired on August 1, 2014. Under the provisions of Business and Professions Code section 118, subdivision (b), neither the cancellation nor the expiration of the permit deprives the Board of its authority to continue these disciplinary proceedings.

3. On September 10, 2014, in the Superior Court of the State of California, County of Ventura, case number 2013024722, the court convicted Respondent on his guilty plea to one count of violating Health and Safety Code section 11153, subdivision (a) (dispensing a controlled substance without a legitimate purpose), a felony. The court sentenced Respondent to serve 180 days in the County Jail but stayed imposition of the sentence and placed Respondent on formal probation for a period of three years on condition that he pay fines and fees totaling \$2,711.36 and a monthly probation fee of \$142.

4. The circumstances underlying the conviction are that between April and May of 2013, Respondent and Home Care sold fentanyl suckers<sup>2</sup> to Patient P.M. without a valid prescription. Respondent sold Patient P.M. over 100 fentanyl suckers in April of 2013 for \$25 each. When questioned by police officers, Respondent admitted that Patient P.M. was addicted to fentanyl and admitted to having "advanced" Patient P.M. fentanyl suckers without a prescription.

5. During their investigation officers obtained Controlled Substance and Utilization Review and Evaluation System (CURES) reports<sup>3</sup> for patients of Respondent that were flagged as being possible "doctor shoppers" (one who visits multiple doctors to obtain prescription for the same real or imagined injury or disability). This included Patient M.R., who had obtained oxycodone<sup>4</sup> tablets from Respondent and from other sources in an amount

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<sup>2</sup> Fentanyl is an opioid analgesic. It is a Schedule II controlled substance designated as such in Health and Safety Code section 11055, subdivision (c)(8), and is categorized as a dangerous drug pursuant to Business and Professions Code section 4022. The "suckers" are in the form of a lollipop.

<sup>3</sup> CURES maintains Schedule II, Schedule III, and Schedule IV prescription information that is received from California pharmacies.

which would equate with a daily usage of approximately 84 tablets and Patient M.M., who obtained oxycodone tablets in an amount which would equate with a daily usage of approximately 54 tablets. When questioned by officers, Respondent stated that if the doctor vouched for the patient, it was not his decision to make regarding whether to dispense the controlled substances, a clear misstatement of his duty under the law.

6. Respondent and Home Care had a “corresponding duty” (corresponding to the same duty as the prescriber) to ensure that prescriptions dispensed to patients were for a legitimate medical purpose. Respondent had access to CURES reports for all of his patients and could have discovered the overlapping and early refilling of prescriptions at Home Care as set forth below had he done so. Investigators reviewed CURES data for Respondents’ patients and found the following:

a. On or about March 11, 2013, the Ventura County Sheriff’s Department notified the Board that Patient A.M. committed suicide. Patient A.M. had received large numbers of controlled substances from Home Care, was a suspected doctor shopper and “early refiller” (one who seeks a refill of a prescription before being entitled to do so). Patient A.M. received at least seven controlled substance prescriptions and early refills that were filled early at Home Care between June 27, 2012 and September 21, 2012. Five of the refills could have been detected if the patient’s profile within Home Care’s computer records had been reviewed.

b. Patient J.C. filled 27 prescriptions from seven different physicians between December 11, 2012, and May 17, 2013. Patient J.C. received overlapping prescriptions of methadone, oxycodone and morphine, including one instance of a prescription of oxycodone that was dispensed on a monthly basis but was filled twice within the same month.

c. Patient A.D. received prescriptions of oxycodone with acetaminophen (APAP) from six physicians over a three month period. Patient A.D. also received overlapping prescriptions of hydrocodone/APAP in January and February of 2013 by two different physicians.

d. Patient V.D. received hydromorphone prescriptions from three different physicians and hydrocodone/APAP prescriptions from four different physicians between January and April of 2013.

e. Patient G.H. received oxycodone prescriptions from four different physicians between December 2012 and May of 2013.

f. Patient A.L. received 22 prescriptions from four different physicians between December 7, 2012, and March 27, 2013. The prescriptions included 180 tablets of

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<sup>4</sup> Oxycodone is an opioid analgesic. It is a Schedule II controlled substance designated as such in Health and Safety Code section 11055, subdivision (c)(8), and is categorized as a dangerous drug pursuant to Business and Professions Code section 4022.

hydromorphone 8 mg,<sup>5</sup> which each of the four physicians prescribed for one month, two prescriptions filled within a two week period for 294 and 420 tablets of methadone 10mg, and prescriptions of morphine 60 mg and 100 mg from each of the four physicians.

g. Patient W.M. received prescriptions of hydrocodone/APAP from 22 physicians over a four month time period wherein he also utilized at least nine pharmacies.

h. Patient D.P. received prescriptions of oxycodone/APAP and hydrocodone/APAP from thirteen different physicians between December of 2012 and May of 2013.

i. Patient S.S. filled 17 prescriptions from six different physicians between January 4, 2013, and May 17, 2013, including prescriptions of suboxone,<sup>6</sup> oxycodone/APAP and morphine sulphate 15mg extended-release.

j. Patient C.W. filled 17 prescriptions from five different physicians between December 19, 2012, and May 4, 2013, which included prescriptions of hydrocodone/APAP and codeine/APAP, which were filled the same day on May 1, but were prescribed by two different physicians. All of Patient C.W.'s prescriptions during this time period were filled at Home Care.

k. Patient M.M. received 25 prescriptions over a six month time period. Patient M.M. obtained oxycodone tablets in an amount which would equate with daily usage of approximately 54 tablets. Patient M.M. also obtained hydromorphone in an amount which would equate with daily usage of 12 tablets or 96 mg per day. The highest recommended normal dose of hydromorphone for an opioid-tolerant patient is 24 mg/day, meaning Patient M.M. received four times the recommended amount.

l. Patient M.R. received 43 prescriptions over a six month time period. Patient M.R. obtained oxycodone tablets in an amount which would equate with a daily usage of approximately 84 tablets. The dispensing records for Patient M.R. also included information that oxycontin was dispensed in doses greater than 80 mg per day, a daily dosage reserved for opioid tolerant patients. Patient M.R. first received a monthly prescription for 60 tablets of oxycontin 80 mg, which would be a daily dosage of 160 mg per dag. The monthly prescription was then increased to 120 tablets of oxycontin 80 mg, which would be a daily dosage of 320 mg per day. The prescription was then increased to 240 tablets of oxycontin 80 mg, which would be a daily dosage of 640 mg per day. All these doses are at an amount reserved for an opioid tolerant patient. There is no upper limit for an opioid tolerant patient, but due to the high volume of the tablets and the short six month period they were dispensed

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<sup>5</sup> Hydromorphone is 5–10 times more potent than morphine and enhances its distribution into the brain making titration of the effects easier. (<http://www.medscape.com/viewarticle/748796>.)

<sup>6</sup> Suboxone is used in the treatment of opioid addiction but is itself addicting.

in, it is unlikely the prescriptions were for therapeutic purposes. Patient M.R. also received fentanyl patch prescriptions at an amount which exceeded the necessary amount of patches needed for the monthly prescription period, and 150 tablets of dextroamphetamine/amphetamine 30 mg, of which the recommended highest dose to treat narcolepsy is 60 mg/day and 40mg/day for pediatric patients in treating A.D.H.D. Patient M.R. was prescribed a dosage of 150mg/day, which is above the highest recommended dosage.

m. When questioned by officers, Respondent stated that he contacted the doctors for many of the above patients and that if the doctor vouched for the patient, it was not his decision to make whether or not to dispense the controlled substances.

7. During an inspection of Home Care on August 7, 2013, a Board investigator determined that a controlled substance inventory, which is supposed to be made every two years, had not been taken since April 25, 2004.

8. Respondent testified and stated that he had, in essence, no evil intent in any of his dealings with his patients. He wanted only what was best for them. With respect to Patient P.M., Respondent noted that she was on a high dose of fentanyl and was addicted to it. She came to him asking for an "advance" on a prescription she would be getting from her doctor and he obliged her. He did not want to see her go into withdrawal and ultimately, her doctors were able to wean her off of this potent drug. Respondent portrayed himself as a kind and caring pharmacist who always had his patient's best interests at heart. This testimony was bolstered by dozens of letters from patients and fellow church goers. These letters are contained in Exhibit B and were originally written on Respondent's behalf during his criminal proceedings. Respondent's credibility was somewhat diminished by his insistence that he did not charge Patient P.M. for the fentanyl suckers he "advanced" her, while the police reports, including Respondent's admissions to them, clearly showed that he charged her \$25 for each sucker. Despite all that Respondent has lost (his drugstore, his stock-in-trade and the like), Respondent still does not "get it." He insisted that his was a "victimless crime" when the victims clearly were those he professed to help.

9. Respondent has been married for 41 years and has five children and 19 grandchildren. He is very active in his church. He teaches a one-hour seminary class five days per week. He is very active in his community. He coaches Little League baseball. He works with the Boy Scouts, teaching first aid and communications. He is currently training to become a high school basketball referee. He owns two restaurants with his daughter; he does the marketing while his daughter does the managing.

10. As a factor to be considered in terms of forming a disciplinary order, Complainant established that on February 24, 2005, Respondent and Home Care were each issued citations because they "failed to implement electronic monitoring of schedule II prescriptions as required by law." (Exhibit 16.) Home Care was fined \$250. Respondent was not fined.

11. The Board reasonably incurred expenses, including fees of the Attorney General, in connection with the investigation and prosecution of this matter in the total sum of \$11,562.50.

### CONCLUSIONS OF LAW

1. Health and Safety Code section 11153, subdivision (a) provides:

(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.

2. Business and Professions Code section 4059, subdivision (a), provides:

A person may not furnish any dangerous drug, except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7. A person may not furnish any dangerous device, except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7.

3. Business and Professions Code section 4301 provides, in pertinent part:

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

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

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

(l) The conviction of a crime substantially related to the qualifications, functions, and duties of a licensee under this chapter. The record of conviction of a violation of Chapter 13 (commencing with Section 801) of Title 21 of the United States Code regulating controlled substances or of a violation of the statutes of this state regulating controlled substances or dangerous drugs shall be conclusive

evidence of unprofessional conduct. In all other cases, the record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime, in order to fix the degree of discipline or, in the case of a conviction not involving controlled substances or dangerous drugs, to determine if the conviction is of an offense substantially related to the qualifications, functions, and duties of a licensee under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this provision. The board may take action when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment. [¶] . . . [¶]

(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.

4. California Code of Regulations, title 16 (Regulation), section 1707.3 states, "Prior to consultation as set forth in section 1707.2, a pharmacist shall review a patient's drug therapy and medication record before each prescription drug is delivered. The review shall include screening for severe potential drug therapy problems."

5. Regulation section 1761 provides:

(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.

6. Regulation 1770 provides:

For the purpose of denial, suspension, or revocation of a personal or facility license pursuant to Division 1.5 (commencing with Section 475) of the Business and Professions Code, a crime or act shall be considered substantially related to the qualifications, functions or duties of a licensee or registrant if to a substantial degree it evidences present or potential unfitness of a licensee or registrant to perform the functions authorized by his license or registration in a manner consistent with the public health, safety, or welfare.

7. Code of Federal Regulations, title 21, section 1304.11, subdivision (c) provides:

Biennial inventory date. After the initial inventory is taken, the registrant shall take a new inventory of all stocks of controlled substances on hand at least every two years. The biennial inventory may be taken on any date which is within two years of the previous biennial inventory date.

8. Respondent's conviction, described in Findings 3 and 4, is substantially related to the functions, duties and qualifications of a Board-licensed pharmacist, within the meaning of Business and Professions Code section 4301, subdivision (l), and Regulation 1770, thereby subjecting his license to discipline.

9. Respondent's and Home Care's licenses are subject to discipline under the provisions of Business and Professions section 4301, subdivisions (d), (j) and (o), in conjunction with Health and Safety Code section 11153, subdivision (a), and Regulation 1761, in that they failed to exercise their corresponding duty to ensure that prescriptions dispensed to patients were for a legitimate medical purpose, by reason of Finding 6 and its subparts.

10. Respondent's and Home Care's licenses are subject to discipline under the provisions of Business and Professions section 4301, subdivisions (j) and (o), in conjunction with Regulation 1707.3, in that they failed to review Patient A.M.'s drug therapy and medication records before dispensing her controlled substances, by reason of Finding 6a.

11. Respondent's and Home Care's licenses are subject to discipline under the provisions of Business and Professions section 4059, subdivision (a), in that they dispensed controlled substances to Patient P.M. without a prescription, by reason of Finding 4.

12. Respondent's and Home Care's licenses are subject to discipline under the provisions of Business and Professions section 4301, subdivision (o), and Code of Federal Regulations, title 21, section 1304.11, subdivision (c), in that they failed to inventory controlled substances every two years, by reason of Finding 7.

13. Respondent's and Home Care's licenses are subject to discipline under the provisions of Business and Professions section 4301 in that they committed acts of unprofessional conduct, by reason of Findings 5 through 7.

14. The Board is entitled to recover from Respondent and Home Care the sum of \$11,562.50 for its costs of investigation and prosecution of this matter under the provisions of Business and Professions Code section 125.3, by reason of Finding 11.

## ORDER

1. Pharmacist license number 30244 issued to Kent La Dell Miles, together with all licensing rights appurtenant thereto, are revoked.

2. Kent La Dell Miles shall pay to the Board the sum of \$11,562.50 at such time and in such manner as the Board, in its discretion, may direct.

3. Original Permit Number PHY 32722 issued to Home Care Pharmacy, Inc., doing business as Home Care Pharmacy, Kent La Dell Miles Pharmacist-in-Charge, together with all licensing rights appurtenant thereto, are revoked.

Date: 10-30-15

A handwritten signature in black ink, appearing to read 'R B DASH', written over a horizontal line.

RALPH B. DASH  
Administrative Law Judge  
Office of Administrative Hearings

1 KAMALA D. HARRIS  
Attorney General of California  
2 MARC D. GREENBAUM  
Supervising Deputy Attorney General  
3 ZACHARY T. FANSELOW  
Deputy Attorney General  
4 State Bar No. 274129  
300 So. Spring Street, Suite 1702  
5 Los Angeles, CA 90013  
Telephone: (213) 897-2562  
6 Facsimile: (213) 897-2804  
*Attorneys for Complainant*  
7

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

10 In the Matter of the Accusation Against:	Case No. 5005
11 <b>KENT LA DELL MILES</b>	<b>ACCUSATION</b>
12 1687 Erringer Rd. #101	
13 Simi Valley, CA 93065	
14 <b>Pharmacist License No. 30244</b>	
15 <b>HOME CARE PHARMACY</b>	
16 1687 Erringer Rd. #101	
17 Simi Valley, CA 93065	
18 <b>Original Permit No. 32722</b>	
19 Respondents.	

20  
21  
22 Complainant alleges:

23 **PARTIES**

- 24 1. Virginia Herold ("Complainant") brings this Accusation solely in her official capacity  
25 as the Executive Officer of the Board of Pharmacy, Department of Consumer Affairs.
- 26 2. On or about June 8, 1976, the Board of Pharmacy issued Pharmacist License Number  
27 30244 to Kent La Dell Miles ("Respondent Miles.") The Pharmacist License will expire on  
28 January 31, 2015, unless it is renewed.



1 "A person may not furnish any dangerous drug, except upon the prescription of a physician,  
2 dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7. A  
3 person may not furnish any dangerous device, except upon the prescription of a physician, dentist,  
4 podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7."

5 9. Section 4301 states:

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

9 ....

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

12 ....

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

15 ....

16 "(l) The conviction of a crime substantially related to the qualifications, functions, and duties  
17 of a licensee under this chapter. The record of conviction of a violation of Chapter 13  
18 (commencing with Section 801) of Title 21 of the United States Code regulating controlled  
19 substances or of a violation of the statutes of this state regulating controlled substances or  
20 dangerous drugs shall be conclusive evidence of unprofessional conduct. In all other cases, the  
21 record of conviction shall be conclusive evidence only of the fact that the conviction occurred.  
22 The board may inquire into the circumstances surrounding the commission of the crime, in order to  
23 fix the degree of discipline or, in the case of a conviction not involving controlled substances or  
24 dangerous drugs, to determine if the conviction is of an offense substantially related to the  
25 qualifications, functions, and duties of a licensee under this chapter. A plea or verdict of guilty or  
26 a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning  
27 of this provision. The board may take action when the time for appeal has elapsed, or the  
28 judgment of conviction has been affirmed on appeal or when an order granting probation is made

1 suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of  
2 the Penal Code allowing the person to withdraw his or her plea of guilty and to enter a plea of not  
3 guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or  
4 indictment.

5 ....

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

10 10. Health and Safety Code Section 11153, subdivision (a), states: A prescription for a  
11 controlled substance shall only be issued for a legitimate medical purpose by an individual  
12 practitioner acting in the usual course of his or her professional practice. The responsibility for the  
13 proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but  
14 a corresponding responsibility rests with the pharmacist who fills the prescription. Except as  
15 authorized by this division, the following are not legal prescriptions: (1) an order purporting to be  
16 a prescription which is issued not in the usual course of professional treatment or in legitimate and  
17 authorized research; or (2) an order for an addict or habitual user of controlled substances, which  
18 is issued not in the course of professional treatment or as part of an authorized narcotic treatment  
19 program, for the purpose of providing the user with controlled substances, sufficient to keep him  
20 or her comfortable by maintaining customary use."

21 **REGULATORY PROVISION**

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

23 "Prior to consultation as set forth in section 1707.2, a pharmacist shall review a patient's  
24 drug therapy and medication record before each prescription drug is delivered. The review shall  
25 include screening for severe potential drug therapy problems."

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

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

1 such prescription, the pharmacist shall contact the prescriber to obtain the information needed to  
2 validate the prescription.

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

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

7 "For the purpose of denial, suspension, or revocation of a personal or facility license  
8 pursuant to Division 1.5 (commencing with Section 475) of the Business and Professions Code, a  
9 crime or act shall be considered substantially related to the qualifications, functions or duties of a  
10 licensee or registrant if to a substantial degree it evidences present or potential unfitness of a  
11 licensee or registrant to perform the functions authorized by his license or registration in a manner  
12 consistent with the public health, safety, or welfare."

13 14. Code of Federal Regulations, title 21, section 1304.11, subdivision (c), states:

14 "Biennial inventory date. After the initial inventory is taken, the registrant shall take a new  
15 inventory of all stocks of controlled substances on hand at least every two years. The biennial  
16 inventory may be taken on any date which is within two years of the previous biennial inventory  
17 date."

#### 18 COST RECOVERY

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

#### 23 CONTROLLED SUBSTANCES

24 16. "Oxycodone," is a Schedule II controlled substance as designated by Health and  
25 Safety Code section 11055, subdivision (b)(1)(M), and is categorized as a dangerous drug  
26 pursuant to Business and Professions Code section 4022.

27 ///

28 ///



1 questioned by officers, Respondent Miles stated that if the doctor vouched for the patient, it was  
2 not his decision to make regarding whether to dispense the controlled substances. Complainant  
3 refers to, and by this references incorporates, the allegations contained in paragraph 19 below,  
4 subparagraphs (a) through (m) inclusive, as though set forth fully.

5 **SECOND CAUSE FOR DISCIPLINE**

6 **(Failure to Exercise Corresponding Responsibility)**

7 19. Respondent Miles and Respondent Pharmacy (collectively, "Respondents") are subject  
8 to disciplinary action under section 4301, subdivisions (d), (j) and (o), in conjunction with Health  
9 and Safety Code section 11153, subdivision (a), and California Code of Regulations, title 16,  
10 section 1761, in that Respondents failed to exercise their corresponding responsibility to ensure  
11 that prescriptions dispensed to patients were for a legitimate medical purpose. Investigators  
12 reviewed CURES<sup>2</sup> data for Respondents' patients over a sixth month period<sup>3</sup> and found the  
13 following:

14 a. On or about March 11, 2013, the Ventura County Sheriff's Department notified the  
15 Board that Patient A.M. committed suicide. Patient A.M. had received large numbers of  
16 controlled substances from Home Care Pharmacy, was a suspected doctor shopper and "early  
17 refiller."<sup>4</sup> Patient A.M. received at least seven controlled substances that were filled early at Home  
18 Care Pharmacy between June 27, 2012, and September 21, 2012. Five of the refills could have  
19 been detected if the patient's profile within Respondent Pharmacy's computer record had been  
20 reviewed.

21 b. Patient J.C. filled twenty-seven prescriptions from seven different physicians between  
22 December 11, 2012, and May 17, 2013. Patient J.C. received overlapping prescriptions of  
23

24 <sup>2</sup> CURES is the Department of Justice's Controlled Substance Utilization Review and  
25 Evaluation System. CURES maintains Schedule II, Schedule III, and Schedule IV prescription  
information that is received from California pharmacies.

26 <sup>3</sup> CURES records for Patient A.M. were reviewed separately from the remaining patients.  
Excluding Patient A.M., the time period reviewed is the noted sixth month period.

27 <sup>4</sup> An "early refiller" is an individual who takes medications more frequently than prescribed,  
28 exhausting their supply of medication before the intended time frame and then asking for an early  
refill.

1 methadone, Oxycodone and morphine, including one instance of a prescription of oxycodone that  
2 was dispensed on a monthly basis but was filled twice within the same month.

3 c. Patient A.D. received prescriptions of Oxycodone and Acetaminophen from six  
4 physicians over a three month period. Patient A.D. also received overlapping prescriptions of  
5 Hydrocodone and Acetaminophen in January and February of 2013 by two different physicians.

6 d. Patient V.D. received Hydromorphone prescriptions from three different physicians  
7 and Hydrocodone / APAP prescriptions from four different physicians between January and April  
8 of 2013.

9 e. Patient G.H. received Oxycodone prescriptions from four different physicians between  
10 December 2012 and May of 2013.

11 f. Patient A.L. received twenty-two prescriptions from four different physicians between  
12 December 7, 2012, and March 27, 2013. The prescriptions included 180 tablets of  
13 Hydromorphone 8 mg, which each of the four physicians prescribed for one month, two  
14 prescriptions filled within a two week period for 294 and 420 tablets of Methadone 10mg, and  
15 prescriptions of Morphine 60 mg and 100 mg from each of the four physicians.

16 g. Patient W.M. received prescriptions of APAP/Hydrocodone from 22 physicians over a  
17 4 month time period wherein he also utilized over nine pharmacies.

18 h. Patient D.P. received prescriptions of APAP/Oxycodone and APAP/Hydrocodone  
19 from thirteen different physicians between December of 2012 and May of 2013. The amount of  
20 APAP / Hydrocodone and APAP/Oxycodone filled during this time period may put Patient D.P. at  
21 risk to exceed the maximum daily dose.

22 i. Patient S.S. filled seventeen prescriptions from six different physicians between  
23 January 4, 2013, and May 17, 2013, including prescriptions of Suboxone 8mg/2mg, APAP /  
24 Oxycodone and Morphine Sulphate 15mg extended-release.

25 j. Patient C.W. filled seventeen prescriptions from five different physicians between  
26 December 19, 2012, and May 4, 2013, which included prescriptions of APAP/Hydrocodone and  
27 APAP/codeine, which were filled the same day on May 1, but were prescribed by two different  
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1 physicians. All of Patient C.W.'s prescriptions during this time period were filled at Home Care  
2 Pharmacy.

3 k. Patient M.M. received 25 prescriptions over a six month time period. Patient M.M.  
4 obtained oxycodone tablets in an amount which would suggest daily usage of approximately fifty-  
5 four (54) tablets. Patient M.M. also obtained hydromorphone in an amount which would suggest  
6 daily usage of 12 tablets or 96 mg per day. The highest recommended normal dose of  
7 hydromorphone for an opioid-tolerant patient is 24 mg/day, the amount Patient M.M. received is  
8 approximately four times this amount.

9 l. Patient M.R. received 43 prescriptions over a six month time period. Patient M.R.  
10 obtained oxycodone tablets in an amount which would suggest a daily usage of approximately  
11 eighty-four (84) tablets. The dispensation records for Patient M.R. also include information that  
12 oxycontin was dispensed in doses greater than 80 mg per day, a daily dosage reserved for opioid  
13 tolerant patients. Patient M.R. first received a monthly prescription for 60 tablets of oxycontin 80  
14 mg, which would be a daily dosage of 160 mg per day. The monthly prescription was then  
15 increased to 120 tablets of oxycontin 80 mg, which would be a daily dosage of 320 mg per day.  
16 The prescription was then increased to 240 tablets of oxycontin 80 mg, which would be a daily  
17 dosage of 640 mg per day. All these doses are at an amount reserved for an opioid tolerant  
18 patient. There is no upper limit for an opioid tolerant patient, but due to the high volume of the  
19 tablets and the short six month period they were dispensed in, it is unlikely the prescriptions were  
20 for therapeutic purposes. Patient M.R. also received fentanyl patch prescriptions at an amount  
21 which exceeded the necessary amount of patches needed for the monthly prescription period, and  
22 150 tablets of Dextroamphetamine / Amphetamine 30 mg, of which the recommended highest dose  
23 to treat narcolepsy is 60 mg/day and 40mg/day for pediatric patients in treating A.D.H.D. Patient  
24 M.R. was prescribed a dosage of 150mg/day, which is above the highest recommended dosage.

25 m. When questioned by officers, Respondent Miles stated that he contacted the doctors  
26 for many of the above patients and that if the doctor vouched for the patient, it was not his  
27 decision to make whether or not to dispense the controlled substances.

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1 **THIRD CAUSE FOR DISCIPLINE**

2 **(Failure to Review Drug Therapy and Patient Medication Records)**

3 20. Respondents are subject to disciplinary action under section 4301, subdivisions (j) and  
4 (o), in conjunction with California Code of Regulations, title 16, section 1707.3, in that  
5 Respondents failed to review Patient A.M.'s drug therapy and medication records before  
6 delivering and dispensing prescribed controlled substances. Complainant refers to, and by this  
7 reference incorporates, the allegations set forth above in paragraph 19, subparagraph (a), as  
8 though set forth fully.

9 **FOURTH CAUSE FOR DISCIPLINE**

10 **(Furnishing Controlled Substances Without a Valid Prescription)**

11 21. Respondents are subject to disciplinary action under section 4059, subdivision (a), in  
12 that Respondents furnished controlled substances to Patient P.M. without a valid prescription.  
13 Complainant refers to, and by this reference incorporates, the allegations set forth above in  
14 paragraph 18 subparagraphs (a) through (c), inclusive, as though set forth fully.

15 **FIFTH CAUSE FOR DISCIPLINE**

16 **(Failure to Inventory Controlled Substances)**

17 22. Respondents are subject to disciplinary action under section 4301, subdivision (o), in  
18 conjunction with Code of Federal Regulations, title 21, section 1304.11, subdivision (c) in that  
19 Respondents failed to inventory controlled substances at least every two years. During an  
20 inspection on August 7, 2013, an investigator determined that the previous controlled substance  
21 biennial inventory for Respondent Pharmacy was taken on April 25, 2004.

22 **SIXTH CAUSE FOR DISCIPLINE**

23 **(Unprofessional Conduct)**

24 23. Respondents are subject to disciplinary action under section 4301 in that Respondents  
25 committed acts of unprofessional conduct. Complainant refers to, and by this reference  
26 incorporates, the allegations set forth above in paragraphs 18 through 22, inclusive, as though set  
27 forth fully.

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1 DISCIPLINARY CONSIDERATIONS

2 24. To determine the degree of discipline, if any, to be imposed on Respondent Pharmacy,  
3 Complainant alleges the following:

4 a. On or about February 24, 2005, the Board of Pharmacy issued Respondent Pharmacy  
5 Citation Number CI 2004 27890, with a \$250.00 fine. Respondent Pharmacy complied with the  
6 citation and it is final. The citation alleged that Respondent Pharmacy failed to implement  
7 electronic monitoring of Schedule II prescriptions as required by law.

8 25. To determine the degree of discipline, if any, to be imposed on Respondent Miles,  
9 Complainant alleges the following:

10 a. On or about February 24, 2005, the Board of Pharmacy issued Respondent Miles  
11 Citation Number CI 2004 29139, with no associated fine. Respondent Miles complied with the  
12 citation and it is final. The citation alleged that Respondent Miles failed to implement electronic  
13 monitoring of Schedule II prescriptions as required by law.

14 PRAYER

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

17 1. Revoking or suspending Pharmacist License Number 30244, issued to Kent La Dell  
18 Miles;

19 2. Ordering Kent La Dell Miles to pay the Board of Pharmacy the reasonable costs of the  
20 investigation and enforcement of this case, pursuant to Business and Professions Code section  
21 125.3;

22 3. Revoking or suspending Original Permit Number PHY 32722, issued to Home Care  
23 Pharmacy, Inc. doing business as Home Care Pharmacy;

24 4. Ordering Home Care Pharmacy, Inc. doing business as Home Care Pharmacy to pay  
25 the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case,  
26 pursuant to Business and Professions Code section 125.3; and,

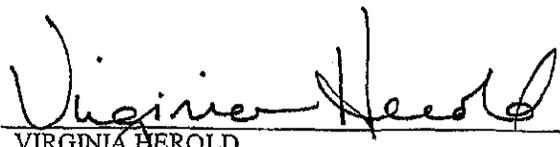
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5. Taking such other and further action as deemed necessary and proper.

DATED: 3/24/15



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

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