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

In the Matter of the Accusation Against: **LDWPC INC., DBA GARFIELD PRESCRIPTION PHARMACY** Pharmacy Permit No. PHY 46072 **PETER FRANZ DOLEZAL** Pharmacist License No. RPH 33437 Respondents.	Case No. 5337 OAH No. 2016050584

DECISION AND ORDER

The attached Proposed Decision of the Administrative Law Judge 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 March 16, 2017.

It is so ORDERED on February 14, 2017.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By _____
Amy Gutierrez, Pharm.D.
Board President

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PROPOSED DECISION

The hearing in the above-captioned matter was conducted by Joseph D. Montoya, Administrative Law Judge (ALJ), Office of Administrative Hearings, on December 20 and 21, 2016, at Los Angeles, California.

Complainant Virginia Herold was represented by Susan Melton Wilson, Deputy Attorney General.

Respondent LDWPC Inc., was represented by Rex Julian Beaber, attorney at law.

Respondent Peter Franz Dolezal (Dolezal) appeared and represented himself, but he and complainant entered into a stipulation to resolve the matter as to Dolezal. While he testified in the matter, he did not participate as a party. Further, as a result of the settlement, Complainant did not go forward on the Fifth Cause for Discipline, as it pertained solely to Dolezal.

During the hearing, it became apparent that many patients were identified in the voluminous records offered in evidence.[1] The court reporter was instructed to use initials in the place of their names. By a separate order, a large portion of the exhibits will be sealed, as redaction of names by the ALJ, spread through hundreds of pages of documents, is not feasible.

[1] Complainant adduced 51 exhibits, totaling several hundred pages.

After receiving evidence and argument, the matter was submitted for decision on December 21, 2016. The ALJ hereby makes his factual findings, legal conclusions, and order.

FACTUAL FINDINGS

The Parties, Prior Disciplinary Actions, and Jurisdiction

1. Complainant brought and maintained the Accusation in her official capacity as Executive Officer of the Board of Pharmacy (Board), Department of Consumer Affairs.

2. (A) On February 20, 2003, the Board issued Pharmacy Permit number PHY 46072 to LDWPC Inc., doing business as Garfield Prescription Pharmacy. At all times relevant to this matter Garfield's permit was in full force and effect. That permit is scheduled to expire on February 20, 2017, unless renewed.

(B) Since October 13, 2004, Lisa Weiss has been the President, Chief Executive Officer (CEO), Secretary and Treasurer of the corporate licensee. She owns all of the shares of the stock of the corporation.

3. On October 9, 1979, the Board issued Pharmacist's License number RPH 33437 to Dolezal. Dolezal's license was in full force and effect at all times relevant to this matter. At the time of the events relevant to this proceeding Dolezal was the Pharmacist in Charge (PIC) of Garfield. He ceased being PIC in 2015.

4. Prior to February 2003, another entity operated the pharmacy under the business name "Garfield Prescription Pharmacy." Dolezal was the PIC for that entity from August 20, 1991, until Respondent LDWPC Inc. purchased the business in approximately March 2001.

5. (A) LDWPC Inc. purchased the pharmacy business following a disciplinary action brought by the Board in July 1999, against Dolezal and the prior owner, in the Board's case number 2128. In that matter Dolezal and his then-employer were accused of violating Business and Professions Code sections 4603, 4301, subdivision (i), 4300, 4301, subdivision (j),[2] as well as Health and Safety Code sections 11200, subdivisions (a) and (b), and 11153. Further, it was alleged that Dolezal and the predecessor pharmacy violated numerous Board regulations relevant to filling prescriptions.

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[2] Hereafter, statutory references shall be to the Business and Professions Code unless otherwise noted.

(B) Among the charges were allegations that Dolezal and the pharmacy filled prescriptions for controlled substances without prescriber authorizations; that they knowingly provided such drugs to addicts; that they failed to keep proper inventory and other records; failed to review a patient's medication profile, failed to notify a prescriber about emergency refills, and for unprofessional conduct by filling prescriptions that were not for legitimate medical purposes.

(C) In a 2001 stipulation that resolved the 1999 disciplinary proceeding, Dolezal agreed that his license would be revoked, with that order stayed and the license placed on probation for three years He agreed to pay costs, and he agreed that his license would be suspended for 15 days.

(D) It was also stipulated that the pharmacy owner would surrender its license, with the surrender stayed so that a sale of the pharmacy could be completed, and the buyer's application for a pharmacy permit completed.[3]

(E) In the stipulation that resolved the prior matter, Dolezal admitted that if the case went to trial, Complainant in that matter could establish a factual basis for the charges, and he waived his right to contest the charges. He further agreed that his license was subject to discipline, and that his admissions were made for the purpose of that proceeding, or other proceedings before the Board. (Ex. 4, ¶¶ 10-12.) The prior owner did not make such admissions.

6. On March 12, 2012, the Board issued citations against Dolezal and LDWPC Inc. for violations of sections 4126.5, subdivision (a)(4) (improperly furnishing drugs to a wholesaler) and 4059.5, subdivision (a) (selling dangerous drugs to an entity but indicating on the shipping label that the drugs were sold by another entity). Respondent LDWPC Inc. paid a fine to resolve the citation against it, and Dolezal enrolled in an ethics class to resolve the citation against him.

7. After the Accusation was filed in this matter, LDWPC Inc. and Dolezal filed Notices of Defense, demanding hearings, and this proceeding ensued. All jurisdictional requirements have been met. Hereafter, LDWPC Inc. shall be referred to as "Garfield."

Sales of Controlled Substances November 1, 2009 through December 12, 2012

8. (A) On numerous occasions between November 1, 2009, and December 12, 2012, Respondents Dolezal and Garfield improperly dispensed controlled substances, in ways that violated applicable Board statutes and regulations,

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[3] While the order was prospective as to the completion of the purchase, paragraph 4 of the stipulation stated that the pharmacy had already been sold. (Ex. 4 at page AGO 40.)

and which actions were contrary to proper practice for pharmacies and PIC's when they dispense controlled substances. While every improper sale will not be described hereafter, the following examples are culled from the record, to illustrate the improper practices.

(B) Among the controlled substances that were improperly dispensed during the subject time period are the following, which are known to be subject to abuse:

Norco—10 mg. hydrocodone/325 mg acetaminophen.
Lortab—either 10 mg. hydrocodone/500 mg. acetaminophen, or 7.5 mg. hydrodocone/750 mg. acetaminophen.
Xanax—alprazolam, typically in 2 mg. tablets
Phenergan with Codeine—promothazine with codeine liquid
Vicodin—hydrocodoneAPAP
Soma—carisoprodol 350 mg.[4]

The Phenergan with Codeine (Phenergan) was sold in two brands, Actavis and Qualitist. Of the controlled substances identified above, Phenergan was the single most dispensed drug at Garfield during the relevant time period. Garfield's records introduced at the hearing by Garfield, showed that just under one quarter of a million doses—in a total of 613 prescriptions—were dispensed in 2012 alone. (See ex. A.)

(C) Phenergan is a Schedule V controlled substance. Norco and Lortab are Schedule III controlled substances, and Soma is Schedule IV. (Ex. 7, p. AGO 85.)

9. (A) There are a number of "red flags" that may appear in a dispensing transaction which indicate that someone is improperly attempting to obtain controlled substances. For example, the patient may be filling the prescription many miles from his or her home. Likewise, the prescribing doctor may be well away from the area where the pharmacy is located. Handwriting on the prescription may hint at forgery, the writing being either too neat, or too illegible, and not using the sort of abbreviations and acronyms common in the medical and prescribing arena. The prescription should be on proper "secured" paper. Early refills, or excuses for them may be a red flag. Further, high doses of a given medication might be a tip-off that the patient is abusing the drug, sometimes with the assistance of the prescribing physician. A patient's medical profile can show a red flag as well, as can be continued pick-up of the medications by someone other than the patient. The pharmacy's records may indicate that a substantial number of prescriptions for controlled substances are coming from the same doctor or doctors, which can be a

[4] This information is taken from the chart in exhibit 7, at page AGO 85. For ease of reference brand names are typically used in this Proposed Decision

sign of impropriety. Dolezal, when interviewed in November 2012 stated that prescriptions being dropped off or picked up by "waves" of people could be a sign of impropriety.

(B) The testimony by Garfield's current PIC and the Board's inspector, William Young (Inspector Young), indicate that not every "red flag" has to mean that the patient in question is attempting to obtain controlled substances improperly. For example, a patient may need to obtain an early refill because a vacation or long business trip will overlap the normal refill date. The customer who lives a significant distance from the pharmacy may work near the licensed premises, or the patient may be visiting the area for business or a vacation. However, basic questions put to the patient, along with a call to the prescriber is often sufficient to ferret out the illegitimate prescription from the one that should be filled.

(C) The record establishes that Dolezal paid little or no attention to any red flags that regularly popped up in Garfield's day-to-day business; those red flags were legion during the relevant time period. When interviewed by Inspector Young on November 1, 2012 and again when he testified at the hearing, Dolezal indicated that he felt obligated to fill prescriptions to make the customer happy. He believed that forged prescriptions were potentials for confrontation and he did not want to jeopardize his own or his staff's safety. However, he did not point to any particular incident or incidents that would justify that concern. (See ex. 7, p. AGO 89.) Dolezal told Inspector Young that after October 2011 he asked for identification for persons filling prescriptions for drugs with high abuse potential. But, in many cases, he allowed others to obtain the drugs for those patients, including on an occasion in October 2012, where 18 forged prescriptions were filled, all written on the same forged prescription pad, and all picked up by a series of young men who were not the patients. (Ex. 7, pp. AGO 90-91, 94; see Factual Findings 18(A & B.) The weight of the record, and all inferences reasonably deduced from it, establish that Dolezal was filling virturally any prescriptions for controlled substances presented to the pharmacy prior to December 2012, regardless of the red flags that appeared in the course of the transactions.

(D) The record establishes that Dolezal was not reviewing patient medication records before filling the prescriptions for controlled substances. He admitted as much when interviewed by Inspector Young in November 2012, and it is clear from the pattern of dispensation, as when at least two patients obtained two bottles of Phernergan on the same day, or where others were able to obtain three bottles of that drug in a span of approximately three weeks. As set forth in Factual Finding 15, a one-pint bottle, at maxim dose, should last a patient about two weeks; hence the sales described above were blatant examples of over-prescribing.

10. Examples of improper dispensing of Phenergan are found through Garfield's records. One such example appears in Garfield's records for September 7, 2012. (See ex. 7, p. 153.) On that day, 28 bottles of Phenergan were dispensed, each

being a one-pint bottle (473 milliliters). Each bottle was sold for $124.50, and each was paid for in cash. The 28 prescriptions were written by five different doctors, several of whom wrote numerous other prescriptions for controlled substances. The prescriptions were often serial in nature. That is, the prescription numbers for the first six prescriptions were sequential, being numbers 280029 through 280034. The last bottle dispensed carried prescription number 280071. Thus, of the 42 prescriptions bearing numbers 280029 through 280071, more than half (28) were for Phenergan, a drug known to be abused.[5] This volume of Phenergan dispensing, especially in one-pint bottles, should have alerted Dolezal and Garfield to improper prescribing, but the 28 prescriptions were filled anyway.

11. (A) Another example of patent over dispensation of Phenergan is found at page AGO 142 of exhibit 7. It shows that on January 20, 2011, Garfield, with Dolazal in charge, filled 39 prescriptions for Phenergan. Each was a one pint bottle, but each was for the less expensive brand, which was sold for $59, with each patient paying cash for the drug. All 39 prescriptions were written by Dr. Nazar Al-Bussam. The prescription numbers range from 265507 to 265624. Thus, of 117 prescriptions in that number range, one third were for Phenergan. Inspector Young determined that the 39 bottles of Phenergan sold on January 11, 2011 amounted to 25 per cent of all the prescriptions filled at Garfield on that day. (Ex. 7, p. AGO 153.)

(B) Inspector Young found that one patient received two bottles of Phenergan on January 20, 2011, one by prescription number 265615, the other by prescription number 265618. (Ex. 7, p. AGO 105.) Garfield's records indicated that one patient was able to refill the Phenergan prescription four days after obtaining his pint of the drug. Another patient received three bottles in a 13 day period, between October 2 and October 15, 2012. Another patient refilled his or her prescription for a one pint bottle three times on the same day, December 6, 2010. (Ex. 7, p. AGO 110.) Just how Dolezal and the pharmacy would not perceive that one person filled three prescriptions for the same controlled substance in one day can not be explained by the record, but plainly indicates that no efforts were being made to ascertain the propriety of filling the three prescriptions, so that the "patient" could obtain one and one-half quarts of codeine-infused cough syrup.

(C) A review of exhibit 31, a drug usage report, shows that a patient, I.S., filled or refilled a prescription for one pint of Phenergan (prescription no.

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[5] The sequential nature of the Phenergan prescription numbers stands out. For example, numbers 280041 through -44; and 280058 through 280071, with only number 280063 missing in the last sequence of prescription numbers for September 7, 2012. As Inspector Young testified, the inference to be drawn is that either 28 people came in and stood in line to get Phenergan, or a "capper" came in and placed the orders. In the former case, they were coming in waves, something Dolezal identified as a red flag to Inspector Young. (Factual Finding 9(A).)

251673) on January 29, February 5, February 15, and March 2, 2010. (Ex. 31, marked as page 1 of 61.) That patient also obtained two one-pint bottles of Phenergan, under a different prescription number—252843—on January 8 and January 29, 2010. (*Id.*) Patient I.S. also filled another prescription for Phenergan, number 253780, on February 5, 2010.[6] Thus, patient I.S. obtained two pints of the cough syrup on January 29, under two different prescription numbers. And, he obtained two pints of the drug on February 5, 2010, under two different prescription numbers.[7] Another patient, C.M., filled or refilled a prescription of Phenergan on January 11, 29, February 15, and March 2, 2010. His prescription was written by Doctor Ebrahim Sajadi.

12. According to Inspector Young's research, the usual adult dose of Phenergan for a cough is five milliliters orally ever four to six hours as needed, with a maximum dose of 30 milliliters per day. Hence, the one pint, 473 milliliter bottles typically dispensed would last a patient 14 to 15 days, assuming they were taking the maximum daily dose. That patients were refilling the Phenergan prescriptions within a shorter period, as set out in Factual Findings 11(B) and (C), above, certainly should have set off alarm bells for the Dolezal.

13. (A) In an extensive report, Inspector Young analyzed Garfield's records and summarized sales of Phenergan as follows:

> February 1, 2010 to December 23, 2010, 570 pint bottles;
> January 11, 2011 to October 7, 2011, 564 pint bottles;
> March 26, 2012 to October 10, 2012, 369 pint bottles.

Inspector Young noted that within the aforementioned time periods, sales at times were very intense, such as during a six day period in September 2012, when Garfield dispensed 72 bottles, or when it dispensed 241 bottles over a 67 day period in the summer of 2011. (Ex. 7, p. AGO 187.)

(C) Inspector Young credibly testified that most pharmacies would not stock more than six to eight bottles of Phenergan, and that a pharmacist would not expect to dispense much of the drug during the summer; because it is a strong cough syrup one would expect to sell more in the winter months when a nagging cold and cough are more likely.[8]

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[6] The three prescriptions were written by the same doctor, Ebrahim Sajedi.

[7] As set out in Factual Findings 17(A)-(C), patient I.S. was later arrested outside the pharmacy after picking up 18 prescriptions of controlled substances.

[8] Young surveyed a number of pharmacists in Beverly Hills regarding the prescribing patterns found in Garfield's records. One commented that he would not dispense a 16 ounce bottle of Phenergan to anyone. (Ex. 7, p. AGO 163.)

(D) There was evidence that the prescriptions for Phenergan were not accompanied by prescriptions for antibiotics, as might be expected where a person, suffering from a painful and severe cough, is prescribed Phenergan by a physician acting in good faith.

14. Garfield's current PIC, Edwin Yadidi (Yadidi), testified to current practices. In the course of doing so, he provided a summary of records that showed that in 2012 Garfield had dispensed 613 prescriptions of Phenergan, and that in the four years beginning in 2013 through the hearing date in late 2016, Garfield had dispensed only 288 prescriptions, less than half of the prior total.

15. (A) While Phenergan was plainly a sales leader at Garfield, other controlled substances were dispensed in a manner that indicated impropriety, and those controlled substances were often dispensed along with the Phenergan.

(B) For example, on January 20, 2011, 38 patients, each paying cash, each received 100 tablets of Soma, 350 mg., which represented 25 per cent of that day's prescription volume. Another 27 patients filled prescriptions for 120 tablets of Norco (hydrocodone/APAP 10/500), which represented 18 per cent of the volume on January 20, 2011. Ten other patients obtained either 120 or 150 tablets of Lortab (hydrocodone/APAP, 10/350). All of the hydrocodone prescriptions were paid for in cash. (Ex. 7, p. AGO 105.)

16. (A) In many instances Dolezal and Garfield dispensed substantial amounts of Norco, Xanax, or other controlled substances to persons who also obtained a pint of Phenergan. For example, on February 5, 2010, patient I.S. filled his two separate prescriptions for Phenergan, but he also filled two prescriptions for Xanax (numbers 252848 and 253779), each for 100 tablets, two milligrams strength. All four prescriptions were written by Dr. Sajedi. (Ex. 21 at p. "report 223.)

(B) Another one of Dr. Sajedi's patients, L.S., filled a prescription for Phenergan and two prescriptions for hydrocodone on June 21, 2011. Each of the prescriptions was for 120 tablets, but one was for the 10-325 mg. strength Lortab, and the other was for the 10-500 mg. Norco. Patient L.S. filled prescriptions for the same group of drugs just six days later, on June 27, 2011. On August 8, 2011, L.S. obtained another pint of Phenergan, the two types of hydrocodone (120 tablets each), and Soma 350 mg., 100 quantity. (Ex. 21, p. "report 223.")

(C) On two of the days that patient L.S. obtained large quantities of controlled substances, Dr. Sajedi's patient C.S. obtained the same drugs at Garfield. On June 21, 2011 she obtained a pint of Phenergan, 100 tablets of Xanax, and 120 tablets of Norco. On August 8, 2011, she obtained another pint of Phenergan, 100 tablets of Soma, and 200 tablets of hydrocodone, 100 each of the 10-325 mg. and 10-500 mg. (Ex. 21, p. "report 224.")

17. (A) On September 12, 2011, the patient identified above as I.S. went to Garfield and picked up prescriptions for 18 patients, each patient receiving the same four controlled substances: Phenergan, Norco, Lortab, and Xanex. The prescriptions were all forgeries, but were filled by Dolezal anyway. It is plain that he made no inquiry of the person who purportedly wrote the prescriptions. A simple phone call would have revealed the forgeries. In this matter I.S. had dropped off the prescriptions, paid for them with a large amount of cash, and then come back later to pick up the drugs. He and another person routinely filled prescriptions for controlled substances in this way, claiming that they were assisting the prescribing doctor in filling prescriptions for patients who had trouble getting around.

(B) The Department of Health Care Services (DHCS) investigated activities at Garfield, and they questioned I.S., and took him into custody. The DHCS investigators obtained 18 prescription forms from Garfield after they took I.S. into custody. The 18 prescriptions were all ostensibly written by Kent Shoji, M.D., an emergency room doctor, who later confirmed that the prescriptions were forgeries.

(C) A quick review of the prescription documents (ex. 18) show that all were purportedly written on the same day. All are plainly written by the same hand. While a patient is named, none have a patient address written in. All are for the same drug, in the same doses, and written in the same order: Phenergan, Norco, Lortab, and Xanax. All were dropped off at the same time, based on statements made by Dolezal and the pharmacy technician to DHCS investigators.

18. (A) Approximately one year later, on or about October 12, 2012, Garfield and Dolezal filled another 18 prescriptions in suspicious circumstances. All the prescriptions were written on a prescription pad carrying the name Urgent Care Center of South Bay, Inc., located in Torrance, a significant distance, in both miles and driving time, from Garfield's Beverly Hills premises. The patient addresses indicated that they typically lived more than five miles from Garfield's premises. One patient ostensibly lived in Chino, California, about 45 miles from Garfield, and another in Victorville, over 90 miles from Garfield. That such patients would treat in Torrance from homes in such locations, and then fill the prescriptions at Garfield is clear notice that something is likely amiss, but Dolezal and Garfield filled the prescriptions anyway. The prescriptions were all written in the same hand, although some were ostensibly issued by a physician at the clinic, and others by a physician's assistant. Each of the prescriptions was for Phenergan.

(B) Inspector Young discussed the October 12, 2012 prescriptions with Dolezal and his technician when Young inspected Garfield on November 1, 2012. Dolezal admitted that he filled the prescriptions before verifying that they were properly issued. Dolezal claimed that they were busy and were not able to call the doctor. (Ex. 7, p. AGO 90.) Later, Dolezal admitted that the prescriptions were all brought in by someone who purportedly had the patient identifications with that

person, and he described the people picking up the prescriptions as mostly young men who came in one after the other. (*Id.*, p. AGO 91.)

DEA Action Against Garfield

19. The federal Drug Enforcement Administration (DEA) conducted an investigation into Garfield's activities in 2012. As a result of the investigation, Garfield surrendered its DEA license on December 12, 2012. Garfield's controlled substances inventory was seized by the DEA as well. Alan Friedman testified for Garfield to the effect that the inventory had a value of approximately $40,000. In his report, Inspector Young stated that documents he received from the DEA showed a street value for the controlled substances of approximately $250,000. (Ex. 7, p. AGO 97.)

20. An unsigned copy of the Memorandum of Agreement between Garfield and the DEA was received in evidence as exhibit 51. Dolezal acted as Garfield's representative in making the agreement. The agreement confirms that Garfield's DEA Certificate of Registration was surrendered on December 12, 2012. The DEA asserted that its investigation revealed that Garfield had dispensed controlled substances to customers who did not live in California, or did not live in the area of the pharmacy, and often paid in cash. The DEA found evidence that Garfield had not complied with its corresponding responsibility, and that in filling prescriptions, Garfield had not complied with regulations pertaining to the manner

21. The DEA-Garfield agreement provided that at some point Garfield could reapply for a certificate, but that if another was issued, Garfield would be barred for one year from ordering, possessing, administering, and dispensing Phenergan. (Ex. 51, p. 3, at ¶ 3.) Garfield was obligated to maintain a log of all controlled substance prescriptions with information regarding the identity of the drugs, the quantity of the drug, patient name and address, and information about the physician.

22. Under the agreement, Garfield agreed that if another DEA certificate were issued to it, then Garfield would dispense controlled substances "only where the doctor and patient were within a reasonable distance from the pharmacy." (Ex. 51, p. 3, PAR 5.) Where a customer requested delivery the recipient had to personally receive the prescription, and be positively identified via government issued identification. (*Id.*, ¶ 6.)

23. The time period for obtaining another DEA certificate is not clear from the document. At paragraph 11, it is stated that "so long as DEA has not received information of violations . . . during this period, within five days of execution of this Agreement, DEA shall grant Garfield Prescription's application for a new DEA Certificate of Registration, which shall be subject to the terms of this Agreement." Just what is meant by "this period" is not clear from the document. And, since the

agreement is not dated it is not clear when another DEA certificate issued, though it is clear that one did.

Garfield's Current Operation

24. Mr. Yadidi, the PIC since April 2016, testified. He was aware of common red flags for prescriptions of controlled substances. He noted one was distance, either in terms of the doctor's proximity to the pharmacy, or the patient's. He stated he will usually call the doctor and inquire as to why the prescription is being filled at his pharmacy. If he perceives a problem, he simply tells the patient that they don't have the drug. He also knew that the same group of patients, with the same doctor is obviously a pattern, and a "huge red flag." (Yadidi's term.) In terms of refills, he treats them on a case-by-case basis, with an eye toward finding patterns of doctors, and he often refills only a few days' supply, rather than giving a large supply.. And, he will inquire of the doctor as appropriate. Yadidi also watches for high dosage range.

25. Garfield does fill prescriptions for controlled substances, but tends to fill small dosages of pain medications, such as five to ten pills, often for dental patients. Much of the traffic comes from prescribers in the building where Garfield is housed.

26. All Schedule II drugs are locked up, and only Yadidi has the key. He keeps a separate log for such drugs. Pharmacy techs are instructed to always check the CURES data base when asked to fill prescriptions for controlled substances, as it will provide information about all of the patient's prescriptions, regardless of where they are filled.

The Corporate Licensee's Passive Role in Garfield's Operation

27. The record is clear that for years, and through the current time, LDWPC has had no oversight of the day-to-day operation of the pharmacy. Ms. Weiss, who controls the corporation, rarely visited the pharmacy. What interaction there was between Dolezal and his employer was undertaken by Alan Friedman, who has been identified during the proceeding as Ms. Weiss's "common law husband."[9] Friedman is not an officer or director of the corporation. As set forth in Factual Finding 2(B), Ms. Weiss holds all of those positions. Friedman stated that prior to the time she became sole shareholder, LDWPC was a "partnership," by which it is inferred there was more than one shareholder. It appears that Friedman's main role was to come by the pharmacy approximately two times per week, pick up bills that needed to be paid, and bring items that might be needed. Friedman stops in on his

[9] California does not recognize common law marriage, but will honor one that is established under the law of a state that does. (*People v. Badgett* (1995) 10 Cal.4th 330, 363.)

way to his place of employment. At one point, he labeled himself as general manager of the corporation. It should be noted that Friedman was identified as the owner in one of the reports, and Young may have heard such from Dolezal. (See ex. 11, p. 1.)

28. Ms. Weiss rarely comes to the business premises, perhaps stopping in if she has other business in the building. She did not appear or testify at the hearing in this matter. There is no evidence that the corporation's officers or directors have ever taken steps to assure themselves that the business was being operated in compliance with state and federal laws. Hence, there is no evidence that they would meet and review sales data with the PIC, or review operations. There is no evidence that a consulting pharmacist was utilized to review the operations and to report to the corporation's officers that Dolezal was operating the pharmacy properly. There is no evidence that any inquiry was made as to why so much cash business was being done at the pharmacy; plainly during the high volume periods, thousand's of dollars in cash was being brought to the pharmacy each day, creating its own security issues. Importantly, the record makes it clear that such hands-off management has not changed at all.

29. Friedman testified that despite the 2012 citations and the 2012 DEA action which cost Garfield $40,000 in inventory, Garfield maintained Dolezal in his position as PIC, in part because the customers like Dolezal. It was only after the Board instituted this proceeding that Dolezal "took a break" in 2015 and retired. He was replaced by another pharmacist, who was replaced by Yadidi. Friedman hired the two PIC's who succeeded Dolezal.

Sale of Phenergan After the DEA Agreement

30. In rebuttal testimony, Young was able to point to at least three occasions when Garfield dispensed Phenergan during the year after Garfield's DEA certificate was surrendered. Such occurred on November 11 and 27, 2013, and on December 27, 2013. Regardless of the date when another DEA certificate issued, this would have been within the one year bar set forth in the agreement.

Costs

31. The Board has incurred costs of investigation and prosecution in this matter. Those costs total $29,307, and are reasonable in their amount.

LEGAL CONCLUSIONS

1. Jurisdiction was established to proceed in this matter pursuant to sections 4011, 4300, subdivision (a), and 4301, based on Factual Findings 1, 2, 3, and 7.

2. Health and Safety Code section 11153, subdivision (a) states:

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

This "corresponding duty" requires the pharmacist to take steps to assure that controlled substances he or she is dispensing pursuant to a prescription be for a legitimate medical purpose.

3. (A) Respondent Garfield and Dolezal violated Health and Safety Code section 11153, subdivision (a), by dispensing controlled substances on numerous occasions when there was reason to believe that the prescriptions had not been issued for a legitimate medical purpose, and that the drugs dispensed were not going to be used for a legitimate medical purpose. This Conclusion is based on Factual Findings 8 through 26.

(B) Cause has been established to discipline the pharmacy permit held by Respondent Garfield pursuant to section 4301, subdivision (j), for the violations of Health and Safety Code section 11153, subdivision (a), based on Legal Conclusions 1 through 3(A), and their factual predicates.

4. Cause has been established to discipline the pharmacy permit held by Respondent Garfield pursuant to section 4301, subdivision (d), for clearly excessive furnishing of controlled substances in violation of Health and Safety Code section 11153, subdivision (a), based on Legal Conclusions 1 through 3(A), and their factual predicates.

5. (A) California Code of Regulations (CCR), title 16, section 1761[10] states:

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[10] All further citations to the CCR shall be to title 16 thereof.

(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.

(B) Respondent Garfield, acting through Dolezal, dispensed prescriptions of controlled substances in violation of CCR section 1761, in that they filled prescriptions that had significant errors, omissions, or irregularities, based on Factual Findings 8 through 26, and 30.

6. (A) CCR 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."

(B) Respondent Garfield , acting through Dolezal, dispensed controlled substances without reviewing patient drug therapy and medication records, in violation of CCR section 1707.3, based on Factual Findings 8 through 23.

7. Cause was established to discipline Garfield's pharmacy permit for its violation of section 4301, subdivision (o), for its violation of CCR sections 1761, and 1707.3, based on Legal Conclusions 6 and 7, and their factual predicates.

8. (A) Cause exists to discipline Garfield's pharmacy permit pursuant to section 4301 for unprofessional conduct, based on Legal Conclusions 1 through 7, and Factual Findings 8 through 26, and 30.

(B) "Unprofessional conduct" may be defined as conduct which violates the rules or ethical code of a profession or is such conduct that is unbecoming of a member of a profession in good standing. (*Board of Education v. Swan* (1953) 41 Cal.2d 546, 553.) It includes both gross and simple negligence. (*Smith v. State Board of Pharmacy* (1995) 37 Cal.App.4th 229, 246-247.) (See also *Vermont & 110th Medical Arts Pharmacy* (1981) 125 Cal.3d 19, 25 [pharmacists are called upon to use common sense and professional judgment, and failure to do so may be gross incompetence, gross negligence, or moral turpitude].)

(C) The record in this case makes it clear that Dolezal failed in professional duties, and filled hundreds of prescriptions for controlled substances in

questionable circumstances. He filled prescriptions for 18 people he never saw on October 12, 2012, each of those people receiving the same "cocktail" of controlled substances. The prescriptions were on unsecured paper, presented by patient I.S., whose own medical profile indicated he obtained quarts of Phenergan in a short period, indeed, obtain two pint bottles on the same day, with different prescription numbers. "Patient" I.S. managed that coup not once, but twice. Plainly, Dolezal was not performing his duties as a licensee and PIC.

(D) Garfield took no steps to monitor or supervise Dolezal's activities. For years the only corporate officer has abdicated any such activities, turning contact with the pharmacy business over to Friedman, whose role (such as it was) led him to be treated as the "owner" of the pharmacy. While Garfield argued that its unlicensed officer and director, and its ostensible general manager, cannot legally have access to records, or even the licensed area, that is plainly not true. They could go into the pharmacy premises if accompanied by the PIC. (§ 4116, subd. (a) [non –licensees performing clerical work, inventory control or similar functions related to the pharmacy may enter if accompanied at all times by the pharmacist].) Further, as noted in the findings, there were other steps that could have been taken by Ms. Weiss or Mr. Friedrnan to supervise Dolezal's activity. In light of the large amounts of cash moving through the pharmacy, those persons were on inquiry notice that some activity might be amiss, and worthy of further inquiry. A few simple questions about the nature of the cash business might have been sufficient to bring corrective action. The only action by Weiss or Friedman appears to have been depositing large amounts of cash proceeds on a daily basis.[11]

10. (A) Garfield has asserted that some violation of due process will occur to Ms. Weiss if Garfield's license is disciplined, because she is not a licensee. It was also asserted that Dolezal's obvious violations of the Pharmacy Law and the Uniform Controlled Substances Act should not be imputed to the corporation. At the end, Garfield's able counsel was forced to argue that the respondeat superior theory that is sometimes cited to impose discipline upon licensees for the acts of their employees should not apply, as it is properly a tort theory.

(B) Garfield would have the ALJ and the Board abrogate case law that has been controlling this question for nearly two generations. The case is *Arenstein v. California State Board of Pharmacy* (1968) 265 Cal.App.2d 179 (*Arenstein*). There a corporate licensee asserted it could not be disciplined for the acts of its employee pharmacists. The Court of Appeal disagreed, stating:

> If a licensee elects to operate his business through employees he must be responsible to the licensing authority for their conduct in the exercise of his license and he is responsible for the acts of

[11] The sale of 28 bottles of Phenergan in one day (Factual Finding 10), all for cash, and each at a price of $124.50, generated $3,486 gross cash receipts.

> his agents or employees done in the course of his business in the operation of the license. (*Cornell v. Reilly,* 127 Cal.App.2d 178, 186-187 [273 P.2d 572].) One permitted to maintain and conduct a pharmacy may be disciplined by the pharmacy board for the unlawful acts of his employees while engaged in the conduct and operation of the pharmacy, although the permittee does not authorize the unlawful acts and did not have actual knowledge of the activities. (*Randle v. California State Board of Pharmacy,* 240 Cal.App.2d 254, 261 [49 Cal.Rptr. 485].) This would be particularly true of a corporate permittee which could act only through its officers, agents or employees.

(*Arenstein, supra*, 125 Cal.App.2d at 192-193.)[12]

(C) The *Arenstein* court did not rely on respondeat superior in coming to the conclusion set forth above. Even if it had, an alternative justification for the rule is that the licensee has a non-delegable duty to assure compliance with applicable laws by its employees, agents, and eyen independent contractors. (*California Assn. of Health Facilities v. Department of Health Services* (1997) 16 Cal.4th 284, 295.) Further, Garfield has benefited from the licensed activity, and it must bear the burden placed on it by licensing laws. (Civ. Code, § 3521.) The record is clear that Dolezal was the PIC, that he failed to comply with the law over a period of years, and that Garfield did nothing to avoid those violations of the law. Instead, Garfield profited by the wrong doing. Garfield is liable for discipline for all the statutory violations established herein.

10. The Board is entitled to recover its reasonable costs of investigation and enforcement, pursuant to section 125.3, based on Legal Conclusions 1 through 10. The cost should be set at one-half of the total amount claimed, as Dolezal bears responsibility for the violations as well. Therefore, costs of $14,654 shall be awarded against Garfield.

11. The purpose of proceedings of this type are to protect the public, and not to punish an errant licensee. (*Camacho v. Youde* (1979) 95 Cal.App.2d 79; *Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 784-786; *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d 1471, 1476.) Public protection is the Board's paramount obligation. (§ 4001.1.) Garfield has allowed its pharmacy to operate in a manner that endangered the public for a period of years. Even after the DEA forced the surrender of its permit—the source of huge sales for the pharmacy—Garfield maintained Dolezal in his job because the customers liked him, which allowed Dolezal to violate the agreement with the DEA by possessing and

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[12] Part of *Arenstein* has been abrogated by subsequent decisions, but that pertains to the nature of review in a petition for a writ of mandate, and not the liability-generating rule quoted herein. (*Barber v. Long Beach Civil Service Commission* (1996) 45 Cal.App.4th 652, 658.)

selling a few more bottles of Phenergan. Only the initiation of this proceeding led to a change of the PIC, but did not bring a new management style. Yet Weiss continues to operate as an absentee licensee. In these circumstances, the pharmacy permit must be revoked.

ORDER

1. The pharmacy permit, number PHY 46072, issued to LDWPC, Inc,, doing business as Garfield Prescription Pharmacy, is hereby revoked.

2. Respondent LDWPC Inc. shall pay $14,654 to the Board to reimburse its costs of investigation and prosecution, with 30 days of the effective date of this order.

January 20, 2017

DocuSigned by:
Joseph D. Montoya
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Joseph D. Montoya
Administrative Law Judge
Office of Administrative Proceedings

KAMALA D. HARRIS
Attorney General of California
GREGORY J. SALUTE
Supervising Deputy Attorney General
DESIREE I. KELLOGG
Deputy Attorney General
State Bar No. 126461
110 West "A" Street, Suite 1100
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2996
Facsimile: (619) 645-2061
Attorneys for Complainant

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

In the Matter of the Accusation Against: **LDWPC INC., DBA GARFIELD PRESCRIPTION PHARMACY** **9400 Brighton Way** **Beverly Hills, CA 90210** **Pharmacy Permit No. PHY 46072** **PETER FRANZ DOLEZAL** **6722 Capps Avenue** **Reseda, CA 91335** **Pharmacist Permit No. RPH 33437** Respondents.	Case No. 5337 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about February 20, 2003, the Board of Pharmacy issued Pharmacy Permit Number PHY 46072 to LDWPC Inc., doing business as Garfield Prescription Pharmacy (Respondent Garfield Prescription Pharmacy). The Pharmacy Permit was in full force and effect

at all times relevant to the charges brought herein and will expire on February 1, 2016, unless renewed.

3. On or about October 9, 1979, the Board of Pharmacy issued Pharmacist License Number RPH 33437 to Peter Franz Dolezal (Respondent Peter Dolezal). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2016, unless renewed.

JURISDICTION

4. 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.

5. Section 4011 of the Code provides that the Board shall administer and enforce both the Pharmacy Law [Bus. & Prof. Code, § 4000 et seq.] and the Uniform Controlled Substances Act [Health & Safety Code, § 11000 et seq.].

6. Section 4300(a) of the Code provides that every license issued by the Board may be suspended or revoked.

7. 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 AND REGULATORY PROVISIONS

8. Section 4301 of the Code states in pertinent part:

> The board shall take action against any holder of a license who is guilty of unprofessional conduct or whose license has been procured by fraud or misrepresentation or issued by mistake. Unprofessional conduct shall include, but is not limited to, any of the following:
>
> ...
>
> (d) The clearly excessive furnishing of controlled substances in violation of subdivision (a) of Section 11153 of the Health and Safety Code.
>
> ...

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

...

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

...

9. Section 4113(c) of the Code states:

The pharmacist-in-charge shall be responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy.

10. Section 4306.5 of the Code states, in pertinent part:

Unprofessional conduct for a pharmacist may include any of the following:

Acts or omissions that involve, in whole or in part, the inappropriate exercise of his or her education, training, or experience as a pharmacist, whether or not the act or omission arises in the course of the practice of pharmacy or the ownership, management, administration, or operation of a pharmacy or other entity licensed by the board.

Acts or omissions that involve, in whole or in part, the failure to consult appropriate patient, prescription, and other records pertaining to the performance of any pharmacy function.

...

11. Health and Safety Code section 11153(a) states:

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

....

12. Section 1707.3 of title 16, California Code of Regulations 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.

13. Section 1716 of title 16, California Code of Regulations 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.

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

> (a) No pharmacist shall compound or dispense any prescription which contains any significant error, omission, irregularity, uncertainty, ambiguity or alteration. Upon receipt of any such prescription, the pharmacist shall contact the prescriber to obtain the information needed to validate the prescription.
>
> (b) Even after conferring with the prescriber, a pharmacist shall not compound or dispense a controlled substance prescription where the pharmacist knows or has objective reason to know that said prescription was not issued for a legitimate medical purpose.

COST RECOVERY

15. Section 125.3 of the Code provides, 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

16. Hycodan is the brand name for hydrocodone, bitartrate and homatropin, a Schedule III controlled substance pursuant to Health and Safety Code section 11056 and a dangerous drug pursuant to Business and Professions Code section 4022.

17. Lortab is the brand name for hydrocodone/APAP, a Schedule III controlled substance pursuant to Health and Safety Code section 11056 and a dangerous drug pursuant to Business and Professions Code section 4022.

18. Norco is the brand name for hydrocodone/acetaminophen, a Schedule III controlled substance pursuant to Health and Safety Code section 11056(e)(5) and a dangerous drug pursuant to Business and Professions Code section 4022.

19. Phenergan with Codeine is the brand name for promethazine with codeine, a Schedule V controlled substance pursuant to Health and Safety Code section 11058(c)(1) and is a dangerous drug pursuant to Business and Professions Code section 4022.

20. Soma is the brand name for carisoprodol, a Schedule IV controlled substance pursuant to 21 California Federal Regulations section 1308.14 and is a dangerous drug pursuant to Business and Professions Code section 4022.

21. Xanax is the brand name for alprazolam, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057(d)(1) and a dangerous drug pursuant to Business and Professions Code section 4022.

FACTUAL ALLEGATIONS

22. From February 20, 2003 through the present, Respondent Peter Dolezal was the Pharmacist-in-Charge of Respondent Garfield Prescription Pharmacy and the only pharmacist on duty at Respondent Garfield Prescription Pharmacy.

23. From November 1, 2009 through December 12, 2012, Respondents dispensed prescriptions for controlled substances written in an identical fashion, for multiple patients at the same time on the same day, sequentially, with individuals other than the patients picking up those prescriptions. Respondents filled many early refills for controlled substances, including Prescription number 280843 dispensed four days after Prescription number 280786 on October 11, 2012 and Prescription number 263568 dispensed three times on December 6, 2010. Prescriptions for controlled substances were also filled multiple times on the same day for the same patient. Prescriptions for alprazolam and promethazine with codeine dispensed by Respondents exceeded the daily maximums recommended to be prescribed for those drugs.

24. Additionally, Respondents dispensed prescriptions which duplicated drug therapies. Respondents also dispensed prescriptions for promethazine with codeine without dispensing a corresponding prescription for an antibiotic. Patients paid for the controlled substance prescriptions in cash at Respondent Garfield Prescription Pharmacy and did not seek reimbursement from an insurance company or government agency. Respondents did not review CURES reports before dispensing controlled substances or otherwise have access to that database.

25. Respondents filled prescriptions for controlled substances for patients who lived a considerable distance from Respondent Garfield Prescription Pharmacy and/or the provider. For example, on October 12 and October 15, 2012, Respondents filled at least eighteen prescriptions for promethazine with codeine from Dr. P.V. and Physician Assistant M.C. who were an average of 15 miles away from those prescribers' offices. Two of those patients lived over forty five miles away from Respondent Garfield Prescription Pharmacy.

26. Respondents dispensed forged prescriptions. On September 9, 2011, Respondents dispensed prescriptions for controlled substances allegedly prescribed by Dr. K.S. but were in fact, not prescribed by him. These prescriptions were also not written on secured paper. No patient addresses were listed on the forged prescriptions.

27. From 2010 through 2012, Respondents' highest volume of dispensed drug was a frequently abused drug, promethazine with codeine.

28. Respondents Garfield Prescription Pharmacy and Peter Dolezal placed orders for suspiciously large amounts of controlled substances with their drug wholesalers.

29. Respondents Garfield Prescription Pharmacy and Peter Dolezal did not follow proper procedures for verifying if a prescription for a controlled substance was written for a legitimate medical purpose in that they dispensed prescriptions to patients who had lost their wallets or social security cards and had been victims of identity theft. If Respondents had attempted to contact the alleged patients, they would have determined that the prescriptions were not dispensed to the victims of identity fraud.

30. Many of the prescriptions dispensed by Respondents were written by Dr. N.A. On October 5, 2011, Dr. N.A. was convicted upon his plea of guilty to the crimes of conspiracy to distribute oxycodone, hydromorphone, hydrocodone, alprazolam and promethazine with codeine in violation of sections 21 United States Code sections 841 (a)(1), (b)(1)(E), (b)(1)(C), (b)(2), (b)(1)(C) and 846 and 18 United States Code section 2(b) in *United States v. N.A.*, Case Number CR 10-01260-SJO, United States District Court for the Central District of California. He was also disciplined by the Medical Board of California for that conviction.

31. Other prescriptions dispensed by Respondents were written by Dr. A.S. In April 2007,

Dr. A.S. was disciplined by the Medical Board of California for gross negligence, repeated negligent acts, incompetence, dishonesty, and prescribing without medical indication or performing a good faith physical examination, among other violations of the Medical Practice Act. In March 2010, he was disciplined again for dishonesty and failing to comply with the term and condition of his probation requiring him to maintain a drug log for all controlled substances ordered, prescribed, dispensed, administered or possessed by Dr. A.S. On or about August 14, 2014, Dr. A.S. was found guilty of fourteen counts of violating title 21 United States Code section 841(a)(1), (b)(1)(E), (b)(2) and (b)(3), distribution of hydrocodone, alprazolam, carisoprodol, diazepam and promethazine with codeine and three counts of violating title 18 United States Code section 1956(A)(1), (B) (i), money laundering, in *United States v. A.S.*, Case Number CR-14-157-R, United States District Court for the Central District of California.

32. Other prescriptions dispensed by Respondents were written by Dr. E.S. On or about February 6, 2014, in *The People of the State of California v. E.S.*, Los Angeles County Superior Court Case No. SA081626, Dr. E.S. was convicted of violating Health & Safety Code section 11153(a), issuing a prescription for a controlled substance for a non-legitimate medical purpose. On or about May 31, 2013, Dr. E.S. was disciplined by the Medical Board of California for that conviction and other violations of the Medical Practice Act.

33. Other prescriptions dispensed by Respondents were written by Dr. B.G. Effective October 21, 2010, Dr. B.G. was disciplined by the Medical Board of California for illegally using controlled substances, cocaine and methamphetamine. Effective August 29, 2012, Dr. B.G. was also disciplined by the Medical Board of California for violations of the Medical Practice Act, including excessive prescribing, dishonesty, false representations and failure to maintain adequate and accurate records for participating in a scheme to sell prescriptions to drug users without medical justification.

34. On November 1, 2012, a Board inspector discussed the obligations of pharmacists when dispensing controlled substances with Respondent Peter Dolezal. Despite the discussion of pharmacists' obligations when dispensing controlled substances, Respondents continued to dispense multiple controlled substances without verifying if all prescriptions were written for a

legitimate medical purposes. For example, prescriptions for hydrocodone 10mg/APAP 325 mg, alprazolam 2mg and promethazine with codeine were dispensed to the same patient, CJW on November 16, 2012 and those same prescriptions were dispensed to JI on November 29, 2012. Other examples include the dispensing of full bottles of promethazine with codeine were dispensed in November 2012, including 8 patients on November 26, 2012 and 8 patients on November 27, 2012.

FIRST CAUSE FOR DISCIPLINE

(Failing to Comply with Corresponding Responsibility for Legitimate Controlled Substance Prescriptions against Respondents)

35. Respondents are subject to disciplinary action under Code section 4301(j), for violating Health and Safety Code section 11153(a), in that they failed to comply with their corresponding responsibility to ensure that controlled substances were dispensed for a legitimate medical purpose when Respondents furnished prescriptions for controlled substances even though "red flags" were present, indicating those prescriptions were not issued for a legitimate medical purpose, as set forth in paragraphs 22 through 34 above, which are incorporated herein by reference.

SECOND CAUSE FOR DISCIPLINE

(Clearly Excessive Furnishing of Controlled Substances against Respondents)

36. Respondents are subject to disciplinary action under Code section 4301(d), for the clearly excessive furnishing of controlled substances in violation of subdivision (a) of Section 11153 of the Health and Safety Code, as set forth in paragraphs 22 through 34 above, which are incorporated herein by reference.

THIRD CAUSE FOR DISCIPLINE

(Dispensing Controlled Substance Prescriptions with Significant Errors, Omissions, Irregularities, Uncertainties, Ambiguities or Alterations against Respondents)

37. Respondents are subject to disciplinary action under Code section 4301(o), for violating title 16, California Code of Regulations, sections 1761(a) and (b) in that they dispensed prescriptions for controlled substances, which contained significant errors, omissions,

irregularities, uncertainties, ambiguities or alterations, as set forth in paragraphs 22 through 34 above, which are incorporated herein by reference.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Review Patients' Medication Record Before Prescription Drugs Delivered against Respondents)

38. Respondents are subject to disciplinary action under Code section 4301(o), for violating title 16, California Code of Regulations, section 1707.3, in that they dispensed prescriptions for drugs, without review of patients' medication records before each prescription drug was delivered. Such a review would have revealed numerous "red flags," as set forth in paragraphs 22 through 34 above, which are incorporated herein by reference.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Exercise or Implement Best Professional Judgment or Corresponding Responsibility when Dispensing Controlled Substances against Respondent Peter Dolezal)

39. Respondent Peter Dolezal is subject to disciplinary action under Code section 4301(o), for violating Business and Professions Code section 4306.5(a) and (b), in that they failed to exercise or implement his best professional judgment or corresponding responsibility when dispensing controlled substances, as set forth in paragraphs 22 through 34 above, which are incorporated herein by reference.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct against Respondents)

40. Respondents are subject to disciplinary action under Code section 4301 for unprofessional conduct in that they engaged in the activities described in paragraphs 22 through 34 above, which are incorporated herein by reference.

DISCIPLINARY CONSIDERATIONS

41. To determine the degree of discipline, if any, to be imposed on Respondents, Complainant alleges:

a. On March 12, 2012, the Board issued Citation number CI 2011 49865 against Respondent Garfield Prescription Pharmacy for violating Business and Professions Code section 4126.5(a)(4) for improperly furnishing drugs to a wholesaler and 4059.5(a) for selling dangerous drugs to an entity but indicating on the shipping label that it was sold by another entity. The Board issued a fine which Respondent paid.

b. On March 12, 2012, the Board issued Citation number CI 2011 51652 against Respondent Peter Dolezal for violating Business and Professions Code section 4126.5(a)(4) for improperly furnishing drugs to a wholesaler and 4059.5(a) for selling dangerous drugs to an entity but indicating on the shipping label that it was sold by another entity. The Board issued a Citation and Fine and Order of Abatement, which was complied with by Respondent's submission of proof of enrollment in a pre-approved ethics course.

c. Effective April 27, 2001, the Board adopted the Stipulated Settlement and Disciplinary Order against Respondent Peter Dolezal and Respondent Garfield Prescription Pharmacy's predecessor in Case No. 2128, OAH No. L-200050072. Respondent Peter Dolezal was placed on probation for three years and the original pharmacy permit issued to Respondent Garfield Prescription Pharmacy's predecessor was voluntarily surrendered for, violating drug laws and regulations, including Health & Safety Code section 11153(a).

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 46072, issued to LDWPC Inc. doing business as Garfield Prescription Pharmacy;

2. Revoking or suspending Pharmacist License Number RPH 33437, issued to Peter Franz Dolezal;

3. Ordering LDWPC Inc. doing business as Garfield Prescription Pharmacy and Peter Franz Dolezal 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;

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

DATED: 3/31/15

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

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