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

In the Matter of the Accusation Against:

CENTURY PHARMACY, INC., DBA, CENTURY PHARMACY,
JOSEPH AMIN,
Pharmacy Permit No. PHY 34252;

MORRIS GHADISHAH
Pharmacist License No. RPH 70585;

JILA MOHAMMADI,
Pharmacist License No. RPH 70372;

SHIVA KIAEE FARZAN,
Pharmacist License No. RPH 44807;

MEHRDAD AHDOOT,
Pharmacist License No. RPH 43292;

SHIRIN AZIZZADEH,
Pharmacist License No. RPH 53320;

YOUNG SOOK CHOI,
Pharmacist License No. RPH 41950;

HENGAMEH SHAKERANEH,
Pharmacist License No. RPH 45821;

PARISA KHANI,
Pharmacist License No. RPH 54486;

SHIRIN HAROONPOOR,
Pharmacist License No. RPH 76314;

and

MAHSHID PAYA KHALIFIAN,
Pharmacist License No. RPH 44675,

Respondents.

Agency Case No. 7075; OAH No. 2022020695

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order for Public Reproval 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 April 28, 2023.

It is so ORDERED on March 29, 2023.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By 

Seung W. Oh, Pharm.D.
Board President

ROB BONTA
Attorney General of California
NANCY A. KAISER
Supervising Deputy Attorney General
KEVIN J. RIGLEY
Deputy Attorney General
State Bar No. 131800
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6301
Facsimile: (916) 731-2126
Attorneys for Complainant

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

In the Matter of the Accusation Against: **JOSEPH AMIN DBA CENTURY PHARMACY** **11870 Santa Monica Blvd, Ste 108** **Los Angeles, CA 90025-2276** **Permit No. PHY 34252,** **MORRIS GHADISHAH** **227 1/2 S. Tower Dr.** **Beverly Hills, CA 90211** **Pharmacist License No. RPH 70585,** **JILA MOHAMMADI** **P.O. Box 5582** **Glendale, CA 91221** **Pharmacist License No. RPH 70372,** **SHIVA KIAEE FARZAN** **18814 Canasta Street** **Tarzana, CA 91356** **Pharmacist License No. RPH 44807,** **MEHDAD AHDOOT** **9196 Crocus Avenue** **Fountain Valley, CA 92708** **Pharmacist License No. RPH 43292,**	Case No. 7075 OAH No. 2022020695 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER AS TO RESPONDENT GHADISHAH, LICENSE NO. RPH 70585**

SHIRIN AZIZZADEH
530 Evelyn Pl
Beverly Hills, CA 90210

Pharmacist License No. RPH 53320,

YOUNG SOOK CHOI
500 S. Lake Street, #301
Los Angeles, CA 90057

Pharmacist License No. RPH 41950,

HENGAMEH SHAKERANEH
2035 Greenfield Avenue
Los Angeles, CA 90025

Pharmacist License No. RPH 45821,

PARISA KHANI
P.O. Box 10625
Beverly Hills, CA 90209

Pharmacist License No. RPH 54486,

SHIRIN HAROONPOOR
10307 Missouri Avenue, #201
Los Angeles, CA 90025

Pharmacist License No. RPH 76314,

and

MAHSHID PAYA KHALIFIAN
10362 Summer Holly Circle
Los Angeles, CA 90077

Pharmacist License No. RPH 44675

Respondents.

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

PARTIES

1. Anne Sodergren (Complainant) is the Executive Officer of the Board of Pharmacy (Board). She brought this action solely in her official capacity and is represented in this matter by

Rob Bonta, Attorney General of the State of California, by Kevin J. Rigley, Deputy Attorney General.

2. Respondent Morris Ghadisha (Respondent) is represented himself in this proceeding, and has chosen not to be represented by counsel.

3. On or about April 4, 2014, the Board issued Pharmacist License Number RPH 70585 to Respondent Ghadishah. The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2024, unless renewed.

JURISDICTION

4. Accusation No. 7075 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on September 21, 2021. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 7075 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, and understands the charges and allegations in Accusation No. 7075. Respondent has also carefully read, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 7075, if proven at a hearing, constitute cause for imposing discipline upon his Pharmacist License.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that his Pharmacist License is subject to discipline and he agrees to be bound by the Board's terms as set forth in the Disciplinary Order below.

CONTINGENCY

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

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

14. This Stipulated Settlement and Disciplinary Order is intended by the parties to be an integrated writing representing the complete, final, and exclusive embodiment of their agreement. It supersedes any and all prior or contemporaneous agreements, understandings, discussions, negotiations, and commitments (written or oral). This Stipulated Settlement and Disciplinary

Order may not be altered, amended, modified, supplemented, or otherwise changed except by a writing executed by an authorized representative of each of the parties.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Pharmacist License Number RPH 70585 issued to Respondent Morris Ghadishah (Respondent) shall be publicly reproved by the Board of Pharmacy under Business and Professions Code section 495 in resolution of Accusation No. 7075 (attached as exhibit A), on the following conditions:

1. No Ownership or Management of Licensed Premises. Respondent shall not own, have any legal or beneficial interest in, nor serve as a manager, administrator, member, officer, director, trustee, associate, or partner of any business, firm, partnership, or corporation currently or hereinafter licensed by the Board for a period of thirty (30) months from the effective date of the Decision and Order.

Respondent shall sell or transfer any legal or beneficial interest in any entity licensed by the Board within ninety (90) days following the effective date of this decision and shall immediately thereafter provide written proof thereof to the Board. Failure to timely divest any legal or beneficial interest(s) or provide documentation thereof shall be considered a violation of this Decision and Order.

2. Prohibited From Serving as Pharmacist-in-Charge. Respondent shall be prohibited from serving as Pharmacist-in-Charge at any pharmacy for a period of thirty (30) months from the effective date of this Decision and Order.

3. No Supervision of Pharmacists or Intern Pharmacists. Respondent shall be prohibited from supervising any Pharmacists and/or Pharmacist Interns for a period of thirty (30) months from the effective date of this Decision and Order. However, Respondent may supervise Pharmacy Technicians during this thirty (30) month period.

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4. Ethics Course. Within sixty (60) calendar days of the effective date of this Decision and Order, Respondent shall enroll in a course in ethics, at Respondent's expense, approved in advance by the Board or its designee that complies with Title 16 California Code of Regulations section 1773.5. Respondent shall provide proof of enrollment upon request. Within five (5) days of completion, Respondent shall submit a copy of the certificate of completion to the Board or its designee. Failure to timely enroll in an approved ethics course, to initiate the course during the first year following the effective date of this Decision and Order, to successfully complete it before the end of the second year following the effective date of this Decision and Order, or to timely submit proof of completion to the Board or its designee, shall be considered a violation of this Decision and Order. Respondent's Pharmacist License will not be renewed until he satisfies this term, as required.

5. Board's One-Day Training Program. Within the first year of the effective date of the Decision and Order, Respondent shall enroll in the Board's one-day, six (6) hour, training program, "Prescription Drug Abuse and Diversion Prevention Training." Respondent shall provide proof of enrollment within five (5) days of enrollment. Within five (5) days of completion, Respondent shall submit a copy of the certificate of completion to the Board. Failure to timely enroll in the training program and/or to initiate the training program during the first year, shall be considered a violation of this Decision and Order. Respondent's Pharmacist License will not be renewed until he satisfies this term, as required.

6. Reimbursement of Board Costs. As a condition precedent to successful compliance of the Disciplinary Order herein, Respondent shall pay to the Board its costs of investigation and prosecution in the amount of $5,000.00. Respondent shall make said payments as follows:

Respondent shall make payments in equal monthly installments over thirty (30) months, until the costs are paid in full. Respondent's Pharmacist License will not be renewed if he fails to pay costs as required. There shall be no deviation from this schedule absent prior written approval by the Board or its designee.

7. Full Compliance. As a resolution of the charges in Accusation No. 7075, this stipulated settlement is contingent upon Respondent's full compliance with all of the terms of this

Decision and Order. If Respondent fails to satisfy any of these terms, Respondent shall not be permitted to renew his Pharmacist License until such unsatisfied terms are successfully completed. If Respondent violates any pharmacy laws during the thirty (30) month period following the effective date of the Decision and Order, all of the charges and allegations contained in Accusation Number 7075 shall be deemed to be true, correct, and admitted by Respondent for purposes of any disciplinary action the Board may take if such occurs.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and fully understand it. I understand the stipulation and the effect it will have on my Pharmacist License. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: _____

MORRIS GHADISHAH
Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Board of Pharmacy.

DATED: January 27, 2023

Respectfully submitted,

ROB BONTA
Attorney General of California
NANCY A. KAISER
Supervising Deputy Attorney General

Kevin J. Rigley

KEVIN J. RIGLEY
Deputy Attorney General
Attorneys for Complainant

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Decision and Order. If Respondent fails to satisfy any of these terms, Respondent shall not be permitted to renew his Pharmacist License until such unsatisfied terms are successfully completed. If Respondent violates any pharmacy laws during the thirty (30) month period following the effective date of the Decision and Order, all of the charges and allegations contained in Accusation Number 7075 shall be deemed to be true, correct, and admitted by Respondent for purposes of any disciplinary action the Board may take if such occurs.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and fully understand it. I understand the stipulation and the effect it will have on my Pharmacist License. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: 01-27-2023 Morris Ghadishah

MORRIS GHADISHAH
Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Board of Pharmacy.

DATED: January 27, 2023

Respectfully submitted,

ROB BONTA
Attorney General of California
NANCY A. KAISER
Supervising Deputy Attorney General

Kevin J. Rigley

KEVIN J. RIGLEY
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 7075

ROB BONTA
Attorney General of California
SHAWN P. COOK
Supervising Deputy Attorney General
KEVIN J. RIGLEY
Deputy Attorney General
State Bar No. 131800
300 So. Spring Street, Suite 1702
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Attorneys for Complainant

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

In the Matter of the Accusation Against**:** **JOSEPH AMIN,** **DBA CENTURY PHARMACY** 11870 Santa Monica Blvd, Ste 108 Los Angeles, CA 90025-2276 Permit No. PHY 34252 and **JILA MOHAMMADI** PO Box 5582 Glendale, CA 91221 Pharmacist License No. RPH 70372 and **MORRIS GHADISHAH** 227 ½ S. Tower Dr. Beverly Hills, CA 90211 Pharmacist License No. RPH 70585 and **MAHSHID PAYA KHALIFIAN** 10362 Summer Holly Circle Los Angeles, CA 90077 Pharmacist License No. RPH 44675 and (***Continued on next page***)	Case No. 7075 **ACCUSATION**

MEHRDAD AHDOOT
9196 Crocus Avenue
Fountain Valley, CA 92708
Pharmacist License No. RPH 43292

and

SHIVA KIAEE FARZAN
18814 Canasta Street
Tarzana, CA 91356
Pharmacist License No. RPH 44807

and

SHIRIN HAROONPOOR
10307 Missouri Avenue #201
Los Angeles, CA 90025
Pharmacist License No. RPH 76314

and

YOUNG SOOK CHOI
500 S. Lake Street #301
Los Angeles, CA 90057
Pharmacist License No. RPH 41950

and

HENGAMEH SHAKERANEH
2035 Greenfield Avenue
Los Angeles, CA 90025
Pharmacist License No. RPH 45821

and

PARISA KHANI
PO Box 16025
Beverly Hills, CA 90209
Pharmacist License No. RPH 54486

and

SHIRIN AZIZZADEH
530 Evelyn Place
Beverly Hills, CA 90210
Pharmacist License No. RPH 53320

Respondents.

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Complainant alleges:

PARTIES

1. Anne Sodergren (complainant) brings this accusation solely in her official capacity as the Executive Officer of the Board of Pharmacy, Department of Consumer Affairs (Board).

Joseph Amin dba Century Pharmacy

2. On or about May 14, 1987, the board issued Permit Number PHY 34252 to Joseph Amin, doing business as Century Pharmacy (respondent Pharmacy). The Permit, which was in full force and effect at all times relevant to the charges brought herein, expired on May 1, 2021, and was canceled.

Jila Mohammadi (Pharmacist-in-Charge from 11/16/15 to 8/26/16)

3. On or about December 30, 2013, the Board issued Pharmacist License Number RPH 70372 to Jila Mohammadi (respondent Mohammadi). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2023, unless renewed.

Morris Ghadishah (Pharmacist-in-Charge from 5/1/14 to 11/1/15)

4. On or about April 4, 2014, the Board issued Pharmacist License Number RPH 70585 to Morris Ghadishah (respondent Ghadishah). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2022, unless renewed.

Mahshid Paya Khalifian (Pharmacist-in-Charge from 9/1/19 to Present)

5. On or about August 15, 1991, the Board issued Pharmacist License Number RPH 44675 to Mashid Paya Khalifian (respondent Khalifian). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2022, unless renewed.

Mehrdad Ahdoot (Pharmacist-in-Charge from 10/5/16 to 2/4/19)

6. On or about March 16, 1990, the Board issued Pharmacist License Number RPH 43292 to Mehrdad Ahdoot (respondent Ahdoot). The Pharmacist License was in full force and

effect at all times relevant to the charges brought herein and will expire on October 31, 2021, unless renewed.

Shiva Kiaee Farzan (Pharmacist-in-Charge from 5/1/19 to 7/8/19)

7. On or about August 27, 1991, the Board issued Pharmacist License Number RPH 44807 to Shiva Farzan (respondent Farzan). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2023, unless renewed.

Shirin Haroonpoor

8. On or about March 6, 2017, the Board issued Pharmacist License Number RPH 76314 to Shirin Haroonpoor (respondent Haroonpoor). The Pharmacist License, which was in full force and effect at all times relevant to the charges brought herein, will expire on March 31, 2023.

Young Sook Choi

9. On or about August 5, 1988, the Board issued Pharmacist License Number RPH 41950 to Young Sook Choi (respondent Choi). The Pharmacist License (license), which was in full force and effect at all times relevant to the charges brought herein, was canceled on July 29, 2020.

Hengameh Shakeraneh

10. On or about October 9, 1992, the Board issued Pharmacist License Number RPH 45821 to Hengameh Shakeraneh (respondent Shakeraneh). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2022, unless renewed.

Parisa Khani

11. On or about April 25, 2003, the Board issued Pharmacist License Number RPH 54486 to Parisa Khani (respondent Khani). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2023, unless renewed.

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Shirin Azizzadeh

12. On or about March 20, 2002, the Board issued Pharmacist License Number RPH 53320 to Shirin Azizzadeh (respondent Azizzadeh). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2023, unless renewed.

JURISDICTION

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

14. Section 4300 of the Code states, in pertinent part:

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

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

"(1) Suspending judgment.

"(2) Placing him or her upon probation.

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

"(4) Revoking his or her license.

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

15. 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."

16. Section 4307 of the Code states:

(a) Any person who has been denied a license or whose license has been revoked or is under suspension, or who has failed to renew his or her license while it was under

suspension, or who has been a manager, administrator, owner, member, officer, director, associate, partner, or any other person with management or control of any partnership, corporation, trust, firm, or association whose application for a license has been denied or revoked, is under suspension or has been placed on probation, and while acting as the manager, administrator, owner, member, officer, director, associate, partner, or any other person with management or control had knowledge of or knowingly participated in any conduct for which the license was denied, revoked, suspended, or placed on probation, shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee as follows:

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

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

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

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

STATUTORY PROVISIONS

17. Section 4073 states:

"(a) A pharmacist filling a prescription order for a drug product prescribed by its trade or brand name may select another drug product with the same active chemical ingredients of the same strength, quantity, and dosage form, and of the same generic drug name as determined by the United States Adopted Names (USAN) and accepted by the federal Food and Drug Administration (FDA), of those drug products having the same active chemical ingredients.

"(b) In no case shall a selection be made pursuant to this section if the prescriber personally indicates, either orally or in his or her own handwriting, "Do not substitute," or words of similar meaning. Nothing in this subdivision shall prohibit a prescriber from checking a box on a prescription marked "Do not substitute"; provided that the prescriber personally initials the box or checkmark. To indicate that a selection shall not be made pursuant to this section for an electronic data transmission prescription as defined in subdivision (c) of Section 4040, a prescriber may

indicate "Do not substitute," or words of similar meaning, in the prescription as transmitted by electronic data, or may check a box marked on the prescription "Do not substitute." In either instance, it shall not be required that the prohibition on substitution be manually initialed by the prescriber.

"(c) Selection pursuant to this section is within the discretion of the pharmacist, except as provided in subdivision (b). The person who selects the drug product to be dispensed pursuant to this section shall assume the same responsibility for selecting the dispensed drug product as would be incurred in filling a prescription for a drug product prescribed by generic name. There shall be no liability on the prescriber for an act or omission by a pharmacist in selecting, preparing, or dispensing a drug product pursuant to this section. In no case shall the pharmacist select a drug product pursuant to this section unless the drug product selected costs the patient less than the prescribed drug product. Cost, as used in this subdivision, is defined to include any professional fee that may be charged by the pharmacist.

"(d) This section shall apply to all prescriptions, including those presented by or on behalf of persons receiving assistance from the federal government or pursuant to the California Medical Assistance Program set forth in Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code.

"(e) When a substitution is made pursuant to this section, the use of the cost-saving drug product dispensed shall be communicated to the patient and the name of the dispensed drug product shall be indicated on the prescription label, except where the prescriber orders otherwise."

18. Section 4104, states, in pertinent part:

"(a) Every pharmacy shall have in place procedures for taking action to protect the public when a licensed individual employed by or with the pharmacy is discovered or known to be chemically, mentally, or physically impaired to the extent it affects his or her ability to practice the profession or occupation authorized by his or her license, or is discovered or known to have engaged in the theft, diversion, or self-use of dangerous drugs.

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"(b) Every pharmacy shall have written policies and procedures for addressing chemical, mental, or physical impairment, as well as theft, diversion, or self-use of dangerous drugs, among licensed individuals employed by or with the pharmacy.

"(c) Every pharmacy shall report and provide to the board, within 14 days of the receipt or development thereof, the following information with regard to any licensed individual employed by or with the pharmacy:

"(1) Any admission by a licensed individual of chemical, mental, or physical impairment affecting his or her ability to practice.

"(2) Any admission by a licensed individual of theft, diversion, or self-use of dangerous drugs.

"(3) Any video or documentary evidence demonstrating chemical, mental, or physical impairment of a licensed individual to the extent it affects his or her ability to practice.

"(4) Any video or documentary evidence demonstrating theft, diversion, or self-use of dangerous drugs by a licensed individual.

"(5) Any termination based on chemical, mental, or physical impairment of a licensed individual to the extent it affects his or her ability to practice.

"(6) Any termination of a licensed individual based on theft, diversion, or self-use of dangerous drugs.

"(d) The report required in subdivision (c) shall include sufficient detail to inform the board of the facts upon which the report is based, including an estimate of the type and quantity of all dangerous drugs involved, the timeframe over which the losses are suspected, and the date of the last controlled substances inventory. Upon request of the board, the pharmacy shall prepare and submit an audit involving the dangerous drugs suspected to be missing."

19. Section 4113 of the Code states:

"(a) Every pharmacy shall designate a pharmacist-in-charge and, within 30 days thereof, shall notify the board in writing of the identity and license number of that pharmacist and the date he or she was designated.

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"(b) The proposed pharmacist-in-charge shall be subject to approval by the board. The board shall not issue or renew a pharmacy license without identification of an approved pharmacist-in-charge for the pharmacy.

"(c) 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.

"(d) Every pharmacy shall notify the board in writing, on a form designed by the board, within 30 days of the date when a pharmacist-in-charge ceases to act as the pharmacist-in-charge, and shall on the same form propose another pharmacist to take over as the pharmacist-in-charge. The proposed replacement pharmacist-in-charge shall be subject to approval by the board. If disapproved, the pharmacy shall propose another replacement within 15 days of the date of disapproval and shall continue to name proposed replacements until a pharmacist-in-charge is approved by the board."

20. 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.

. . . .

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

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

. . . .

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

. . . .

"(o) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any provision or term of this chapter 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."

21. Section 4305 of the Code states:

"(a) Failure by any pharmacist to notify the board in writing that he or she has ceased to act as the pharmacist-in-charge of a pharmacy, or by any pharmacy to notify the board in writing that a pharmacist-in-charge is no longer acting in that capacity, within the 30-day period specified in Sections 4101 and 4113 shall constitute grounds for disciplinary action.

"(b) Operation of a pharmacy for more than 30 days without supervision or management by a pharmacist-in-charge shall constitute grounds for disciplinary action.

"(c) Any person who has obtained a license to conduct a pharmacy, who willfully fails to timely notify the board that the pharmacist-in-charge of the pharmacy has ceased to act in that capacity, and who continues to permit the compounding or dispensing of prescriptions, or the furnishing of drugs or poisons, in his or her pharmacy, except by a pharmacist subject to the supervision and management of a responsible pharmacist-in-charge, shall be subject to summary suspension or revocation of his or her license to conduct a pharmacy."

22. Section 4306.5 of the Code states:

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

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

"(b) Acts or omissions that involve, in whole or in part, the failure to exercise or implement his or her best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances, dangerous drugs, or dangerous devices, or with regard to the provision of services.

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

"(d) Acts or omissions that involve, in whole or in part, the failure to fully maintain and retain appropriate patient-specific information pertaining to the performance of any pharmacy function."

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

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

"(b) Any person who knowingly violates this section shall be punished by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or in a county jail not exceeding one year, or by a fine not exceeding twenty thousand dollars ($20,000), or by both that fine and imprisonment."

24. Health and Safety Code section 11162.1 states:

"(a) The prescription forms for controlled substances shall be printed with the following features:

"(1) A latent, repetitive "void" pattern shall be printed across the entire front of the prescription blank; if a prescription is scanned or photocopied, the word "void" shall appear in a pattern across the entire front of the prescription.

"(2) A watermark shall be printed on the backside of the prescription blank; the watermark shall consist of the words "California Security Prescription."

"(3) A chemical void protection that prevents alteration by chemical washing.

"(4) A feature printed in thermochromic ink.

"(5) An area of opaque writing so that the writing disappears if the prescription is lightened.

"(6) A description of the security features included on each prescription form.

"(7) (A) Six quantity check off boxes shall be printed on the form so that the prescriber may indicate the quantity by checking the applicable box where the following quantities shall appear:

"1–24

"25–49

"50–74

"75–100

"101–150

"151 and over.

"(B) In conjunction with the quantity boxes, a space shall be provided to designate the units referenced in the quantity boxes when the drug is not in tablet or capsule form.

"(8) Prescription blanks shall contain a statement printed on the bottom of the prescription blank that the "Prescription is void if the number of drugs prescribed is not noted."

"(9) The preprinted name, category of licensure, license number, federal controlled substance registration number, and address of the prescribing practitioner.

"(10) Check boxes shall be printed on the form so that the prescriber may indicate the number of refills ordered.

"(11) The date of origin of the prescription.

"(12) A check box indicating the prescriber's order not to substitute.

"(13) An identifying number assigned to the approved security printer by the Department of Justice.

"(14) (A) A check box by the name of each prescriber when a prescription form lists multiple prescribers.

"(B) Each prescriber who signs the prescription form shall identify themselves as the prescriber by checking the box by the prescriber's name.

"(15) A uniquely serialized number, in a manner prescribed by the Department of Justice in accordance with Section 11162.2.

"(b) Each batch of controlled substance prescription forms shall have the lot number printed on the form and each form within that batch shall be numbered sequentially beginning with the numeral one.

"(c) (1) A prescriber designated by a licensed health care facility, a clinic specified in Section 1200, or a clinic specified in subdivision (a) of Section 1206 that has 25 or more physicians or surgeons may order controlled substance prescription forms for use by prescribers when treating patients in that facility without the information required in paragraph (9) of subdivision (a) or paragraph (3).

"(2) Forms ordered pursuant to this subdivision shall have the name, category of licensure, license number, and federal controlled substance registration number of the designated prescriber and the name, address, category of licensure, and license number of the licensed health care facility the clinic specified in Section 1200, or the clinic specified in Section 1206 that has 25 or more physicians or surgeons preprinted on the form. Licensed health care facilities or clinics exempt under Section 1206 are not required to preprint the category of licensure and license number of their facility or clinic.

"(3) Forms ordered pursuant to this section shall not be valid prescriptions without the name, category of licensure, license number, and federal controlled substance registration number of the prescriber on the form.

"(4) (A) Except as provided in subparagraph (B), the designated prescriber shall maintain a record of the prescribers to whom the controlled substance prescription forms are issued, that shall include the name, category of licensure, license number, federal controlled substance registration number, and quantity of controlled substance prescription forms issued to each prescriber. The record shall be maintained in the health facility for three years.

"(B) Forms ordered pursuant to this subdivision that are printed by a computerized prescription generation system shall not be subject to subparagraph (A) or paragraph (7) of subdivision (a). Forms printed pursuant to this subdivision that are printed by a computerized

prescription generation system may contain the prescriber's name, category of professional licensure, license number, federal controlled substance registration number, and the date of the prescription.

"(d) Within the next working day following delivery, a security printer shall submit via web-based application, as specified by the Department of Justice, all of the following information for all prescription forms delivered:

"(1) Serial numbers of all prescription forms delivered.

"(2) All prescriber names and Drug Enforcement Administration Controlled Substance Registration Certificate numbers displayed on the prescription forms.

"(3) The delivery shipment recipient names.

"(4) The date of delivery."

25. Health and Safety Code section 11164 states, in pertinent part:

"Except as provided in Section 11167, no person shall prescribe a controlled substance, nor shall any person fill, compound, or dispense a prescription for a controlled substance, unless it complies with the requirements of this section.

"(a) Each prescription for a controlled substance classified in Schedule II, III, IV, or V, except as authorized by subdivision (b), shall be made on a controlled substance prescription form as specified in Section 11162.1 and shall meet the following requirements:

"(1) The prescription shall be signed and dated by the prescriber in ink and shall contain the prescriber's address and telephone number; the name of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services; refill information, such as the number of refills ordered and whether the prescription is a first-time request or a refill; and the name, quantity, strength, and directions for use of the controlled substance prescribed.

"(2) The prescription shall also contain the address of the person for whom the controlled substance is prescribed. If the prescriber does not specify this address on the prescription, the pharmacist filling the prescription or an employee acting under the direction of the pharmacist

shall write or type the address on the prescription or maintain this information in a readily retrievable form in the pharmacy."

26. Health and Safety Code section 111295 states:

"It is unlawful for any person to manufacture, sell, deliver, hold, or offer for sale any drug or device that is adulterated."

REGULATORY PROVISIONS

27. California Code of Regulations, title 16, section 1714 states, in pertinent part:

. . . .

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

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

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

"Pharmacists shall not deviate from the requirements of a prescription except upon the prior consent of the prescriber or to select the drug product in accordance with Section 4073 of the Business and Professions Code. Nothing in this regulation is intended to prohibit a pharmacist from exercising commonly-accepted pharmaceutical practice in the compounding or dispensing of a prescription."

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

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

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

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

DRUG CLASSIFICATIONS

30. OxyContin, which is a brand name for oxycodone, is a Schedule II controlled substance and a dangerous drug pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and Code section 4022. OxyContin is indicated for moderate to severe pain.

31. Xanax, which is a brand name for alprazolam, is a Schedule IV controlled substance and a dangerous drug pursuant to Health and Safety Code section 11057, subdivision(d)(1), and Code section 4022. Xanax is indicated for anxiety.

32. Soma, which is a brand name for carisoprodol, is a Schedule IV controlled substance and a dangerous drug pursuant to California Code of Regulations, title 21, section 1308.14, subdivision (c)(7), and Code section 4022. Soma is indicated for musculoskeletal conditions.

33. Phenergan with Codeine syrup, which is a brand name for promethazine with codeine syrup, is a Schedule V controlled substance and a dangerous drug pursuant to Health and Safety Code section 11058, subdivision (c)(1); and Code section 4022. Phenergan with Codeine syrup is indicated for cough.

34. Zosyn, which is a brand name for piperacillin 2 gm with tazobactam 375 mg, is an IV antibiotic and a dangerous drug pursuant to Code section 4022.

35. Vancocin, which is a brand name for vancomycin, is an IV antibiotic and a dangerous drug pursuant to Code section 4022.

36. Cleocin, which is a brand name for clindamycin, is an IV, oral, or topical antibiotic, and is a dangerous drug pursuant to Code section 4022.

37. Rocephin, which is a brand name for ceftriaxone, is an IV antibiotic and a dangerous drug pursuant to Code section 4022.

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38. Estrace, which is a brand name for estradiol, and is a dangerous drug pursuant to Code section 4022. Estrace is indicated for estrogen replacement.

39. Niaspan, which is a brand name for niacin extended-release, and is a dangerous drug pursuant to Code section 4022. Niaspan is indicated for dyslipidemia.

40. Deltasone, which is a brand name for prednisone, and is a dangerous drug pursuant to Code section 4022. Deltasone is indicated for allergic states.

41. Janumet XR, which is a brand name for sitagliptin and metformin, and is a dangerous drug pursuant to Code section 4022. Janumet XR is indicated for diabetes.

42. Lovenox, which is a brand name for enoxaparin, and is a dangerous drug pursuant to Code section 4022. Lovenox is indicated for deep vein thrombosis.

43. Pneumovax 23, which is a brand name for pneumococcal polysaccharide vaccine, 23-valent, and is a dangerous drug pursuant to Code section 4022. Pneumovax 23 is indicated for prevention of pneumococcal disease.

44. Fluvirin, which is a brand name for influenza virus vaccine (inactivated), and is a dangerous drug pursuant to Code section 4022. Fluvirin is indicated for prevention of influenza.

45. Byetta, which is a brand name for exenatide, and is a dangerous drug pursuant to Code section 4022. Byetta is indicated for diabetes.

46. Lotrel, which is a brand name for amlodipine/benazepril, and is a dangerous drug pursuant to Code section 4022. Lotrel is indicated for high blood pressure.

47. Roxicodone, sold under the generic name oxycodone, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M) and a dangerous drug pursuant to Business and Professions Code section 4022.

48. Hydrocodone-Acetaminophen 10/325, sold under the brand name Norco is a Schedule II controlled is substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(l)(ii), and a dangerous drug pursuant to Business and Professions Code section 4022.

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COST RECOVERY

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

BOARD INVESTIGATION REPORT DATED JUNE 13, 2017

50. On or about July 21, 2016, a Board Inspector conducted an investigation regarding respondent Pharmacy, which included an inspection of the pharmacy. The Board Inspector obtained documents from respondent Pharmacy, along with others from reliable sources, and thereafter determined that violations of Pharmacy Law occurred.

51. On July 21, 2016, during a routine inspection by the Board, the Board Inspector determined that respondent Pharmacy had failed to have in place a current written policy or procedures for impaired licensed employees. On or about December 3, 2008, respondent Pharmacy had previously been issued a Notice of Correction for failing to have a policy and procedures in place for impaired licensed persons. On or about June 21, 2011, respondent Pharmacy was again issued a Notice of Correction for failing to have a policy and procedures in place for impaired licensed persons. However, respondent Pharmacy and respondent Mohammadi failed to establish compliance. As of the Board inspection on July 21, 2016, when respondent Mohammadi was the PIC of respondent Pharmacy, compliance still had not been established.

52. The Board investigation further determined that on or about July 21, 2016, respondent Pharmacy, with respondent Mohammadi as PIC, had in its active stock Estradiol 1 mg with an expiration date of June 30, 2016; Niaspan 1000 mg with an expiration date of July 1, 2016; Niaspan 750 mg with an expiration date of March 25, 2016; Prednisone 1 mg with an expiration date of June 30, 2016; Janumet XR 100/1000 mg with an expiration date of November 30, 2015; Enoxaparin 60 mg/0.6 ml with an expiration date of March 31, 2016; Pneumovax 23 with an expiration date of March 3, 2014; Fluvirin with an expiration date of May 31, 2014; Amlodipine/Benazapril 10/20 mg with an expiration date of June 30, 2016; and Byetta 10 mcg

with an expiration date of January 31, 2014.

FIRST CAUSE FOR DISCIPLINE

(Failure to Have Theft or Impairment Policy)

(As to respondents Pharmacy and Mohammadi)

53. Respondent Pharmacy and respondent Mohammadi are subject to disciplinary action under Code sections 4301, subdivision (o), and 4113, subdivision (c), in conjunction with Code section 4104, subdivision (c), on the grounds of unprofessional conduct. Complainant hereby incorporates paragraphs 50-52 above as though set forth in full herein.

SECOND CAUSE FOR DISCIPLINE

(Holding and/or Offering for Sale Adulterated Drugs)

(As to Respondents Pharmacy and Mohammadi)

54. Respondent Pharmacy and respondent Mohammadi are subject to disciplinary action under Code sections 4301, subdivision (o), and 4113, subdivision (c), in conjunction with Health and Safety Code section 111295, on the grounds of unprofessional conduct. Complainant hereby incorporates paragraphs 50-52 above as though set forth in full herein.

BOARD INVESTIGATION REPORT DATED FEBRUARY 10, 2018

55. From December 2016 through early February 2017, the Board conducted a series of investigations regarding respondent Pharmacy. Respondent Pharmacy's controlled substances log, prescription copies, Patient Activity Reports (PARs) and other documents revealed violations of Pharmacy Law.

56. The Board investigation determined that between July 20, 2013 and July 20, 2016, respondent Pharmacy, respondent Ghadishah, and respondent Mohammadi dispensed prescriptions for controlled substances that were erroneous, uncertain, and/or fraudulent, under the prescribing authority of Dr. Prosser and Dr. Piety. Respondent Ghadishah was the PIC of respondent Pharmacy from May 1, 2014 to November 1, 2015. Respondent Mohammadi was the PIC of respondent Pharmacy from November 16, 2015 to August 26, 2016. The table below lists some of the fraudulent prescriptions filled at respondent Pharmacy:

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Script No.	RX No.	Date Written	Date Processed	Patient Name	Drugs Prescribed (Quantity)	Prescriber
8 0204	578697 578698	3/24/2015	3/25/2015	L.D.	Oxycodone 30mg(120); ibuprofen 600mg (30)	Dr. Prosser
9 0706	579371 579372 579370	4/6/2015	4/13/2015	A.S.	Oxycodone 30mg (120); Xanax 2mg (60); Phenergan w/codeine (480ml)	Dr. Prosser
9 0728	579206 579207 579208	4/7/2015	4/7/2015	M.E.	Oxycodone 30mg (120); Xanax 2mg (60); Phenergan w/Codeine (240ml)	Dr. Prosser
9 0722	579618 579619 579620	4/9/2015	4/16/2015	T.F.	Oxycodone 30mg (120); Xanax 2mg (60); Phenergan w/Codeine (480ml)	Dr. Prosser
9 0746	579953 579960 579952	4/20/2015	4/28/2015	M.P.	Oxycodone 30mg (120); Xanax 2mg (60); Phenergan w/Codeine (240ml)	Dr. Prosser
2 0654	579918 579919 579920	4/23/2015	4/27/2015	L.B.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (21)	Dr. Piety
9 0334	580434 580435 580436	5/6/2015	5/12/2015	M.E.	Oxycodone 30mg (120); Xanax 2mg (60); Phenergan w/Codeine (240ml)	Dr. Prosser
2 0663	580427 580428 580429	5/6/2015	5/12/2015	W.H.	Oxycodone 30mg (120); Xanax 2mg (60); Phergan w/Codeine (240ml)	Dr. Priety
2 0678	580630 580631 580632	5/13/2015	5/18/2015	R.J.	Oxycodone 30mg (120); Xanax 2mg (60); Ibuprofen 600mg (90)	Dr. Piety

2 0682	580627	5/13/2015	5/18/2015	J.P.	Oxycodone 30mg (120); Xanax 2mg (60); Ibuprofen 600mg (90)	Dr. Piety
2 0685	580680 580681 580679	5/13/2015	5/19/2015	T.R.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
2 0972	581441 581442 581444	6/3/2015	6/8/2015	M.E.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
2 0977	581597 581598 581599	6/3/2015	6/10/2015	L.D.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
2 0987	581742 581743 581744	6/10/2015	6/15/2015	A.S.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
3 0762	582330 582331 582332	6/16/2015	6/30/2015	M.M.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
1 0162	582340 582341 582342	6/29/2015	6/30/2015	M.P.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Prosser
3 0792	583051 583052 583053	7/8/2015	7/16/2015	T.F.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety

3 0786	582954 582955	7/8/2015	7/14/2015	S.C.	Oxycodone 30mg (120); Phenergan w/Codeine (480ml); Amoxicillin 500mg (20)	Dr. Piety
3 0796	582882 582883 582884	7/8/2015	7/13/2015	M.E.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
3 0798	582944 582945 582946	7/8/2015	7/14/2015	D.J.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
1 0186	583308 583309 583312	7/15/2015	7/23/2015	L.D.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Prosser
3 0814	583305 583306 583307	7/22/2015	7/23/2015	A.S.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Xanax 2mg (60)	Dr. Piety
3 0810	583318 583319 583320	7/22/2015	7/23/2015	J.P.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Ibuprofen 600mg (90)	Dr. Piety
3 0811	593475 583476 583477	7/22/2015	7/28/2015	L.M.	Oxycodone 30mg (120); Phenergan w/Codeine (480ml); Xanax 2mg (60)	Dr. Piety
3 0840	584412 584413 584414	8/19/2015	8/20/2015	M.E.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety

3 0034	584644 584645 584646	8/26/2015	8/27/2015	D.J.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
3 0035	584650 584651 584652	8/26/2015	8/27/2015	J.P.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
1 0144	584641 584642 584643	8/26/2015	8/27/2015	A.S.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Prosser
3 0033	584805 584806 584807	8/26/2015	9/1/2015	T.F.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
1 0204	584897 584898 584899	9/1/2015	9/2/2015	L.M.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Prosser
1 0208	585693 585694 585695	9/25/2015	9/25/2015	A.S.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Prosser
1 0222	585786	9/29/2015	9/30/2015	L.M.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Prosser
1 0238	586380 586382 586383	10/12/2015	10/14/2015	T.F.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Xanax 2mg (60)	Dr. Prosser

3 0418	590504 590505 590506	2/15/2016	2/16/2016	T.F.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
3 0426	590689 590690 590691	2/18/2016	2/22/2016	T.R.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
5 0103	592949 592951 592950	4/18/2016	4/22/2016	L.Y.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
3 0211	593983 593984 593985	5/19/2016	5/20/2016	T.R.	Oxycodone 30mg (120); Phenergan w/Codeine (480ml); Amoxicillin 500mg (20)	Dr. Prosser
5 0212	595031	6/20/2016	6/21/2016	R.J.	Oxycodone 30mg (180); Ibuprofen 800mg (90)	Dr. Piety
3 0800	582960	7/8/2015	7/14/2015	S.C.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
SPACE INTENTIONALLY LEFT BLANK						
9 0741	579755	4/20/2015	4/21/2015	S.C.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Prosser
3 0786	582953	7/8/2015	7/14/2015	S.C.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety

1 0149	584840	9/1/2015	9/1/2015	A.C.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Prosser
3 0752	581954	6/16/2015	6/22/2015	L.B.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
9 0743	579751	4/20/2015	4/21/2015	S.C.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Prosser
3 0841	584400	8/19/2015	8/20/2015	S.C.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety

57. The Board investigation further determined that that between July 20, 2013, and July 20, 2016, respondent Pharmacy and respondent Ghadishah failed to exercise or implement their best professional judgment or failed to exercise or implement their corresponding responsibility to ensure that controlled substances were dispensed for a legitimate medical purpose. They failed to evaluate the totality of the circumstances to determine whether controlled substances prescriptions they filled and dispensed served legitimate medical purposes, including evaluating information from and about the patients receiving prescriptions for controlled substances, information from and about the physicians prescribing those controlled substances, and information about how the medications prescribed related to patients' diagnoses and their overall course of treatment. They also ignored information available to them that could have helped them determine whether the controlled substance prescriptions they filled were for legitimate medical purpose. Respondent Ghadisha was the PIC of respondent Pharmacy during the period between May 1, 2014 and November 1, 2015.

58. As part of its investigation from December 2016 to February 2017, Board Inspectors reviewed the pharmacy's drug inventories, its drug usage reports, selected patient prescription profiles, drug acquisition records, and reviewed reports from the Controlled Substances Utilization Review and Evaluation System, also known as CURES.

59. CURES is a system for monitoring patient controlled substance history information. (See Health and Safety Code section 11165, and Code section 209.) (See also *In the Matter of the Accusation Against Pacifica Pharmacy; Thang Tran* (August 9, 2013) Board of Pharmacy Case No. 3802, Precedential Decision No. 2013-01, page 6, n.1, available at http://www.pharmacy.ca.gov/enforcement/precedential.shtml.)

60. Health and Safety Code section 11165 requires pharmacies to report within seven (7) days to the California Department of Justice every schedule II, III and IV drug prescription that is written or dispensed, and the information provided establishes the CURES database, which includes information about the drug dispensed, drug quantity and strength, patient name, address, prescriber name, and prescriber authorization number including DEA number and prescription number. (See Health & Safety Code section 11165.) (*In the Matter of the Accusation Against Pacifica Pharmacy; Thang Tran*, *supra*, at p. 6.) The CURES database is intended to allow licensed healthcare prescribers and pharmacists the ability to access patient controlled substance history information. (See Health and Safety Code section 11165, and Code section 209 [requiring DOJ and the Department of Consumer Affairs to streamline process to allow licensed health care practitioners and pharmacists to access CURES and run reports.])

61. The following factors are some that have been determined to constitute red flags that should give a pharmacy and pharmacist inquiry notice of a potential problem with prescriptions for drugs of common abuse and invoke in them a duty of inquiry:

- Irregularities on the face of the prescription itself
- Nervous patient demeanor
- Age or presentation of patient (e.g. youthful patients seeking chronic pain medications)
- Multiple patients at the same address

- Cash payments
- Requests for early refills of prescriptions
- Prescriptions written for an unusually large quantity of drugs
- Prescriptions written for potentially duplicative drugs
- The same combinations of drugs prescribed for multiple patients
- Initial prescriptions written for strong opiates (e.g. OxyContin 80 mg)
- Long distances traveled from the patient's home, to the prescriber's office or pharmacy
- Irregularities in the prescriber's qualifications in relation to the medication(s) prescribed
- Prescriptions that are written outside of the prescriber's medical specialty
- Prescriptions for medications with no logical connection to diagnosis or treatment

62. Board Inspectors reviewed the CURES report for respondent Pharmacy for the period of July 20, 2013 through July 20, 2016. The records provided included all controlled substance prescriptions (Schedule II-IV) filled at respondent Pharmacy within that time frame.

63. According to the CURES data, respondent Pharmacy filled 5,230 controlled substance prescriptions (Schedule II-IV) during the query period. Out of these 5,230 controlled substance prescriptions, 1,572 were filled for generic oxycodone (Schedule II controlled substance); and 12 were filled for OxyContin (Schedule II controlled substance); and 1,428 were filled for generic alprazolam (Schedule IV controlled substance). Out of 1,572 generic oxycodone prescriptions, 1,559 were filled for generic oxycodone 30 mg (which was 99.1% of the total number of prescriptions filled for generic oxycodone). Because the majority of the prescriptions were filled for generic oxycodone 30 mg (a higher strength of oxycodone usually used for an opioid tolerant patient), it was a factor of irregularity or red flag for a prescriber to initially prescribe oxycodone 30 mg instead of 5 to 15 mg, which was then titrated (adjusted) based on the individual patient’s response to the initial dose.

64. During the query period (based on the CURES data), approximately 24.41% of generic oxycodone 30 mg prescriptions and 17.65% of alprazolam 2 mg prescriptions filled at

respondent Pharmacy were paid for by billing prescription insurance. Approximately 35.81% of generic oxycodone 30 mg, and 22.02% of alprazolam prescriptions were paid for in "cash," meaning without the assistance of prescription insurance. Because of the higher percentage of prescriptions filled as cash for oxycodone 30 mg and alprazolam 2 mg compared to billing insurances, this was a factor of irregularity or red flag.

65. During the query period, Dr. Goldstein's oxycodone 30 mg prescriptions filled at Respondent Pharmacy by different patients, located at different addresses, had script numbers which were in consecutive order. These consecutively numbered prescriptions were all prescribed on the same day, and the majority of the prescriptions were filled for different patients on the same day, as shown in the table below:

a. Table: Prescriptions filled at respondent Pharmacy that had script numbers in consecutive order.

Patient	**Date Prescribed**	**Script Number**	**Medication Prescribed and Quantity**	**Prescription Number**	**Dated Processed/Filled by Respondent Pharmacy**
Alvin B.	10/9/2015	6742	Oxycodone 30mg #150; Phenergan w/Codeine 6oz	586329 586330	10/13/2015 10/13/2015
Abel C.	10/9/2015	6743	Oxycodone 30mg #150; Phenergan w/Codeine 6oz	586314 586315	10/13/2015 10/13/2015
Angela C.	10/9/2015	6744	Oxycodone 30mg #120; Phenergan w/Codeine 16oz	586320 586321	10/13/2015 10/13/2015
Claudell G.	10/9/2015	6746	Oxycodone 30mg #120; Phenergan w/Codeine 16oz	586311 586312	10/13/2015 10/13/2015

Claudia F.	10/13/2015	6636	Oxycodone 30mg #120; Xanax 2mg #60; Phenergan w/Codeine 10oz	586554 586555 586556	10/19/2015 10/19/2015 10/19/2015
Elba R.	10/13/2015	6637	Oxycodone 30mg #120; Xanax 2mg #60; Phenergan w/Codeine 16oz	586547 586548	10/19/2015 10/19/2015
Andrea S.	10/14/2015	6752	Oxycodone 30mg #130; Phenergan w/Codeine 16oz; Xanax 2mg #60	586439 586440 586441	10/15/2015 10/15/2015 10/15/2015
Linda Y.	10/14/2015	6753	Oxycodone 30mg #120; Phenergan w/Codeine 16oz; Soma 350mg #60	586374 586375 586376	10/14/2015
Michell H.	10/14/2015	6754	Oxycodone 30mg #120; Phenergan w/Codeine 16oz	586472 586473 586474	10/16/2015
Mario M.	10/14/2015	6755	Oxycodone 30mg #120; Phenergan w/Codeine 16oz	586371 586372	10/14/2015
Tyrone R.	10/14/2015	6756	Oxycodone 30mg #120; Phenergan w/Codeine 16oz; Soma 350mg #60	586377 586378 586379	10/14/2015
James P.	10/13/2015	6757	Oxycodone 30mg #130; Phenergan w/Codeine 16oz	586458 586459	10/15/2015
Ariel E.	10/14/2015	6758	Oxycodone 30mg #120; Phenergan w/Codeine 16oz	586442 586443	10/15/2015

Dejon A.	10/15/2015	6799	Oxycodone 30mg #120; Phenergan w/Codeine 16oz	586616 586617	10/20/2015
Kiemia C.	10/15/2015	6800	Oxycodone 30mg #150; Phenergan w/Codeine 8oz; Xanax 2mg #60	586613 586614 586615	10/20/2015
Steve C.	10/23/2015	6674	Oxycodone 30mg #130; Phenergan w/Codeine 8oz; Xanax 2mg #60	587044 587045 587046	11/3/2015
Shawtrice C.	10/23/2015	6678	Oxycodone 30mg #120; Phenergan w/Codeine 8oz	587050 587051	11/3/2015
Michelle P.	10/23/2015	6679	Oxycodone 30mg #130; Phenergan w/Codeine 16oz; Soma 350mg #60	587041 587042 587043	11/3/2015
Andrea S.	10/23/2015	6680	Oxycodone 30mg #120; Phenergan w/Codeine 8oz	587038 587039	11/3/2015
Lakecha D.	10/23/2015	6681	Oxycodone 30mg #130; Phenergan w/Codeine 8oz; Xanax 2mg #60	587047 587048 587049	11/3/2015
Denise J.	10/23/2015	6682	Oxycodone 30mg #120; Phenergan w/Codeine 8oz	587271 587272	11/9/2015
Marsha E.	10/23/2015	6684	Oxycodone 30mg #150; Phenergan w/Codeine 16oz; Soma 350mg #60	587035 587036 587037	11/3/2015

Curley D.	10/23/2015	6686	Oxycodone 30mg #150; Phenergan w/Codeine 16oz	587249 587250	11/9/2015
Shawntrice C.	12/15/2015	4518	Oxycodone 30mg #150; Phenergan w/Codeine 8oz; Xanax 2mg #60	588227 588428 588429	12/16/2015
Tina F.	12/15/15	4520	Oxycodone 30mg #120; Phenergan w/Codeine 8oz	588433 588434	12/16/2015
Michelle P.	12/15/2015	4521	Oxycodone 30mg #120; Phenergan w/Codeine 8oz	588436 588437	12/16/2015
Latosha B.	12/15/2015	4522	Oxycodone 30mg #120; Xanax 2mg #60	588424 588425	12/16/2015
Lakisha M.	12/15/2016	4523	Oxycodone 30mg #120; Xanax 2mg #60	588430 588431	12/16/2015

b. Because nearly all of Dr. Goldstein's prescriptions written for different patients and filled at respondent Pharmacy were in consecutive order (with some of these prescriptions written for different patients filled by respondent Pharmacy on the same day), it was a factor of irregularity or red flag, since it was unlikely that prescriptions written in consecutive order, for different patients, would get filled at one pharmacy, on the same day.

66. During the query period, Dr. Goldstein, Dr. Piety, and Dr. Prosser prescribed the following total count of prescriptions dispensed at respondent Pharmacy, as shown in the table below:

a. Table: Based on CURES, count of oxycodone, alprazolam, and carisoprodol controlled substance prescriptions prescribed by the following doctors at respondent Pharmacy from July 20, 2013 to July 20, 2016.

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Doctor's Name	Name of Medication	Total Quantity of Prescriptions
Dr. Goldstein	Oxycodone HCL, 30mg, tab	27
	Alprazolam, 2mg, tab	9
	Carisoprodol, 350mg, tab	4
Dr. Piety	Oxycodone HCL, 30mg, tab	105
	Alprazolam, 2mg, tab	14
	Carisoprodol, 350mg, tab	2
Dr. Prosser	Oxycodone HCL, 30mg, tab	57
	Alprazolam, 2mg, tab	17
	Carisoprodol, 350mg, tab	1

67. Because the majority of prescriptions filled at respondent Pharmacy for Dr. Goldstein, Dr. Piety, and Dr. Prosser were written for oxycodone 30mg (a pain reliever) and alprazolam (an anti-anxiety medication), it was a factor of irregularity or red flag for the patients of Dr. Goldstein, Dr. Piety, and Dr. Prosser to suffer from the same aliments necessitating the same combination of medications.

68. Two medications, oxycodone 30 mg, for quantities of 100 to 120 tablets (1,381 prescriptions of oxycodone 30 mg out of 1,572 total prescriptions filled for generic oxycodone); and generic alprazolam 2 mg, for quantities of 30 to 60 tablets (1,026 prescriptions of alprazolam 2 mg) out of 1,428 total prescriptions filled for generic alprazolam) comprised the majority of the controlled substance prescriptions dispensed by respondent Pharmacy during the query period. Because the majority of prescriptions filled at respondent Pharmacy during the query period were dispensed for large quantities of oxycodone 30 mg (the highest strength dosage of the most commonly abused controlled substance) and alprazolam 2 mg (another commonly abused controlled substance) - which were then dispensed to many different patients, this was a factor of irregularity or red flag because it was unlikely for one pharmacy to dispense mostly the same combination of drugs, in this case oxycodone 30 mg and alprazolam 2 mg, to many different patients.

69. After reviewing the CURES data for respondent Pharmacy, Board Inspectors identified patients for Dr. Prosser/Dr. Piety that also had prescriptions issued by Dr. Goldstein, who were obtaining oxycodone 30 mg and were outside of the service area for respondent Pharmacy and/or Dr. Prosser/Dr. Piety. As shown by the table below, these patients were traveling long distances between respondent Pharmacy, the provider and their residence to obtain controlled substances. In most examples, the patients were traveling long distances to both the prescriber and respondent Pharmacy to have their prescriptions filled, which was a factor of irregularity or red flag.

a. Table: Patient, prescriber, and respondent Pharmacy distance evaluation.

Patient Name[1]	**Distance: Patient to MD**	**Distance: Patient to Pharmacy**	**Distance: MD to Pharmacy**[2]
Latosha B.	23.3 miles	12.9 miles	30.7 miles
Angela C.	26.2 miles	10.3 miles	30.7 miles
Shawntrice C.	22.5 miles	12.5 miles	30.7 miles
Steven C.	31.4 miles	22.9 miles	30.7 miles
Lakecha D.	85.1 miles	58.1 miles	30.7 miles
Marsha E.	33.6 miles	1.0 mile	30.7 miles
Ting F.	32.5 miles	2.0 miles	30.7 miles
Willie H.	26.6 miles	10.9 miles	30.7 miles
Rhonda J.	20.1 miles	18.3 miles	30.7 miles
Mario M.	30.2 miles	5.3 miles	30.7 miles
Lakisha R.	15.1 miles	20.7 miles	30.7 miles
Michelle P.	15.1 miles	21.6 miles	30.7 miles
James P.	33.9 miles	5.2 miles	30.7 miles
Tyrone R.	18.6 miles	18.2 miles	30.7 miles
Andre S.	25.3 miles	12.2 miles	30.7 miles
Andrea S.	25.3 miles	12.2 miles	30.7 miles
Linda Y.	30.2 miles	8.6 miles	30.7 miles

b. Prescription blanks for Dr. Goldstein had two or three different addresses listed, which included addresses in the cities of Orange, Van Nuys, and Simi Valley, California. The prescriptions were marked with either the Van Nuys or Simi Valley address. However, all of the prescriptions were typed using Dr. Goldstein's Orange, California address. Dr. Goldstein's

[1] The patients' address information is not provided in the table in order to protect the privacy rights of those individuals.

[2] The Board was unable to fully determine where Dr. Goldstein's office was located, thus only Dr. Piety and Dr. Prosser's office location was used to compare the distance traveled by the patients of Dr. Piety and Dr. Posser to their office and to respondent Pharmacy.

location in Orange, California was approximately 45.6 miles away from respondent Pharmacy, located in Los Angeles, California.

70. The factors of irregularity or red flags with respect to the listed practitioners' prescriptions were such that a prudent pharmacist could have reasonably concluded that these were not medically legitimate prescriptions. The pharmacist reviewing these prescriptions should have noted the highly irregular prescribing patterns of the practitioners, the irregular or non-compliant prescription documents, the distance patients travelled to obtain these prescriptions, and the patients' profiles consisting almost exclusively of controlled substances, often at the highest available does. In addition, the prescribing patterns for Drs. Piety and Prosser appear to be incongruent with the physicians' specialty listed on the California Medical Board website. For example, Dr. Piety and Dr. Prosser, both Family Medicine practitioners, prescribed primarily oxycodone 30 mg, promethazine/codeine cough syrup, and Xanax 2 mg tablets more often than any other medication during the query period. The red flags in the prescribers' prescriptions amounted to significant irregularities or uncertainties the pharmacist was required to address. In addition to these significant irregularities, Drs. Piety and Prosser advised a Board Inspector that they did not write the prescriptions filled at respondent Pharmacy under their prescribing authority. It appears then that Drs. Piety and Prosser would have been able to identify these fraudulent prescriptions if they had been contacted by respondent Pharmacy or respondent Ghadishah to verify or validate the prescriptions.

71. The Board investigation further determined that between July 20, 2013 and July 20, 2016, respondent Pharmacy, respondent Ghadishah, and respondent Mohammadi filled several controlled substance prescriptions under the prescribing authority of Dr. Goldstein, Dr. Prosser, and Dr. Priety, for prescriptions that were written on forms which did not comply with Health and Safety Code section 11162.1, to wit, the check boxes to indicate the number of refills were omitted from these prescription forms. Respondent Ghadishah was the PIC of respondent Pharmacy during the period between May 1, 2014 through November 1, 2015.

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THIRD CAUSE FOR DISCIPLINE

(Dispensing Erroneous, Uncertain, and/or Fraudulent Prescriptions)

(As to respondents Pharmacy, Ghadishah, and Mohammadi)

72. Respondent Pharmacy, respondent Ghadishah, and respondent Mohammadi are subject to disciplinary action under Code sections 4301, subdivision (o), and 4113, subdivision (c), in conjunction with California Code of Regulations, title 16, section 1761, on the grounds of unprofessional conduct. Complainant hereby incorporates paragraphs 55-56 above as though set forth in full herein.

FOURTH CAUSE FOR DISCIPLINE

(Violation of Corresponding Responsibility to Verify Prescriptions)

(As to respondents Pharmacy and Ghadishah)

73. Respondent Pharmacy and respondent Ghadishah are subject to disciplinary action under Code sections 4113, 4301, and 4306.5, in conjunction with Health and Safety Code section 11153 and California Code of Regulations, title 16, section 1761, on the grounds of unprofessional conduct. Complainant hereby incorporates paragraphs 55, and 57-70 above as though set forth in full herein.

FIFTH CAUSE FOR DISCIPLINE

(Dispensing of Controlled Substances Based on Non-Compliant Prescription Forms)

(As to respondents Pharmacy, Ghadishah, and Mohammadi)

74. Respondent Pharmacy, respondent Ghadishah, and respondent Mohammadi are subject to disciplinary action under Code sections 4113, and 4301, subdivision (j), in conjunction with Health and Safety Code sections 11162.1 and 11164, on the grounds of unprofessional conduct. Complainant hereby incorporates paragraphs 61 and 71 above as though set forth in full herein.

BOARD INVESTIGATION REPORT DATED FEBRUARY 9, 2018

75. From September 2017 through early February 2018, the Board conducted an investigation of respondent Pharmacy, which included an inspection of respondent Pharmacy. The Board Inspector obtained documents from respondent Pharmacy, along with others from

reliable sources, and thereafter determined that violations of Pharmacy Law occurred.

76. The Board investigation determined that respondent Pharmacy failed to ensure that possession of a key to the pharmacy where dangerous drugs and controlled substances are stored was restricted to a pharmacist. The Board investigation also determined that respondent Pharmacy failed to ensure that when a pharmacy owner has possession of a key to the pharmacy to provide access in case of an emergency, that such key be secured in a tamper-evident container. Specifically, on or about November 2, 2017, at approximately 9:00 a.m., a Board Inspector observed pharmacy technician V.N. (TCH V.N.) open respondent Pharmacy before the arrival of the pharmacist-in-charge at that time. When the pharmacist-in-charge arrived at respondent Pharmacy, the Board Inspector observed TCH V.N. retrieve a key from an amber vial and hand the key over to the pharmacist-in-charge, who then unlocked the door to respondent Pharmacy, where dangerous drugs and/or controlled substances were stored.

77. The investigation further determined that respondent Pharmacy dispensed controlled substances which deviated from the requirements of the prescriptions without the prior consent of the prescribers. Specifically, a review of respondent Pharmacy's prescription records between 2014 and 2016 revealed that respondent Pharmacy added one additional refill during the process of transferring five (5) prescriptions from Century Discount Pharmacy to respondent Pharmacy, as set forth in more detail in the table, below.

a. Table: Prescriptions filled at respondent Pharmacy with one additional refill added

Rx No.	**Date of Service**	**Date Written**	**Comment by Board Inspector**
581210	6/2/2015	6/2/2015	Rx No. 476954 was transferred from Century Discount Pharmacy to respondent Pharmacy on 6/2/15. Rx No. 476954 was issued on 3/30/15 by Dr. Manavi with two (2) refills. Last refill date was 5/1/2015 and the remaining refill was one. This means the prescription can only dispense one time. After transferring Rx No. 476954, respondent Pharmacy dispensed Rx No. 581210 on 6/2/2015 with one (1) refill, instead of zero (0) refills.

581615	6/10/2015	6/10/2015	Rx No. 479630 was transferred from Century Discount Pharmacy to respondent Pharmacy on 6/10/15. Rx No. 479630 was issued on 6/10/15 by Dr. Zarian with two (2) refills. This means the prescription can only dispense three times. After transferring Rx No. 479630, respondent Pharmacy dispensed Rx No. 581615 on 6/10/2015 with three (3) refills, instead of two (2) refills.
582285	6/29/2015	6/29/2015	Rx No. 477335 was transferred from Century Discount Pharmacy to respondent Pharmacy on 6/29/2015. Rx No. 477335 was issued on 4/13/2015 by Dr. Nourparvar with four (4) refills. Last fill was 6/2/2015 and there were three (3) remaining refills. This means the prescription can only dispense three (3) more times. After transferring Rx No. 477335, respondent Pharmacy dispensed Rx No. 582285 on 6/29/2015 with three (3) refills, instead of two (2) refills.
585320	9/16/2015	9/16/2015	Rx No. 474842 was transferred from Century Discount Pharmacy to respondent Pharmacy on 9/16/2015. Rx No. 474842 was issued on 2/13/2015 by Dr. Azizad with three (3) refills. The last fill date was 8/11/2015 and there were two (2) remaining refills. This means the prescription can only dispense two (2) more times. After transferring Rx No. 474842, respondent Pharmacy dispensed Rx No. 585320 on 9/16/2015 with two (2) refills, instead of one (1) refill.
586697	10/22/2015	10/22/2015	Rx No. 481285 was transferred from Century Discount Pharmacy to respondent Pharmacy on 10/22/2015. Rx No. 586697 was issued on 8/19/2015 by Dr. Cairo with eleven (11) refills. The last refill date was 9/25/2015 and there were ten (10) remaining refills. This means the prescription can only dispense ten (10) more times. After transferring Rx No. 481285, Respondent Pharmacy dispensed Rx No. 586697 on 10/22/2015 with ten (10) refills, instead of nine (9) refills.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Security of Pharmacy)

(As to respondent Pharmacy)

78. Respondent Pharmacy is subject to disciplinary action under Code section 4301, subdivisions (j) and (o) and California Code of Regulations, title 16, section 1714 subdivisions (d) and (e). Complainant hereby incorporates paragraphs 75-76 above as though set forth in full herein.

SEVENTH CAUSE FOR DISCIPLINE

(Dispensing Controlled Substances with Variations from Prescriptions)

(As to respondent Pharmacy)

79. Respondent Pharmacy is subject to disciplinary action under Code section 4301, subdivision (o), for violating Code section 4063 and California Code of Regulations, title 16, section 1716. Complainant hereby incorporates paragraphs 75 and 77 above as though set forth in full herein.

BOARD INVESTIGATION REPORT DATED SEPTEMBER 8, 2020

80. A Board investigation at another pharmacy determined that John Korzelius, M.D. Physician's Assistant, JE (PA JE), failed to act in the usual course of her professional practice by prescribing controlled substances to patients for illegitimate medical purposes. A review of CURES records by the Board discovered that respondent Pharmacy also dispensed controlled substance prescriptions written under the prescribing authority of PA JE. Accordingly, an internal Board complaint was filed and an investigation of respondent Pharmacy was initiated to evaluate the legitimacy and appropriateness of respondent Pharmacy's dispensing of controlled substances and/or dangerous drugs.

81. This is a second corresponding responsibility case following one completed in February 2018. An internal review by the Board determined respondent Pharmacy potentially continued failing to exercise their corresponding responsibility to only dispense medically legitimate controlled substance prescriptions. The investigation substantiated the allegations and found the pharmacy continued to dispense controlled substances pursuant to orders written on

non-compliant controlled substance prescription documents, made multiple prescription errors, and operated without a pharmacist-in-charge for a period of greater than 30 days.

82. The Board Inspector analyzed the CURES data for respondent Pharmacy from April 27, 2017 – April 27, 2020 and identified factors of irregularity or red flags consistent with possible illegitimate prescribing and indiscriminate pharmacy dispensing pertaining to multiple other prescribers. Due to the Coronavirus pandemic and shelter-in-place order, the Board Inspector was unable to perform an inspection at respondent Pharmacy. Hence, on April 29, 2020, the Board Inspector sent an e-mail to respondent Pharmacy requesting the following:

- Original prescription documents potentially displaying illegitimate prescribing based on her CURES data analysis.
- Respondent Pharmacy's electronic dispensing records from 04/27/2017 - 04/27/2020.
- Any and all notes pertaining to the requested prescriptions or patients.

83. As part of this investigation, the Board Inspector requested and received from respondent Pharmacy a sample of prescriptions written under the prescribing authority of PA JE and six physicians, to wit: Bhasker Venkateswaralu, M.D., Joseph Dinglasan, M.D., Jared Piety, M.D., Rahil Khan, M.D., Randall Gilbert, M.D., and John Korzelius, M.D.

84. The following is an analysis of respondent Pharmacy's electronic dispensing records from April 27, 2017 through April 27, 2020:

- Respondent Pharmacy dispensed 60,622 prescriptions.
- Non-controlled medications: 57,192 prescriptions (94%).
- Controlled medications: 3,430 prescriptions (6%).
- The number of non-controlled medications that are commercially available is greater than controlled medications, therefore, these percentages were not unusual for a retail pharmacy.
- Payment method for all medications (controlled and non-controlled) dispensed during the query period was approximately 11% cash and 89% third party (this number includes both insurance and discount cards, which are essentially considered cash payment).
- 10% of non-controlled medications were paid for with cash.
- 39% of controlled medications were paid for with cash.

- The percentage of cash payment for controlled substances was approximately four times that of non-controlled substances. Typically, patients do not desire to pay high out-of-pocket costs for medications and therefore prefer the assistance of insurance. The high percentage of cash payment for controlled medications was irregular for a retail pharmacy.
- 65% of the schedule II controlled substance medications were paid for with cash.
- This was almost seven times greater than non-controlled medications and over 1.5 times that of all controlled substances dispensed by respondent Pharmacy, which was a factor of irregularity or red flag.
- The number one drug dispensed by respondent Pharmacy was the highly abused schedule II controlled substance, oxycodone 30 mg.
- As previously mentioned, 94% of the drugs dispensed by respondent Pharmacy were non-controlled substances.
- Schedule II controlled substances only accounted for 3% (l,675/60,622) of the drugs dispensed by the respondent Pharmacy
- Hence, it was a glaring factor of irregularity or red flag for a schedule II controlled substance to be the top drug dispensed by respondent Pharmacy.
- It was also a factor of irregularity for one drug, oxycodone 30 mg, to account for 79% (l,323/1,675) of the schedule II controlled substances dispensed by respondent Pharmacy.
- Oxycodone immediate-release tablets are available in 5, 10, 15, 20 and 30 mg tablets. All but two oxycodone prescriptions dispensed by respondent Pharmacy were for the highest strength oxycodone. This was a factor of irregularity or red flag for the following reasons:
- Given oxycodone therapy should be initiated at the lowest effective dosage as the risk associated with use, especially fatal respiratory depression, increases with higher dosages, one would expect to find lower doses dispensed by respondent Pharmacy at much greater frequencies.
- Additionally, a great variability exists between patients such as age, weight, drug allergies, medical histories, tolerance to narcotic medications, and preferences regarding their drug therapy plan. Due to this interpatient variability, a prescriber would often choose different strengths of the same medication to treat their patients.

- 73% of respondent Pharmacy's oxycodone prescriptions were paid for with cash, which was a factor of irregularity or red flag.

85. The two investigations illuminated the level of respondent Pharmacy's and its pharmacists' incompetence, negligence and flagrant disregard for the laws adopted by the California State Board of Pharmacy to protect patients. Respondent Pharmacy and its pharmacists filled non-compliant controlled substance prescriptions, ignored glaring red flags and factors of irregularity, dispensed high dose opioids to naive patients and made prescription errors. After the initial investigation, either respondent Pharmacy did not understand the underlying principles of red flags and corresponding responsibility and how to apply changes to comply with pharmacy law, or it and its pharmacists deliberately disregarded them in order to turn a profit from the illegitimate distribution of controlled substances. In either case, the actions of respondent Pharmacy were more aligned with those of a pill-mill rather than a legitimate pharmacy entrusted with the public's well-being and safety.

Allegations against respondent Pharmacy

86. As documented in the Board Investigation Report dated September 8, 2020, the Board Inspector determined that between April 27, 2017 and April 27, 2020, respondent Pharmacy committed multiple violations of Pharmacy Law, as follows.

87. Respondent Pharmacy dispensed at least 1,274 controlled substance prescriptions (and 122,307.5 units of controlled substances) in the presence of multiple factors of irregularity or red flags, evidencing that they were not written for legitimate medical purposes. These multiple factors of irregularity or red flags included the following:

- A large percentage of the prescription written by various prescribers were for highly abused controlled substances.
- Utilizing cash payment instead of a third party for controlled substances.
- The prescribing profiles of various prescribers being seemingly incongruent with their self- reported areas of practice on the Board of Medicine's online database. Additionally, their prescribing patterns were unusually limited, with a small number of commonly abused controlled substances accounting for a large percentage of the total prescriptions.

- The highest strength of oxycodone, 30 mg, was prescribed by various prescribers to all patients receiving the medication without regard for interpatient variability. Most of the prescriptions listed identical quantities and directions for use.
- Multiple patients being diagnosed with similar or identical ailments by the same prescriber.
- Patients travelling excessive distances between the medical offices of various prescribers and the pharmacy.
- Patients presenting to the pharmacy with prescriptions for identical controlled substances, strengths and directions for use. These prescriptions were assigned consecutive or nearly consecutive pharmacy prescription numbers indicating they were processed sequentially.
- Prescriptions for controlled substances written on prescription documents lacking multiple security features and failing to comply with HSC section 11162.1.
- Respondent Pharmacy dispensed at least 539 controlled substance prescriptions (and 50,427 tablets of controlled substances) written on non-compliant prescription documents.
- Opioid naïve patients (those who had not filled an opioid for over two months) presenting with prescriptions for the highest strength oxycodone, 30 mg, and mostly at total daily doses of almost three times the recommended safe dose.
- Supporting documentation intimated CURES was checked by respondent Pharmacy to inquire about the controlled substance dispensing histories of the various patients. However, the information was either inappropriately scrutinized or simply ignored, as respondent Pharmacy dispensed 446 prescriptions to opioid naïve patients.

88. The Board investigation determined that during the period in question, respondent Pharmacy dispensed 19 prescriptions with incorrect directions for use and two prescriptions written for OxyContin 30 mg as oxycodone 30 mg.

89. The Board investigation further determined that during the period in question, respondent Pharmacy dispensed 539 controlled substance prescriptions which were written on prescription documents lacking multiple required security features and failing to comply with Health and Safety Code section 11162.1.

90. The Board investigation also determined that according to Board of Pharmacy records, respondent Pharmacy was operating without a PIC from February 5, 2019 to April 30, 2019.

Allegations against respondent Khalifian

91. As documented in the Board Investigation Report dated September 8, 2020, the Board Inspector determined that between April 27, 2017 and April 27, 2020, respondent Khalifian committed multiple violations of Pharmacy Law, as follows.

92. While respondent Khalifian was employed as PIC at respondent Pharmacy, the pharmacy dispensed at least 357 controlled substance prescriptions (and 31,850 units of controlled substances) in the presence of multiple factors of irregularity or red flags, evidencing that they were not written for legitimate medical purposes. These multiple factors of irregularity or red flags included the following:

- A large percentage of the prescriptions written by various prescribers were for highly abused controlled substances.
- Utilizing cash payment instead of a third party for controlled substances.
- The prescribing profiles of various prescribers being seemingly incongruent with their self- reported areas of practice on the Board of Medicine's online database. Additionally, their prescribing patterns were unusually limited, with a small number of commonly abused controlled substances accounting for a large percentage of the total prescriptions.
- The highest strength of oxycodone, 30 mg, was prescribed by various prescribers to all patients receiving the medication without regard for interpatient variability. Most of the prescriptions listed identical quantities and directions for use.
- Multiple patients being diagnosed with similar or identical ailments by the same prescriber.
- Patients travelling excessive distances between the medical offices of various prescribers and the pharmacy.

- Patients presenting to the pharmacy with prescriptions for identical controlled substances, strengths and directions for use. These prescriptions were assigned consecutive or nearly consecutive pharmacy prescription numbers indicating they were processed sequentially.
- Opioid naïve patients (those who had not filled an opioid for over two months) presenting with prescriptions for the highest strength oxycodone, 30 mg, and mostly at total daily doses of almost three times the recommended safe dose.
- Supporting documentation intimated CURES was checked to inquire about the controlled substance dispensing histories of the various patients. However, the information was either inappropriately scrutinized or simply ignored as respondent Pharmacy dispensed 114 prescriptions to opioid naïve patients.

93. While employed as a pharmacist at respondent Pharmacy, respondent Khalifian personally dispensed:

- At least 190 controlled substance prescriptions (and 16,340 tablets of controlled substances) in the presence of multiple factors of irregularity or red flags.
- At least 53 prescriptions of the highest strength oxycodone, 30 mg, and mostly at total daily doses of almost three times the recommended safe dose, to opioid naive patients.

94. While employed as a pharmacist at respondent Pharmacy, respondent Khalifian dispensed one prescription with incorrect directions for use (RX 630155) and two prescriptions written for Oxycontin 30 mg as oxycodone 30 mg (RXs 625503 and 625856).

Allegations against respondent Ahdoot

95. As documented in the Board Investigation Report dated September 8, 2020, the Board Inspector determined that between April 27, 2017 and April 27, 2020, respondent Ahdoot committed multiple violations of Pharmacy Law, as follows.

96. While respondent Ahdoot was employed as PIC at Respondent Pharmacy, the pharmacy dispensed at least 670 controlled substance prescriptions (and 69,357.5 units of controlled substances) in the presence of multiple factors of irregularity or red flags, evidencing that they were not written for legitimate medical purposes. These multiple factors of irregularity or red flags included the following:

- A large percentage of the prescriptions written by various prescribers were for highly abused controlled substances.
- Utilizing cash payment instead of a third party for controlled substances.
- The prescribing profiles of various prescribers being seemingly incongruent with their self- reported areas of practice on the Board of Medicine's online database. Additionally, their prescribing patterns were unusually limited, with a small number of commonly abused controlled substances accounting for a large percentage of the total prescriptions.
- The highest strength of oxycodone, 30 mg, was prescribed by various prescribers to all patients receiving the medication without regard for interpatient variability. Most of the prescriptions listed identical quantities and directions for use.
- Multiple patients being diagnosed with similar or identical ailments by the same prescriber.
- Patients travelling excessive distances between the medical offices of various prescribers and respondent Pharmacy.
- Patients presenting to respondent Pharmacy with prescriptions for identical controlled substances, strengths and directions for use. These prescriptions were assigned consecutive or nearly consecutive pharmacy prescription numbers indicating they were processed sequentially.
- Prescriptions for controlled substances written on prescription documents lacking multiple security features and failing to comply with HSC section 11162.1.
- Respondent Pharmacy dispensed at least 539 controlled substance prescriptions (and 50,427 tablets) written on non-compliant prescription documents.
- Opioid naïve patients (those who had not filled an opioid for over two months) presenting with prescriptions for the highest strength oxycodone, 30 mg, and mostly at total daily doses of almost three times the recommended safe dose.
- Supporting documentation intimated CURES was checked to inquire about the controlled substance dispensing histories of the various patients. However, the information was either inappropriately scrutinized or simply ignored as respondent Pharmacy dispensed 253 prescriptions to opioid naïve patients.

97. While employed as a pharmacist at respondent Pharmacy, respondent Ahdoot personally dispensed:

- At least 229 prescriptions of the highest strength oxycodone, 30 mg, and mostly at total daily doses of almost three times the recommended safe dose, to opioid naive patients.
- At least 584 controlled substance prescriptions (and 60,281 units of controlled substances) in the presence of multiple factors of irregularity or red flags.

98. While employed as a pharmacist at respondent Pharmacy, respondent Ahdoot personally dispensed one prescription with incorrect directions for use (RX 610681).

99. While respondent Ahdoot was employed as PIC at respondent Pharmacy, the pharmacy dispensed 539 controlled substance prescriptions (50,427 tablets) that were written on prescription documents lacking multiple required security features and failing to comply with Health and Safety Code section 11162.1.

100. While employed as a pharmacist at respondent Pharmacy, respondent Ahdoot personally dispensed 488 controlled substance prescriptions (45,557 tablets) written on non-compliant prescription documents.

Allegations against respondent Farzan

101. As documented in the Board Investigation Report dated September 8, 2020, the Board Inspector determined that between April 27, 2017 and April 27, 2020, respondent Farzan committed multiple violations of Pharmacy Law, as follows.

102. While respondent Farzan was employed as PIC at respondent Pharmacy, the pharmacy dispensed at least 80 controlled substance prescriptions (and 6,660 tablets of controlled substances) in the presence of multiple factors of irregularity or red flags, evidencing that they were not written for legitimate medical purposes. These multiple factors of irregularity or red flags included the following:

- A large percentage of the prescriptions written by various prescribers were for highly abused controlled substances.
- Utilizing cash payment instead of a third party for controlled substances.

- The prescribing profiles of various prescribers being seemingly incongruent with their self- reported areas of practice on the Board of Medicine's online database. Additionally, their prescribing patterns were unusually limited, with a small number of commonly abused controlled substances accounting for a large percentage of the total prescriptions.
- The highest strength of oxycodone, 30 mg, was prescribed by various prescribers to all patients receiving the medication without regard for interpatient variability. Most of the prescriptions listed identical quantities and directions for use.
- Multiple patients being diagnosed with similar or identical ailments by the same prescriber.
- Patients travelling excessive distances between the medical offices of various prescribers and the pharmacy.
- Patients presenting to the pharmacy with prescriptions for identical controlled substances, strengths and directions for use. These prescriptions were assigned consecutive or nearly consecutive pharmacy prescription numbers indicating they were processed sequentially.
- Opioid naïve patients (those who had not filled an opioid for over two months) presenting with prescriptions for the highest strength oxycodone, 30 mg, and mostly at total daily doses of almost three times the recommended safe dose.
- Supporting documentation intimated CURES was checked to inquire about the controlled substance dispensing histories of the various patients. However, the information was either inappropriately scrutinized or simply ignored as respondent Farzan dispensed 20 prescriptions to opioid naïve patients.

103. While employed as a pharmacist at respondent Pharmacy, respondent Farzan personally dispensed:

- At least 80 controlled substance prescriptions (and 7,020 tablets of controlled substances) in the presence of multiple factors of irregularity or red flags.
- At least 28 prescriptions of the highest strength oxycodone, 30 mg, and mostly at total daily doses of almost three times the recommended safe dose, to opioid naive patients.

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Allegations against respondent Haroonpoor

104. As documented in the Board Investigation Report dated September 8, 2020, the Board Inspector determined that between April 27, 2017 and April 27, 2020, respondent Haroonpoor committed multiple violations of Pharmacy Law, as follows.

105. While employed as a pharmacist at respondent Pharmacy, respondent Haroonpoor dispensed at least 155 controlled substance prescriptions (and 13,950 tablets of controlled substances) in the presence of multiple factors of irregularity or red flags, evidencing that they were not written for legitimate medical purposes. These multiple factors of irregularity or red flags included the following:

- A large percentage of the prescriptions written by various prescribers were for highly abused controlled substances.
- Utilizing cash payment instead of a third party for controlled substances.
- The prescribing profiles of various prescribers being seemingly incongruent with their self- reported areas of practice on the Board of Medicine's online database. Additionally, their prescribing patterns were unusually limited, with a small number of commonly abused controlled substances accounting for a large percentage of the total prescriptions.
- The highest strength of oxycodone, 30 mg, was prescribed by various prescribers to all patients receiving the medication without regard for interpatient variability. Most of the prescriptions listed identical quantities and directions for use.
- Multiple patients being diagnosed with similar or identical ailments by the same prescriber.
- Patients travelling excessive distances between the medical offices of various prescribers and the pharmacy.
- Patients presenting to the pharmacy with prescriptions for identical controlled substances, strengths and directions for use. These prescriptions were assigned consecutive or nearly consecutive pharmacy prescription numbers indicating they were processed sequentially.

- Opioid naïve patients (those who had not filled an opioid for over two months) presenting with prescriptions for the highest strength oxycodone (30 mg) and mostly at total daily doses of almost three times the recommended safe dose.

- Supporting documentation intimated CURES was checked to inquire about the controlled substance dispensing histories of the various patients. However, the information was either inappropriately scrutinized or simply ignored as respondent Haroonpoor dispensed 46 prescriptions to opioid naïve patients.

106. While employed as a pharmacist at respondent Pharmacy, respondent Haroonpoor dispensed 13 prescriptions with incorrect directions for use.

Allegations against respondent Choi

107. As documented in the Board Investigation Report dated September 8, 2020, the Board Inspector determined that between April 27, 2017 and April 27, 2020, respondent Choi committed multiple violations of Pharmacy Law, as follows.

108. While employed as a pharmacist at respondent Pharmacy, respondent Choi dispensed at least 65 controlled substance prescriptions (5,790 tablets of controlled substances) in the presence of multiple factors of irregularity or red flags, evidencing that they were not written for legitimate medical purposes. These multiple factors of irregularity or red flags included the following:

- A large percentage of the prescriptions written by various prescribers were for highly abused controlled substances.

- Utilizing cash payment instead of a third party for controlled substances.

- The prescribing profiles of various prescribers being seemingly incongruent with their self- reported areas of practice on the Board of Medicine's online database. Additionally, their prescribing patterns were unusually limited, with a small number of commonly abused controlled substances accounting for a large percentage of the total prescriptions.

- The highest strength of oxycodone, 30 mg, was prescribed by various prescribers to all patients receiving the medication without regard for interpatient variability. Most of the prescriptions listed identical quantities and directions for use.

- Multiple patients being diagnosed with similar or identical ailments by the same prescriber.
- Patients travelling excessive distances between the medical offices of various prescribers and the pharmacy.
- Patients presenting to the pharmacy with prescriptions for identical controlled substances, strengths and directions for use. These prescriptions were assigned consecutive or nearly consecutive pharmacy prescription numbers indicating they were processed sequentially.
- Opioid naïve patients (those who had not filled an opioid for over two months) presenting with prescriptions for the highest strength oxycodone, 30 mg, and mostly at total daily doses of almost three times the recommended safe dose.
- Supporting documentation intimated CURES was checked to inquire about the controlled substance dispensing histories of the various patients. However, the information was either inappropriately scrutinized or simply ignored as respondent Choi dispensed 24 prescriptions to opioid naïve patients.

109. While employed as a pharmacist at respondent Pharmacy, respondent Choi dispensed one prescription with incorrect directions for use (RX 622734).

Allegations against respondent Shakeraneh

110. As documented in the Board Investigation Report dated September 8, 2020, the Board Inspector determined that between April 27, 2017 and April 27, 2020, respondent Shakeraneh committed multiple violations of Pharmacy Law, as follows.

111. While employed as a pharmacist at respondent Pharmacy, respondent Shakeraneh dispensed at least 61 controlled substance prescriptions (and 5,300 tablets of controlled substances) in the presence of multiple factors of irregularity or red flags, evidencing that they were not written for legitimate medical purposes. These multiple factors of irregularity or red flags included the following:

- A large percentage of the prescriptions written by various prescribers were for highly abused controlled substances.
- Utilizing cash payment instead of a third party for controlled substances.

- The prescribing profiles of various prescribers being seemingly incongruent with their self-reported areas of practice on the Board of Medicine's online database. Additionally, their prescribing patterns were unusually limited, with a small number of commonly abused controlled substances accounting for a large percentage of the total prescriptions.
- The highest strength of oxycodone, 30 mg, was prescribed by various prescribers to all patients receiving the medication without regard for interpatient variability. Most of the prescriptions listed identical quantities and directions for use.
- Multiple patients being diagnosed with similar or identical ailments by the same prescriber.
- Patients travelling excessive distances between the medical offices of various prescribers and the pharmacy.
- Patients presenting to the pharmacy with prescriptions for identical controlled substances, strengths and directions for use. These prescriptions were assigned consecutive or nearly consecutive pharmacy prescription numbers indicating they were processed sequentially.
- Opioid naïve patients (those who had not filled an opioid for over two months) presenting with prescriptions for the highest strength oxycodone, 30 mg, and mostly at total daily doses of almost three times the recommended safe dose.
- Supporting documentation intimated CURES was checked to inquire about the controlled substance dispensing histories of various patients. However, the information was either inappropriately scrutinized or simply ignored as respondent Shakeraneh dispensed 23 prescriptions to opioid naïve patients.

112. While employed as a pharmacist at respondent Pharmacy, respondent Shakeraneh dispensed three prescriptions with incorrect directions for use (RXs 628862, 628865 and 628869).

Allegations against respondent Khani

113. As documented in the Board Investigation Report dated September 8, 2020, the Board Inspector determined that between April 27, 2017 and April 27, 2020, respondent Khani committed multiple violations of Pharmacy Law, as follows.

114. While employed as a pharmacist at respondent Pharmacy, respondent Khani dispensed at least 65 controlled substance prescriptions (and 7,0565.5 units of controlled substances) in the presence of multiple factors of irregularity or red flags, evidencing that they were not written for legitimate medical purposes. These multiple factors of irregularity or red flags included the following:

- A large percentage of the prescriptions written by various prescribers were for highly abused controlled substances.
- Utilizing cash payment instead of a third party for controlled substances.
- The prescribing profiles of various prescribers being seemingly incongruent with their self- reported areas of practice on the Board of Medicine's online database. Additionally, their prescribing patterns were unusually limited, with a small number of commonly abused controlled substances accounting for a large percentage of the total prescriptions.
- The highest strength of oxycodone, 30 mg, was prescribed by various prescribers to all patients receiving the medication without regard for interpatient variability. Most of the prescriptions listed identical quantities and directions for use.
- Multiple patients being diagnosed with similar or identical ailments by the same prescriber.
- Patients travelling excessive distances between the medical offices of various prescribers and the pharmacy.
- Patients presenting to the pharmacy with prescriptions for identical controlled substances, strengths and directions for use. These prescriptions were assigned consecutive or nearly consecutive pharmacy prescription numbers indicating they were processed sequentially.
- Prescriptions for controlled substances written on prescription documents lacking multiple security features and failing to comply with HSC section 11162.1.
- Respondent Khani dispensed at least 35 controlled substance prescriptions (and 3,330 tablets) written on non-compliant prescription documents.

• Opioid naïve patients (those who had not filled an opioid for over two months) mostly presenting with prescriptions for the highest strength oxycodone, 30 mg, at total daily doses of between three and five times the recommended safe dose.

• Supporting documentation intimated CURES was checked to inquire about the controlled substance dispensing histories of various patients. However, the information was either inappropriately scrutinized or simply ignored as respondent Khani dispensed 17 prescriptions to opioid naïve patients.

115. While employed as a pharmacist at respondent Pharmacy, respondent Khani dispensed 35 controlled substance prescriptions which were written on prescription documents lacking multiple required security features and failing to comply with Health and Safety Code section 11162.l.

Allegations against respondent Azizzadeh

116. As documented in the Board Investigation Report dated September 8, 2020, the Board Inspector determined that between April 27, 2017 and April 27, 2020, respondent Azizzadeh committed multiple violations of Pharmacy Law, as follows.

117. While employed as a pharmacist at respondent Pharmacy, respondent Azizzadeh dispensed 16 controlled substance prescriptions which were written on prescription documents lacking multiple required security features and failing to comply with Health and Safety Code section 11162.1.

118. While employed as a pharmacist at respondent Pharmacy, respondent Azizzadeh dispensed at least six prescriptions (RXs 617039, 617817, 617822, 617945, 617950 and 617954) for the highest strength oxycodone, 30 mg, to opioid naïve patients (those who had not filled an opioid for over two months) at total daily doses of between three and five times the recommended safe dose. Supporting documentation intimated CURES was checked to inquire about the controlled substance dispensing histories of the various patients, however, the information was either inappropriately scrutinized or simply ignored.

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EIGHTH CAUSE FOR DISCIPLINE

(Violation of Corresponding Responsibility to Verify Prescriptions)

(As to respondent Pharmacy)

119. Respondent Pharmacy is subject to disciplinary action under Code sections 4301 and 4306.5, Health and Safety Code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, subdivisions (a) and (b). Complainant hereby incorporates paragraphs 80-87 above as though set forth in full herein.

NINTH CAUSE FOR DISCIPLINE

(Variation from Prescriptions)

(As to respondent Pharmacy)

120. Respondent Pharmacy is subject to disciplinary action under California Code of Regulations, title 16, section 1716, and Code section 4073. Complainant hereby incorporates paragraphs 80-86 and 88 above as though set forth in full herein.

TENTH CAUSE FOR DISCIPLINE

(Dispensed Controlled Substance Prescriptions Written on Prescription Documents Lacking Multiple Required Security Features)

(As to respondent Pharmacy)

121. Respondent Pharmacy is subject to disciplinary action under Health and Safety Code sections 11164, subdivision (a), and 11162.1. Complainant hereby incorporates paragraphs 80-86 and 89 above as though set forth in full herein.

ELEVENTH CAUSE FOR DISCIPLINE

(Operating Without Pharmacist-in-Charge for More Than 30 Days)

(As to respondent Pharmacy)

122. Respondent Pharmacy is subject to disciplinary action under Code sections 4113, subdivision (d), and 4305. Complainant hereby incorporates paragraphs 80-86 and 90 above as though set forth in full herein.

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TWELFTH CAUSE FOR DISCIPLINE

(Violation of Corresponding Responsibility to Verify Prescriptions)

(As to respondent Khalifian)

123. Respondent Khalifian is subject to disciplinary action under Code sections 4113, 4301, and 4306.5, Health and Safety Code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, subdivisions (a) and (b). Complainant hereby incorporates paragraphs 80-85, and 91-93 above as though set forth in full herein.

THIRTEENTH CAUSE FOR DISCIPLINE

(Variation from Prescriptions)

(As to respondent Khalifian)

124. Respondent Khalifian is subject to disciplinary action under California Code of Regulations, title 16, section 1716, and Code section 4073. Complainant hereby incorporates paragraphs 80-85, 91, and 94 above as though set forth in full herein.

FOURTEENTH CAUSE FOR DISCIPLINE

(Violation of Corresponding Responsibility to Verify Prescriptions)

(As to respondent Ahdoot)

125. Respondent Ahdoot is subject to disciplinary action under Code sections 4113, 4301, and 4306.5, Health and Safety Code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, subdivisions (a) and (b). Complainant hereby incorporates paragraphs 80-85, and 95-97 above as though set forth in full herein.

FIFTEENTH CAUSE FOR DISCIPLINE

(Variation from Prescriptions)

(As to respondent Ahdoot)

126. Respondent Ahdoot is subject to disciplinary action under California Code of Regulations, title 16, section 1716, and Code section 4073. Complainant hereby incorporates paragraphs 80-85, 95, and 98 above as though set forth in full herein.

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SIXTEENTH CAUSE FOR DISCIPLINE

(Dispensed Controlled Substance Prescriptions Written on Prescription Documents Lacking Multiple Required Security Features)

(As to respondent Ahdoot)

127. Respondent Ahdoot is subject to disciplinary action under Health and Safety Code sections 11164, subdivision (a), and 11162.1. Complainant hereby incorporates paragraphs 80-85, 95, and 99-100 above as though set forth in full herein.

SEVENTEENTH CAUSE FOR DISCIPLINE

(Violation of Corresponding Responsibility to Verify Prescriptions)

(As to respondent Farzan)

128. Respondent Farzan is subject to disciplinary action under Code sections 4113, 4301, and 4306.5, Health and Safety Code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, subdivisions (a) and (b). Complainant hereby incorporates paragraphs 80-85, and 101-103 above as though set forth in full herein.

EIGHTEENTH CAUSE FOR DISCIPLINE

(Violation of Corresponding Responsibility to Verify Prescriptions)

(As to respondent Haroonpoor)

129. Respondent Haroonpoor is subject to disciplinary action under Code sections 4301 and 4306.5, Health and Safety Code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, subdivisions (a) and (b). Complainant hereby incorporates paragraphs 80-85, and 104-105 above as though set forth in full herein

NINETEENTH CAUSE FOR DISCIPLINE

(Variation from Prescriptions)

(As to respondent Haroonpoor)

130. Respondent Haroonpoor is subject to disciplinary action under California Code of Regulations, title 16, section 1716, and Code section 4073. Complainant hereby incorporates paragraphs 80-85, 104, and 106 above as though set forth in full herein.

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TWENTIETH CAUSE FOR DISCIPLINE

(Violation of Corresponding Responsibility to Verify Prescriptions)

(As to respondent Choi)

131. Respondent Choi is subject to disciplinary action under Code sections 4301 and 4306.5, Health and Safety Code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, subdivisions (a) and (b). Complainant hereby incorporates paragraphs 80-85, and 107-108 above as though set forth in full herein

TWENTY-FIRST CAUSE FOR DISCIPLINE

(Variation from Prescriptions)

(As to respondent Choi)

132. Respondent Choi is subject to disciplinary action under California Code of Regulations, title 16, section 1716, and Code section 4073. Complainant hereby incorporates paragraphs 80-85, 107, and 109 above as though set forth in full herein.

TWENTY-SECOND CAUSE FOR DISCIPLINE

(Violation of Corresponding Responsibility to Verify Prescriptions)

(As to respondent Shakeraneh)

133. Respondent Shakeraneh is subject to disciplinary action under Code sections 4301 and 4306.5, Health and Safety Code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, subdivisions (a) and (b). Complainant hereby incorporates paragraphs 80-85, and 110-111 above as though set forth in full herein.

TWENTY-THIRD CAUSE FOR DISCIPLINE

(Variation from Prescriptions)

(As to respondent Shakeraneh)

134. Respondent Shakeraneh is subject to disciplinary action under California Code of Regulations, title 16, section 1716, and Code section 4073. Complainant hereby incorporates paragraphs 80-85, 110, and 112 above as though set forth in full herein.

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TWENTY-FOURTH CAUSE FOR DISCIPLINE

(Violation of Corresponding Responsibility to Verify Prescriptions)

(As to respondent Khani)

135. Respondent Khani is subject to disciplinary action under Code sections 4301 and 4306.5, Health and Safety Code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, subdivisions (a) and (b). Complainant hereby incorporates paragraphs 80-85, and 113-114 above as though set forth in full herein.

TWENTY-FIFTH CAUSE FOR DISCIPLINE

(Dispensed Controlled Substance Prescriptions Written on Prescription Documents Lacking Multiple Required Security Features)

(As to respondent Khani)

136. Respondent Khani is subject to disciplinary action under Health and Safety Code sections 11164, subdivision (a), and 11162.1. Complainant hereby incorporates paragraphs 80-85, 113, and 115 above as though set forth in full herein.

TWENTY-SIXTH CAUSE FOR DISCIPLINE

(Dispensed Controlled Substance Prescriptions Written on Prescription Documents Lacking Multiple Required Security Features)

(As to respondent Azizzadeh)

137. Respondent Azizzadeh is subject to disciplinary action under Health and Safety Code sections 11164, subdivision (a), and 11162.1. Complainant hereby incorporates paragraphs 80-85, and 116-117 above as though set forth in full herein.

TWENTY-SEVENTH CAUSE FOR DISCIPLINE

(Erroneous or Uncertain Prescriptions)

(As to respondent Azizzadeh)

138. Respondent Azizzadeh is subject to disciplinary action under California Code of Regulations, title 16, section 1761, subdivisions (a) and (b). Complainant hereby incorporates paragraphs 80-85, 116, and 118 above as though set forth in full herein.

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DISCIPLINE CONSIDERATIONS

139. To determine the degree of discipline, if any, to be imposed on respondent Pharmacy, complainant alleges that on or about April 27, 2005, in a previous matter entitled *In the Matter of the Accusation and First Amended Accusation and Supplemental Accusation against Joseph Amin dba Century Pharmacy and Javad Ferdowsi*, Board of Pharmacy Case No. 2280, the Board issued a citation as to respondent Pharmacy in the amount of $2,500 for violating the following: Business and Professions Code section 4081, in conjunction with Code of Federal Regulations, title 21, section 1304.21, subdivision (a) [failure to maintain accurate DEA inventory of dangerous drugs/controlled substances] and Business and Professions Code section 4059, subdivision (a) [furnishing a drug or controlled substance without a prescription for a person unlawfully authorized to prescribe]. That citation is now final and is incorporated by reference as if fully set forth herein.

140. To determine the degree of discipline, if any, to be imposed on respondent Pharmacy, with Joseph Amin, as owner, complainant alleges that on or about June 11, 2018, in a previous matter entitled *In the Matter of the Second Amended Accusation against Century Discount Pharmacy, Inc. Farhad D. Sharim and Joseph Amin, owners, et al.*, Board of Pharmacy Case No. 4829, Century Discount Pharmacy, Inc.'s Pharmacy Permit Number PHY 39871 was surrendered. Century Discount Pharmacy, Inc., with Farhad D. Sharim and Joseph Amin, as owners, were ordered to pay the Board its costs of investigation and enforcement in the amount of $37,199.25 prior to the issuance of a new or reinstated license. That decision is now final and is incorporated by reference as if fully set forth herein.

141. To determine the degree of discipline, if any, to be imposed on respondent Pharmacy, complainant alleges that on or about June 21, 2021, in a previous matter entitled *In the Matter of the Accusation against Joseph Amin dba Century Pharmacy and Javad Ferdowsi*, Board of Pharmacy Case No. 4670, the Board ultimately withdrew its accusation and issued a citation as to respondent Pharmacy in the amount of $1,000 for the following violations: Code sections 4301(f) and (g); 4113(c) [Insurance Fraud]; Code sections 4301(g) and (o), and 4113(c), in conjunction with Code section 4076(a) [False and Improper Prescription Labels]; Code sections 4301(o), and

4113(c), in conjunction with California Code of Regulations, title 16, section 1761 [Dispensing Erroneous or Uncertain Prescriptions]; Code sections 4301(o), and 4113(c), in conjunction with Code section 4081(a) [Records of Dangerous Drugs Open for Inspection]; Code sections 4301(o), and 4113(c), in conjunction with California Code of Regulations, title 16, section 1715 [Failure to Complete a Self-Assessment]; Code sections 4301(o), and 4113(c), in conjunction with Code of Federal Regulations, title 16, section 1304.11(a) and (c) [Failure to Keep Controlled Substance Inventory]; Code sections 4301(o), and 4113(c), in conjunction with Code of Federal Regulations, title 16, section 1304.04(h) [Failure to Maintain controlled Substance Inventory]; Code sections 4301(o), and 4113(c), in conjunction with Code section 4076(a)(11) [Violation of Prescription Container Labeling Requirement]; and Code sections 4301(o), and 4113(c), in conjunction with Code section 4104(b) [Failure to Have Theft or Impairment Policy]. That citation is now final and is incorporated by reference as if fully set forth herein.

142. To determine the degree of discipline, if any, to be imposed on respondent Ghadishah, complainant alleges that on or about February 28, 2018, the Board issued Citation Number CI 2017 78968 to respondent Ghadishah for violating Business and Professions Code section 4063, in conjunction with California Code of Regulations, title 16, section 1716. Respondent Ghadishah was ordered to pay a fine of $1,000. That citation is now final and is incorporated herein by reference as if fully set forth herein.

143. To determine the degree of discipline, if any, to be imposed on respondent Choi, complainant alleges that on or about July 29, 2020, in a previous matter entitled *In the Matter of the Accusation against I.MC16, Inc. dba R & X Compounding Pharmacy, Young Sook Choi, Owner and Young Sook Choi,* Board of Pharmacy Case No. 5922, respondent Choi's Pharmacist License Number 41950 was surrendered. Respondent Choi was ordered to pay the Board its costs of investigation and enforcement in the amount of $55,572.75 prior to the issuance of a new or reinstated license. The decision is now final and is incorporated herein by reference as if fully set forth herein.

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OTHER MATTERS

144. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 34252, issued to Joseph Amin (Amin), doing business as Century Pharmacy, while acting as the manager, administrator, owner, member, office, director, associate, or partner of Century Pharmacy, had knowledge of or knowingly participated in any conduct for which Pharmacy Permit Number PHY 34252, issued to Joseph Amin, doing business as Century Pharmacy was revoked, suspended or placed on probation, Amin shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number 34252 issued to Joseph Amin, doing business as Century Pharmacy is placed on probation or until Pharmacy Permit Number PHY 34252 issued to Joseph Amin, doing business as Century Pharmacy is reinstated if it is revoked.

145. Pursuant to Code section 4307, if Pharmacist License Number RPH 70372, issued to Jila Mohammadi, is disciplined as part of the Board's Decision, then Jila Mohammadi shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee for a period (1) not to exceed five years if Pharmacist License Number RPH 70372 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision.

146. Pursuant to Code section 4307, if Pharmacist License Number RPH 70585, issued to Morris Ghadishah, is disciplined as part of the Board's Decision, then Morris Ghadishah shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee for a period (1) not to exceed five years if Pharmacist License Number RPH 70585 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision.

147. Pursuant to Code section 4307, if Pharmacist License Number RPH 44675, issued to Mahshid Paya Khalifian, is disciplined as part of the Board's Decision, then Mahshid Paya Khalifian shall be prohibited from serving as a manager, administrator, owner, member, officer,

director, associate, partner, or in any other position with management or control of a licensee for a period (1) not to exceed five years if Pharmacist License Number RPH 44675 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision.

148. Pursuant to Code section 4307, if Pharmacist License Number RPH 43292, issued to Mehrdad Ahdoot, is disciplined as part of the Board's Decision, then Mehrdad Ahdoot shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee for a period (1) not to exceed five years if Pharmacist License Number RPH 43292 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision.

149. Pursuant to Code section 4307, if Pharmacist License Number RPH 44807, issued to Shiva Kiaee Farzan, is disciplined as part of the Board's Decision, then Shiva Kiaee Farzan shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee for a period (1) not to exceed five years if Pharmacist License Number RPH 44807 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision.

150. Pursuant to Code section 4307, if Pharmacist License Number RPH 76314, issued to Shirin Haroonpoor, is disciplined as part of the Board's Decision, then Shirin Haroonpoor shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee for a period (1) not to exceed five years if Pharmacist License Number RPH 76314 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision.

151. Pursuant to Code section 4307, if Pharmacist License Number RPH 41950, issued to Young Sook Choi, is disciplined as part of the Board's Decision, then Young Sook Choi shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate,

partner, or in any other position with management or control of a licensee for a period (1) not to exceed five years if Pharmacist License Number RPH 41950 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision.

152. Pursuant to Code section 4307, if Pharmacist License Number RPH 45821, issued to Hengameh Shakeraneh, is disciplined as part of the Board's Decision, then Hengameh Shakeraneh shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee for a period (1) not to exceed five years if Pharmacist License Number RPH 45821 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision.

153. Pursuant to Code section 4307, if Pharmacist License Number RPH 54486, issued to Parisa Khani, is disciplined as part of the Board's Decision, then Parisa Khani shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee for a period (1) not to exceed five years if Pharmacist License Number RPH 54486 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision.

154. Pursuant to Code section 4307, if Pharmacist License Number RPH 53320, issued to Shirin Azizzadeh, is disciplined as part of the Board's Decision, then Shirin Azizzadeh shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee for a period (1) not to exceed five years if Pharmacist License Number RPH 53320 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision.

PRAYER

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

1. Revoking or suspending Permit Number PHY 34252, issued to Joseph Amin, doing business as Century Pharmacy;

2. Prohibiting Joseph Amin, pursuant to Business and Professions Code section 4307, from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee for a period (1) not to exceed five years if Pharmacy Permit Number PHY 34252 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision;

3. Revoking or suspending Pharmacist License Number RPH 70372, issued to Jila Mohammadi;

4. Prohibiting Jila Mohammadi, pursuant to Business and Professions Code section 4307, from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee for a period (1) not to exceed five years if Pharmacist License Number RPH 70372 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision;

5. Revoking or suspending Pharmacist License Number RPH 70585, issued to Morris Ghadishah;

6. Prohibiting Morris Ghadishah, pursuant to Business and Professions Code section 4307, from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee for a period (1) not to exceed five years if Pharmacist License Number RPH 70585 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision;

7. Revoking or suspending Pharmacist License Number RPH 44675, issued to Mahshid Paya Khalifian;

8. Prohibiting Mahshid Paya Khalifian, pursuant to Business and Professions Code section 4307, from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee for a period

(1) not to exceed five years if Pharmacist License Number RPH 44675 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision;

9. Revoking or suspending Pharmacist License Number RPH 43292, issued to Mehrdad Ahdoot;

10. Prohibiting Mehrdad Ahdoot, pursuant to Business and Professions Code section 4307, from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee for a period (1) not to exceed five years if Pharmacist License Number RPH 43292 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision;

11. Revoking or suspending Pharmacist License Number RPH 44807, issued to Shiva Kiaee Farzan;

12. Prohibiting Shiva Kiaee Farzan, pursuant to Business and Professions Code section 4307, from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee for a period (1) not to exceed five years if Pharmacist License Number RPH 44807 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision;

13. Revoking or suspending Pharmacist License Number RPH 76314, issued to Shirin Haroonpoor;

14. Prohibiting Shirin Haroonpoor, pursuant to Business and Professions Code section 4307, from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee for a period (1) not to exceed five years if Pharmacist License Number RPH 76314 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision;

15. Revoking or suspending Pharmacist License Number RPH 41950, issued to Young Sook Choi;

16. Prohibiting Young Sook Choi, pursuant to Business and Professions Code section 4307, from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee for a period (1) not to exceed five years if Pharmacist License Number RPH 41950 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision;

17. Revoking or suspending Pharmacist License Number RPH 45821, issued to Hengameh Shakeraneh;

18. Prohibiting Hengameh Shakeraneh, pursuant to Business and Professions Code section 4307, from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee for a period (1) not to exceed five years if Pharmacist License Number RPH 45821 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision;

19. Revoking or suspending Pharmacist License Number RPH 54486, issued to Parisa Khani;

20. Prohibiting Parisa Khani, pursuant to Business and Professions Code section 4307, from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee for a period (1) not to exceed five years if Pharmacist License Number RPH 54486 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision;

21. Revoking or suspending Pharmacist License Number RPH 53320, issued to Shirin Azizzadeh;

22. Prohibiting Shirin Azizzadeh, pursuant to Business and Professions Code section 4307, from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee for a period (1) not to

exceed five years if Pharmacist License Number RPH 53320 is placed on probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision;

23. Ordering Joseph Amin, doing business as Century Pharmacy, Jila Mohammadi, Morris Ghadishah, Mahshid Paya Khalifian, Mehrdad Ahdoot, Shiva Kiaee Farzan, Shirin Haroonpoor, Young Sook Choi, Hengameh Shakeraneh, Parisa Khani, and Shirin Azizzadeh, jointly and severally, to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

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

DATED: 9/20/2021

Signature on File

ANNE SODERGREN
Executive Officer
Board of Pharmacy
Department of Consumer Affairs
State of California
Complainant