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STATE OF WISCONSIN
BEFORE THE PHARMACY EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER LS9104261PHM
HAMPTON PHARMACY, INC., and SALVATORE R. DeIANNI, R.Ph., RESPONDENTS.	:	

The State of Wisconsin, Pharmacy Examining Board, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, makes the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Pharmacy Examining Board.

The rights of a party aggrieved by this Decision to petition the Board for rehearing and the petition for judicial review are set forth on the attached "Notice of Appeal Information."

Dated this 11 day of February, 1992.

Virginia Zehren, R.Ph., Ph.D.

STATE OF WISCONSIN
BEFORE THE PHARMACY EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
HAMPTON PHARMACY, INC., and SALVATORE R. DeIANNI, R.Ph., RESPONDENTS.	:	PROPOSED DECISION LS9104261PHM

The parties to this proceeding for the purposes of Wis. Stats., sec. 227.53 are:

Hampton Pharmacy, Inc.
Salvatore R. DeIanni, R.Ph.
Jeanne L. DeIanni
5020 West Hampton Avenue
Milwaukee, Wisconsin 53218

Salvatore R. DeIanni, R.Ph.
4151 South 103rd Street
Milwaukee, Wisconsin 53228

Pharmacy Examining Board
P.O. Box 8935
Madison, Wisconsin 53708

Department of Regulation & Licensing
P.O. Box 8935
Madison, Wisconsin 53708

This proceeding was commenced by the filing of a Petition for Summary Suspension on April 16, 1991. The Pharmacy Examining Board issued an Order of Summary Suspension against the Respondents on April 18, 1991. Complainant filed a Notice of Hearing and Complaint on April 26, 1991. Respondents having failed to file an Answer to the Complaint within the appropriate time period were granted an extension of time, until June 17, 1991, to file an Answer. The respondents failed to file an Answer by June 17, 1991.

On July 31, 1991, the Complainant filed a Motion for Default Judgment. A hearing on the motion was held on August 6, 1991. Robert T. Ganch, Attorney at Law, appeared on behalf of the Department of Regulation and Licensing. Mark S. Stern, Attorney at Law, Stupar & Schuster, S.C., appeared on behalf of the Respondents. Respondent, Salvatore R. DeIanni, R. Ph., did not appear in person at the hearing. Legal briefs were filed by the parties on or before September 15, 1991.

Based upon the record herein, the Administrative Law Judge recommends that the Pharmacy Examining Board adopt as its final decision in this matter the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Respondent, Hampton Pharmacy, Inc., of 5020 West Hampton Avenue, Milwaukee, Wisconsin was at all times relevant to this proceeding currently licensed as a pharmacy by the Wisconsin Pharmacy Examining Board, license #6527, first granted on January 13, 1984.

2. Respondent, Salvatore R. DeIanni, R.Ph., date of birth March 31, 1939, of 4151 South 103rd Street, Milwaukee, Wisconsin 53228, was at all times relevant to this proceeding currently licensed as a pharmacist by the Wisconsin Pharmacy Examining Board, license #7565, first granted on October 31, 1966.

3. Salvatore R. DeIanni was at all times relevant to this proceeding the managing pharmacist of Hampton Pharmacy, Inc., and responsible for the professional operations of the pharmacy.

4. At all times relevant to this proceeding, Respondent, Salvatore R. DeIanni, owned 50% interest in Hampton Pharmacy, Inc., and Respondent's wife, Jeanne L. DeIanni owned the remaining 50% interest in the pharmacy.

5. On December 15, 1980, Respondent, Salvatore R. DeIanni was convicted of three felony violations of sections 161.41 (1)(c) and 161.20 (2)(cr), Wis. Stats., upon pleas of not guilty and jury verdicts of guilty in the Circuit Court for Milwaukee County. The three charges upon which DeIanni was convicted were that on three separate occasions in June 1980 DeIanni knowingly delivered without a prescription Diazepam, a controlled substance, to a City of Milwaukee police officer. Based upon such criminal convictions of violations of the Wisconsin Controlled Substances Act, on June 15, 1982 the Wisconsin Pharmacy Examining Board suspended the pharmacist license of DeIanni for an indefinite period of not less than one year, effective July 15, 1982.

6. On December 8, 1987, the Department of Regulation and Licensing issued a Notice of Compliance to Respondents. In response to violations cited in the Notice, the Respondent, Salvatore DeIanni, signed the Notice of Compliance on December 15, 1987, stating that all outdated drugs had been removed from the pharmacy shelves for destruction. At least on August 10, 1989, the outdated drugs had not been removed from the pharmacy shelves as represented by Respondent in the Notice of Compliance.

7. In August, 1989, Respondents prepared for dispensing to a patient by the name of Robert Shaw, five prepackaged bottles of Hycodan syrup, a Schedule III controlled substance, without a prescription order from a practitioner authorizing the dispensing of such substance.

8. On April 22, 1991, the U.S. Department of Justice, Drug Enforcement Administration revoked the DEA Certificate of Registration, #AH2468874, previously issued to Hampton Pharmacy, Inc., based upon a 1989 DEA investigation of the pharmacy which revealed violations of federal regulations concerning controlled substances dispensing and record keeping. The type of violations cited in the Justice Department's order included:

a. Failure to take a biennial inventory in violation of 21 CFR 1304.13;
b. Failure to maintain complete order forms in violation of 21 CFR 1305.09 (e);
c. Failure to maintain complete and accurate records in violation of 21 CFR 1304.21 and 1304.24;
d. Failure to maintain Schedule II controlled substances prescriptions separate from all other records in violation of 21 CFR 1304.04 (h)(1);

e. Between May, 1987 and June, 1989, Respondent Hampton Pharmacy dispensed Schedule III - V controlled substances pursuant to prescriptions and/or refills which were not authorized by the treating physician;

f. An audit of selected Schedule II controlled substances for the period between January 1, 1988 through March 9, 1989, revealed that Respondent Hampton Pharmacy was unable to account for approximately 1200 dosage units of Percocet, 220 dosage units of Ritalin 5mg., and 42 dosage units of Dilaudid 2mg.

9. The Drug Enforcement Administration, Milwaukee office, conducted an investigation of Hampton Pharmacy, Inc., of 5020 W. Hampton Avenue, Milwaukee, Wisconsin and Salvatore R. DeIanni, R.Ph., owner and managing pharmacist of Hampton Pharmacy, Inc., concerning controlled substances purchases, record keeping and dispensing, covering a period of time from approximately May, 1987 to at least July, 1989. Based upon its investigation, the Drug Enforcement Administration revoked the DEA Certificate of Registration of Hampton Pharmacy, Inc. The results of DEA investigation indicate the following violations of controlled substances laws:

a. On each of March 8, 1989, March 21, 1989 and March 30, 1989, Hampton Pharmacy, Inc., and R.Ph. DeIanni, as owner and managing pharmacist of Hampton Pharmacy, Inc., failed to have available and produce for inspection pursuant to request by DEA investigators the controlled substances biennial inventory required to have been conducted on January 31, 1988 by Hampton Pharmacy, Inc., in violation of 21 CFR 1304.13, 21 CFR 1304.04 (a), and 21 USC 842 (a)(5).

b. A controlled substances audit of Hampton Pharmacy, Inc., of selected Schedule II controlled substances for the period of January 1, 1988 through March 9, 1989 showed Hampton Pharmacy, Inc., to be unable to account for the following amounts of certain controlled substances in violation of 21 CFR 1304.21:

Percodan/Percocet	-2,458 (-35.1%)
Ritalin 5 mg.	-220 (-16.9%)
Dilaudid 2 mg.	-42 (-21.0%)

c. Examination of controlled substances prescription orders dispensed by Hampton Pharmacy stored in boxes marked October 31, 1988 and November 1, 1988, containing approximately 217 prescription orders for Schedule III through IV controlled substances, some of which prescriptions were apparently from dates other than October 1, 1988 and November 1, 1988, revealed that approximately 197 of said prescription orders, or approximately 91% of the total Schedule III through IV prescription orders exhibited one or more of the following violations: failure to indicate the patient's address in violation of 21 CFR 1306.05 (a); failure to document the prescribing practitioner's name in violation of 21 CFR 1306.05 (a); failure to document dispensing information in violation of 21 CFR 1304.24; failure to be filed in a readily retrievable manner in violation of 21 CFR 1304.04 (h)(2); failure to document accurate prescribing practitioner information such as prescribing practitioner's name or DEA registration number in violation of 21 CFR 1304.21 (a).

d. Examination of 15 selected patient profiles of Hampton Pharmacy and investigation indicated that Hampton Pharmacy and R.Ph. DeIanni dispensed unauthorized refills of controlled substances prescriptions for four patients: Patient J.B.P was dispensed 36 unauthorized refills of Lomotil, Diazepam, Esgic with Codeine during the period from October 3, 1988 to June 12, 1989; Patient B.M. was dispensed an unauthorized refill of Acetaminophen with Codeine on October 11, 1988; Patient P.H. was dispensed 35 unauthorized refills of Fiorinal and Xanax during the period from October 8, 1988 to May 11, 1989; and Patient I.H., wife of Patient P.H., was dispensed 21 unauthorized refills of Fiorinal during the period from October 7, 1988 to June 13, 1989, all in violation of 21 USC 841 (a)(1). R.Ph. DeIanni acknowledged to investigator Federico that he believed patients P.H and I.H. "were addicted to the stuff".

e. DEA investigators found that from the period of March 1989 through July 1989, Hampton Pharmacy failed to have readily retrievable a controlled substances refill history or daily refill printout in violation of 21 CFR 1306.22 (b).

f. Hampton Pharmacy refilled prescription order No. 23094, for Fiorinal, a Schedule III controlled substance more than 5 times, in violation of 21 CFR 1306.22 (a).

g. DEA investigators reviewed dispensing records for over-the-counter dispensing of Schedule V cough syrups for the period October 3, 1988 to March 8, 1989, for 8 randomly selected customers of Hampton Pharmacy, and found that Hampton Pharmacy on 107 occasions sold more that 4 ounces or 120 cc. of Schedule V cough syrups to the same individual within a given 48 hour period in violation of 21 CFR 1306.32.

h. DEA investigators examined controlled substances invoices and determined that approximately 99% of the Schedule III through IV controlled substances invoices from March 1987 through March 1989 failed to document the date received, in violation of 21 CFR 1304.21 (d).

10. On August 21, 1990, Respondents sold a bottle containing approximately 60 cc. of the cough syrup, Tussar-2, a Schedule V controlled substance, to an employee of the Department of Regulation & Licensing without the involvement of a pharmacist in any manner in the dispensing and sale of the cough syrup.

11. From July 6, 1990 through August 21, 1990, Respondents failed to record in the Schedule V controlled substance nonprescription dispensing record, the amount for any sale of Schedule V controlled substances dispensed by Respondents.

12. From October 3, 1989 through July 16, 1990, Respondents dispensed Dilaudid tablets, 4 mg., a narcotic Schedule II controlled substance, to a patient, S.K., on at least 86 occasions without contacting the prescribing practitioner to inquire and confirm the legitimacy and authenticity of such prescription orders. All prescriptions after December, 1989 were for Dilaudid, 4 mg., #40, sig 1 tablet every 4 to 6 hours prn for pain, and were dated or presented on average every 2 to 3 days. Most of the 86 prescription orders were written on prescription order blanks that appear to be photocopied. At least 80 of the prescription orders purport to be written by Robert S. Chudnow, M.D. Dr. Chudnow did not write any of the prescriptions examined. Therefore, all of the aforesaid 80 prescription orders purporting to be written by Dr. Chudnow and dispensed by Hampton Pharmacy and R.Ph. DeIanni are forged prescriptions. Dr. Chudnow and his staff indicated that they never received a contact from Hampton Pharmacy concerning the legitimacy of prescriptions for Patient S.K.

13. Complainant's examination of 10 prescription orders obtained from Respondents show that from July 10, 1990 to August 20, 1990, Respondents dispensed Percodan or Percocet tablets, #100, with directions sig 1 every 4 hours prn for pain, each for a different patient without contacting the purported prescribing practitioner to inquire and confirm the legitimacy and authenticity of such prescription orders. One of the orders was for a male patient. Each of the prescription orders purport to be from the same physician, Benjamin M. Victoria, Jr., M.D., and each order has printed on the face of the order the physician specialty of "OB-GYN". None of the orders bear the handwriting or signature of Dr. Victoria. None of the patients on the prescription orders were patients of Dr. Victoria's at the time of the dispensing of the subject prescription orders. Dr. Victoria's office was not contacted by Hampton Pharmacy concerning the legitimacy of any of the aforesaid prescription orders.

14. Complainant's examination of 50 prescription orders obtained from Respondents show that from May 16, 1990 through August 10, 1990, Respondents dispensed Percodan or Percocet tablets, #100, with directions sig 1 every 4 hours prn for pain, for various patients. The prescription orders purport to be from Dr. Michael Gilman, or Dr. Daniel Gilman, each an obstetrician/gynecologist. Forty-one of the prescription orders are written for male patients. None of the aforesaid prescription orders were written by or authorized by either Dr. Michael Gilman or Dr. Daniel Gilman. Each of Dr. Michael Gilman, Dr. Daniel Gilman and Dr. Leon Gilman, all of the same clinic, Ansfield-Gilman Clinic, advised that he has never received a contact from Hampton Pharmacy concerning the legitimacy of any prescription orders. Further, Dr. Michael Gilman and Dr. Daniel Gilman each advised that he is an Ob/Gyn specialist and does not see male patients or write prescriptions for male patients. All of the aforesaid prescription orders are forgeries.

15. Complainant's examination of 4 prescription orders obtained from Respondents show that from July 31, 1990 through August 6, 1990, Respondents dispensed Percocet tablets, #100, with directions sig one every 6 or 8 hours prn for pain, to various patients without first contacting the purported prescribing practitioner to inquire and confirm the authenticity and legitimacy of such prescription orders. Each of the prescription orders purport to be from the same physician, Steven J. Kaplan, M.D. Each of the prescription orders are written on prescription blanks that appear to be photocopied blanks. None of the 4 prescriptions were written by Steven J. Kaplan, M.D. None of the patients on the purported prescription orders were patients of Dr. Kaplan. Dr. Kaplan's office did not receive any contact from Hampton Pharmacy concerning the legitimacy of the prescription orders. The aforesaid prescription orders are forgeries.

16. Complainant's examination of 21 prescription orders obtained from Respondents show that from July 24, 1990 through August 20, 1990, Respondents dispensed Percocet or Percodan tablets, #100, with directions sig 1 every 4 to 6 hours prn for pain, to various patients without first contacting the purported prescribing practitioner to inquire and confirm the authenticity and legitimacy of such prescription orders. Each of the prescription orders purport to be from the same physician, William P. McDaniel, M.D. Some of the prescription orders are written on prescription blanks that appear to have been photocopied. None of the purported prescriptions were written by Dr. McDaniel. All of the aforesaid prescription orders are forgeries. Dr. McDaniel's office was not contacted by Hampton Pharmacy, Inc., concerning the legitimacy of the aforesaid prescription orders.

17. Complainant's examination of 44 prescription orders obtained from Respondents show that from March 27, 1990 through August 18, 1990, Respondents dispensed Percocet or Percodan tablets, 2 for #50 and 42 for #100 with directions sig one every 4 or 4 to 6 hours prn for pain, for various patients without first contacting the purported prescribing practitioner to inquire and confirm the authenticity and legitimacy of such prescriptions. Each of the prescription orders are on prescription blanks from St. Michael Hospital Pharmacy and purport to be from either John Rosebush, M.D., or James Scott Miller, M.D. The 44 prescription orders are written on prescription order blanks which are obviously photocopied. All of the 44 prescription orders lack a hospital identification number which the hospital places on original prescription order blanks. The hospital does not have a James Scott Miller, M.D. on its staff, nor is there a record of a James Scott Miller, M.D., ever having been licensed in the state of Wisconsin. All of the aforesaid prescription orders appear to be forgeries.

18. In January, 1991 Respondents purchased 22 bottles of Temazepam 30 mg. capsules, 100 capsules each, 200 tabs Acetaminophen with Codeine; 2,000 tablets APAP with Codeine; 500 tablets Propoxyphene; and 100 tablets Xanax, all controlled substances. On March 4, 1991, DEA investigators inspected Hampton Pharmacy and questioned R.Ph. DeIanni regarding accountability for the aforesaid controlled substances purchased in January 1991. The DEA investigators found that the Temazepam capsules were not in the pharmacy area; that there were no prescription orders to account for dispensing of Temazepam, and the Respondents could not otherwise account for the 2,200 Temazepam 30 mg. capsules. Also the full amounts of the Acetaminophen with Codeine, APAP with Codeine, Propoxyphene, and Xanax could not be found in the pharmacy nor were accounted for by Respondents.

19. On April 17, 1991, while the sundry outlet portion of the business premises of Hampton Pharmacy were open for business to the general public, from approximately 10:00 a.m. to 12:30 p.m., Respondents left the professional service area of the pharmacy open and unsecure, without any barrier in place, and with no licensed pharmacist present in the premises.

CONCLUSIONS OF LAW

1. The Pharmacy Examining Board has jurisdiction in this matter pursuant to s. 450.10 (1) Wis. Stats., and s. Phar 10.03 Wis. Adm. Code.

2. Respondents, by having stated in the Notice of Compliance issued by the Department of Regulation and Licensing dated December 15, 1987, that all outdated drugs had been removed from the pharmacy shelves for destruction, when in fact the outdated drugs had not been removed from the shelves, as described in Finding of Fact #6 herein, violated s. Phar 10.03 (11) Wis. Adm. Code, and s. 450.10 (1) Wis. Stats.

3. Respondents, by having prepared for dispensing five prepackaged bottles of Hycodan syrup, a Schedule III controlled substance, for delivery to a patient without a prescription order from a practitioner authorizing the dispensing of such substance, as described in Finding of Fact #7 herein, violated ss. 161.38 (3) and 450.11 (1) Wis. Stats., and s. Phar 8.05 (2) Wis. Adm. Code.

4. Respondent, Hampton Pharmacy, Inc., by having been found by the U.S. Department of Justice, Drug Enforcement Administration on April 22, 1991 to have violated federal regulations concerning controlled substances dispensing and record keeping, as described in Finding of Fact #8 herein, violated laws substantially related to the practice of pharmacy under s. Phar 10.03 (1), Wis. Adm. Code and s. 450.10 (1)(a) Wis. Stats.

5. Respondent, Hampton Pharmacy, Inc., by having been found by the U.S. Department of Justice, Drug Enforcement Administration to have violated federal regulations concerning controlled substances dispensing and record keeping, as described in Finding of Fact #9 herein, violated laws substantially related to the practice of pharmacy under s. Phar 10.03 (1) Wis. Adm. Code and s. 450.10 (1)(a) Wis. Stats.

6. The conduct of Respondents, as described in Finding of Fact #10 herein, in violating s. 161.23 (2) Wis. Stats., and 21 CFR 1306.32 (a), by dispensing Tussar-2, a Schedule V controlled substance to an individual without the involvement of a pharmacist in any manner in the dispensing and sale of the cough syrup constitutes violations of laws substantially related to the practice of pharmacy under s. Phar 10.03 (1) Wis. Adm. Code, and s. 450.10(1)(a)2 Wis. Stats.

7. The conduct of the Respondents, as described in Finding of Fact #11 herein, in violating s. 161.23 (4) Wis. Stats., and 21 CFR 1306.32 (e), by failing to record in the Schedule V controlled substance nonprescription dispensing record, from July 6, 1990 through August 21, 1990, the amount of any sales of Schedule V controlled substances dispensed constitutes violations of laws substantially related to the practice of pharmacy under s. Phar 10.03 (1), Wis. Adm. Code, and s. 450.10 (1)(a)2 Wis. Stats.

8. The conduct of Respondents, as described in Findings of Fact #12-17, in dispensing Schedule II drugs pursuant to prescriptions order without first contacting the purported prescribing practitioner to inquire and confirm the authenticity and legitimacy of the prescriptions is conduct which falls below minimal standards of competent practice of pharmacy; constitutes a danger to the health, welfare and safety of patient and public; constitutes conduct that substantially departs from the standard of care ordinarily exercised by a pharmacist; constitutes dispensing of drugs other than in legitimate practice or as prohibited by law, and constitutes violations of s. 161.38 Wis. Stats., ss. Phar 8.04 (1) and 8.05 (1), (2) and (4) and Phar 10.03 (1), (3) and (4), Wis. Adm. Code.

9. The conduct of the Respondents, as described in Finding of Fact #18 herein, in failing to account for controlled substances in violation of 21 CFR 1304.21 and s. Phar 8.02 Wis. Adm. Code constitutes violations of laws substantially related to the practice of pharmacy under s. 450.10 (1)(a)2 Wis. Stats., and s. Phar 10.03 (1) Wis. Adm. Code.

10. Respondents' conduct, as described in Finding of Fact #19 herein, in violation of s. Phar 6.04 (3) Wis. Adm. Code by leaving the professional service area of the pharmacy open and unsecure, without any barrier in place, and without a licensed pharmacist present in the premises, while the sundry outlet portion of the business premises were open for business to the general public constitutes violations of laws substantially related to the practice of pharmacy under s. Phar 10.03 (1) Wis. Adm. Code, and s. 450.10 (1)(a)2 Stats.

ORDER

NOW, THEREFORE, IT IS ORDERED that the pharmacy license of HAMPTON PHARMACY, INC., #6527, be and hereby is **REVOKED.** Hampton Pharmacy, Inc., and Salvatore R. DeIanni, as owner and managing pharmacist thereof shall immediately forward to the Pharmacy Examining Board all indicia of licensure heretofore issued to Hampton Pharmacy, Inc., to operate as a pharmacy in the State of Wisconsin.

IT IS FURTHER ORDERED that:

1. The license to practice pharmacy issued to SALVATORE R. DeIANNI, date of birth March 31, 1939, of 4151 South 103rd Street, Milwaukee, Wisconsin, license #7565, shall be and hereby is **REVOKED.** Salvatore R. DeIanni shall forward immediately to the Pharmacy Examining Board all indicia of licensure heretofore issued to him to practice pharmacy in the State of Wisconsin.

2. Pursuant to s. 450.10 (2) Wis. Stats., Salvatore R. DeIanni is hereby assessed and ordered to pay a forfeiture of $32,000.00 (Thirty-two Thousand Dollars).

3. Pursuant to s. 440.22 Wis. Stats., the costs of this proceeding shall be assessed against Respondents, and shall be payable by them to the Department of Regulation and Licensing.

This order is effective on the date on which it is signed by the Pharmacy Examining Board or its designee.

OPINION

I. UNPROFESSIONAL CONDUCT

A) Finding of Unprofessional Conduct

Unprofessional conduct as defined in s. 450.10 (1) Wis. Stats., and sec. Phar 10.03 Wis. Adm. Code, includes but is not limited to, administering, dispensing, supplying or obtaining a drug other than in legitimate practice, or as prohibited by law; engaging in any pharmacy practice which constitutes a danger to the health, welfare, or safety of patient or public; providing false information to the Pharmacy Examining Board or its agent, and violating Chapters 450 or 161 Wis. Stats., or any federal or state statute or rule which substantially relates to the practice of pharmacy.

The evidence presented in this case establishes that the Respondents engaged in unprofessional conduct as defined in s. 450.10 (1) Wis. Stats., and s. Phar 10.03 Wis. Adm. Code.

Respondents were properly served with a copy of the Notice of Hearing and Complaint on April 26, 1991, but elected not to file an Answer to the Complaint. (Tran. p.5, lines 19-25; p. 6, lines 1-3; Exhibits #1 and 2). Respondents by having failed to deny the allegations stated in the Complaint admitted such allegations.

Based upon Respondents' admissions, the affidavit of Robert Schwartz, R.Ph., (Exhibit #4), and additional evidence presented at the hearing, it can be concluded that the Respondents' conduct as described in the proposed Findings of Fact constitutes unprofessional conduct.

B) Analysis of Evidence

(1) General Overview

The evidence presented establishes that the Pharmacy Examining Board granted a pharmacist license to Respondent, Salvatore R. DeIanni, R.Ph., on October 31, 1966. In December, 1980, Respondent DeIanni was convicted of knowingly delivering without a prescription Diazepam, a controlled substance, to a City of Milwaukee police officer on three separate occasions in June, 1980. On June 15, 1982, based upon Respondent's criminal conviction, the Pharmacy Examining Board suspended his pharmacist license for an indefinite period of not less than one year, effective July 15, 1982. The Board order permitted DeIanni to reinstate his license after one year upon application and upon successful completion of the jurisprudence examination administered by the board to determine applicants' familiarity with Wisconsin and federal laws and regulations governing the practice of pharmacy.

There is no evidence in the record regarding the conduct of DeIanni, R.Ph., during the time period from October 31, 1966, the day on which the Board first granted Respondent a pharmacist license and June, 1980, the month during which Respondent delivered Diazepam to a City of Milwaukee police office.

In January, 1984, the Board granted a pharmacy license to Hampton Pharmacy, Inc., At all times relevant to this proceeding, Respondent DeIanni owned 50% interest in the pharmacy and his wife, Jeanne L. DeIanni owned the remaining 50% interest in the pharmacy.

No evidence was presented at the hearing regarding Respondents' conduct or practices during the time period from 1984 to 1987. The evidence presented at the hearing relates primarily to Respondents' conduct and practices between the time period from March, 1987 to April, 1991, involving violations of federal law as cited in the Justice Department findings and order, and violations of numerous provisions of Chapters 161 and 450 Wis. Stats., and Chapters Phar 6, 8 and 10 Wis. Adm. Code. Respondents' conduct and practices involving violations of Wisconsin statutes and regulations can be summarized as follows:

1) Improper dispensing of controlled substances;
2) Providing false information to the Board;
3) Failure to account for controlled substances;
4) Leaving the professional service area of the pharmacy open and unsecure and without a licensed pharmacist on the premises; and
5) Failure to comply with record keeping requirements.

In March, 1991, the U.S. Department of Justice, Drug Enforcement Administration, revoked the DEA Certificate of Registration of Hampton Pharmacy, Inc., effective April 22, 1991, for violations of federal regulations concerning controlled substances dispensing and record keeping. The Justice Department's action was based upon an investigation conducted by the Drug Enforcement Administration in 1989, relating to Respondents' practices between the time period from May, 1987 to at least July, 1989. (Findings of Fact #8-9).

(2) Violations

The Complaint filed in this matter alleges and the evidence establishes that Respondents' conduct and practices as described in the proposed Findings of Fact constitutes unprofessional conduct in violations of s. 450.10 (1) Wis. Stats., and s. Phar 10.03 Wis. Adm. Code. Discussions regarding specific violations are set forth below.

(a) Violations of Substantially Related Law

The Complainant alleges in Counts I-IX of the Complaint that the Respondents violated state and federal laws which substantially relate to the practice of pharmacy, in violation of s. 450.10 (1)(a)2 Wis. Stats., and s. Phar 10.03 (1) Wis. Adm. Code.

Respondents' conduct involving violations of state statutes is described in Finding of Fact #7 (s. 161.38(3) and s. 450.11(1) Stats), Finding of Fact #11 (s. 161.23 (4) Stats), and Findings of Fact #12-17 (s. 161.38 Stats). Respondents' conduct involving violations of state rules is described in Findings of Fact #6 and 7 (s. Phar 10.03 (11) and 8.05), Findings of Fact #12-17 (s. Phar 8.04 (1), and 8.05 (1)(2) and (4) Wis. Adm. Code), and in Findings of Fact #18-19 (s. Phar 6.04 (3) and 8.02). In reference to federal regulations, refer to Findings of Fact #8, 9 and 18.

(b) Conduct Dangerous to Patient or Public

The Complainant alleges in Count VII of the Complaint that the Respondents engaged in conduct which constituted a danger to the health, welfare, or safety of patient or public, including but not limited to, practicing in a manner which substantially departs from the standard of care ordinarily exercised by a pharmacist which harmed or could have harmed a patient, in violation of sec. Phar 10.03 (4) Wis. Adm. Code.

Respondents' conduct as set forth in Count VII of the Complaint and proposed Findings of Fact #12-17 herein involves the dispensing of control substances to patients without first contacting the prescribing practitioner to inquire and confirm the authenticity and legitimacy of the prescriptions. Respondents dispensed drugs for at least 215 prescription orders (129 orders for Percodan or Percocet tablets #50 or #100, and 86 orders for Dilaudid tablets, 4mg.) most of which were dispensed during the time period from March, 1990 to August, 1990. In most cases the prescription orders are written on prescription order blanks that appear to be photocopies, and purport to be written by practitioners who when questioned by the Complainant, indicated that they did not write the orders and that the Respondents had not been in contact with them regarding the legitimacy of the orders.

Based upon the opinion of Robert Schwartz, R.Ph., an expert witness who offered evidence at the request of the Complainant, the Respondents' conduct as described in Count VII of the Complaint and as summarized in his affidavit is below minimal competent practice of pharmacy, constitutes a danger to the health, welfare and safety of the patient, and public and departs from the standard of care ordinarily exercised by a pharmacist which could harm a patient. R.Ph. Schwartz's conclusions are based upon his opinion that Dilaudid, Percocet and Percodan are Schedule II narcotic drugs that have a high abuse potential and are commonly known to be highly sought after by drug abusers and abuse of which may cause and promote drug dependency. (Ex. #4).

(c) Improper Dispensing of Drugs

The Complainant alleges in Count VII of the Complaint that Respondents dispensed drugs other than in legitimate practice, or as prohibited by law, in violation of sec. Phar 10.03 (3) Wis. Adm. Code.

Respondents' conduct as described in Findings of Fact #12-17, involves the dispensing of controlled substances to patients without first contacting the prescribing practitioner to inquire or confirm the authenticity and legitimacy of the prescriptions.

(d) Providing False Information

The Complainant alleges in Count I of the Complaint that Respondent DeIanni provided false information to the Pharmacy Examining Board or its agent, in violation of sec. Phar 10.03 (11) Wis. Adm. Code.

The evidence establishes that in December, 1987, R. Ph. DeIanni represented to Investigator Krudwig, an employee of the Department of Regulation and Licensing, that outdated drugs had been removed from the pharmacy shelves for destruction, when in fact such drugs had not been removed from the shelves. Investigator Krudwig revisited the pharmacy in August, 1989, and observed that the outdated drugs which R.Ph. DeIanni represented had been taken off the shelves for destruction had never been removed. (Finding of Fact #6).

II. DISCIPLINARY MEASURES

Having found that the Respondents engaged in unprofessional conduct, a determination must be made regarding whether discipline should be imposed and, if so, what discipline is appropriate.

The Pharmacy Examining Board is authorized under s. 450.10 (1)(b) Wis. Stats., to reprimand a licensee, deny, revoke, suspend or limit the license or any combination thereof, of any person licensed under Ch. 450 Stats., who engages in unprofessional conduct. In addition to or in lieu of reprimand or denial, limitation, suspension or revocation of a license under s. 450.10 (1)(b) Stats., the Board is also authorized under s. 450.10 (2) Stats., to assess a forfeiture of not more than $1,000 for each separate offense against a licensee who engages in unprofessional conduct.

The purposes of discipline by occupational licensing boards are to protect the public, deter other licensees from engaging in similar misconduct, and to promote the rehabilitation of the licensee. State v. Aldrich, 71 Wis. 2d 206 (1976). Punishment of the licensee is not a proper consideration. State v. MacIntyre, 41 Wis. 2d 481 (1969).

III. RECOMMENDATIONS REGARDING DISCIPLINE

The Administrative Law Judge recommends that the Pharmacy Examining Board revoke Respondents' licenses and assess and order Respondent, Salvatore R. DeIanni, R.Ph., to pay a forfeiture in the amount of $32,000.00.

The Complainant recommends that the Board revoke Respondents' licenses and assess forfeiture in an amount between $10,000 and $30,000. Respondents offer to voluntarily surrender their licenses and request that the Board not assess forfeiture.

The evidence presented establishes that the Respondents' conduct as described in the proposed Findings of Fact constitutes unprofessional conduct; that the revocation of Respondents' licenses is warranted to insure protection of the public, and that the assessment of forfeiture is an appropriate measure to deter other licensees from engaging in similar misconduct.

In reference to revocation of Respondents licenses, it is clear from the evidence that the imposition of any discipline short of revocation will leave the public virtually unprotected. Respondent, DeIanni has shown by his conduct that he does not intend to meet or to maintain the standard of conduct required for the practice of pharmacy. Respondent obviously has the intellectual capacity to grasp the knowledge and information required to meet and maintain the standards, but evidently lacks the desire. It appears from the evidence that DeIanni's primary interest or concern in the practice of pharmacy is that of a pecuniary nature. DeIanni has been presented with numerous opportunities to show that he is capable of practicing pharmacy in a manner consistent with established standards, but has failed to do so.

In 1982, the Board suspended DeIanni's pharmacist license for an indefinite period of not less than one year, based upon his conviction in 1980 for knowingly delivering without a prescription Diazepam, a controlled substance, to a City of Milwaukee police officer. The Board order permitted DeIanni to resume the practice of pharmacy upon successful completion of the jurisprudence examination administered by the board to determine applicants' familiarity with Wisconsin and federal laws and regulations governing the practice of pharmacy. DeIanni was presented with an opportunity at that time to meet and maintain the standard of conduct established by the Board.

In December, 1987, James Krudwig, a Compliance Investigator with the Department of Regulation and Licensing issued a Notice of Compliance to Respondents. In response to the Notice, DeIanni, R.Ph., represented to Investigator Krudwig that all outdated drugs had been removed from the pharmacy shelves, when in fact the drugs had not been removed and were still on the pharmacy shelves in August, 1989, when Investigator Krudwig revisited the pharmacy. DeIanni was presented with another opportunity to modify his conduct and to maintain the applicable standards of practice.

Finally, in 1989, the U.S. Department of Justice, Drug Enforcement Administration conducted an investigation of Hampton Pharmacy, Inc., and found numerous violations of federal laws relating to controlled substances purchases, dispensing and record keeping requirements. Respondent DeIanni was presented with yet another opportunity to modify his conduct and comply with applicable standards. Yet, after the Justice Department's 1989 investigation, Delanni continued to disregard state and federal laws relating to the practice of pharmacy. (Findings of Fact #8 and 9; Exhibit #1).

Between March, 1990 and August, 1990 Respondents dispensed drugs for 215 prescription orders (129 orders for Percodan or Percocet tablets #50 and #100, and 86 orders for Dilaudid tablets, 4 mg.) to various patients without first contacting the prescribing practitioners to inquire and confirm the authenticity and legitimacy of the prescriptions. In most cases, the prescription orders are written on prescription order blanks that appear to be photocopies and purport to be written by practitioners who when questioned by Complainant indicate that they did not write the prescription orders, and that the Respondents had not contacted them regarding the legitimacy of the orders. (Findings of Fact #12-17; Exhibit #4).

From July 6, 1990 to August 21, 1990 Respondents failed to record in the Schedule V controlled substance nonprescription dispensing record, the amount for any sale of Schedule V controlled substances dispensed by Respondents. (Finding of Fact #11).

In addition, on August 21, 1990, Respondents sold a bottle containing approximately 60 cc. of the cough syrup, Tussar-2, a Schedule V controlled substance, to an employee of the Department of Regulation & Licensing without the involvement of a pharmacist in any manner in the dispensing and sale of the cough syrup. (Finding of Fact #10).

In January, 1991 Respondents purchased 22 bottles of Temazepam 30 mg. capsules, 100 capsules each, 200 tabs Acetaminophen with Codeine; 2,000 tablets APAP with Codeine; 500 tablets Propoxyphene; and 100 tablets Xanax, all controlled substances. On March 4, 1991, DEA investigators inspected Hampton Pharmacy and questioned R.Ph. DeIanni regarding accountability for the aforesaid controlled substances purchased in January 1991. The DEA investigators found that the Temazepam capsules were not in the pharmacy area; that there were no prescription orders to account for dispensing of Temazepam, and the Respondents could not otherwise account for the 2,200 Temazepam 30 mg. capsules. Also the full amounts of the Acetaminophen with Codeine, APAP with Codeine, Propoxyphene, and Xanax could not be found in the pharmacy nor were accounted for by Respondents. (Finding of Fact #18).

Finally, on April 17, 1991, (approximately 5 days before the effective date of the DEA order providing for the revocation of the Certificate of Registration of Hampton Pharmacy,Inc.) Respondents left the professional service area of the pharmacy open and unsecure, without any barrier in place, and with no licensed pharmacist present in the premises while the sundry outlet portions of the business premises of Hampton Pharmacy were open for business to the general public, from approximately 10:00 a.m. to 12:30 p.m. (Finding of Fact #19).

Despite the fact that three governmental agencies were monitoring Respondents' conduct and practices, each at various points in time over a period of at least four years, Respondents continued to violate state and federal laws relating to the practice of pharmacy. Based upon Respondents' repeated and continued violations of state and federal laws relating to the practice of pharmacy, revocation of Respondents' licenses is the most appropriate measure available to insure protection of the public.

In reference to the assessment of forfeiture, the Administrative Law Judge recommends that the Respondent, Salvatore R. DeIanni, R.Ph., be required to pay a forfeiture in the amount of $32,000.00. Such assessment will deter other licensees from engaging in similar misconduct, and is designed to send a clear message to other licensees that the type of conduct and practices which Respondents' engaged in, as described in the proposed Findings of Fact, is illegal and will not be tolerated in this state.

The recommended forfeiture of $32,000.00 is based upon an adoption of the category of violations identified by the Complainant for purposes of suggesting a range of forfeiture (refer to Complainant's Final Argument, p.7). The range of forfeiture for each category was determined as follows:

1. Filling or refilling controlled substances prescription orders without proper authorization of a practitioner. For violations based upon conduct described in each of Findings of Fact #7, 8 and 9: (3 x $2,000) or **$6,000**.

2. Filling forged controlled substances prescriptions. For violations based upon conduct described in each of Findings of Fact #12,13,14,15,16 and 17: (6 x $1,000) or **$6,000**.

3. Failure to account for missing controlled substances. For violations based upon conduct described in each of Findings of Fact #8, 9 and 19: (3 x $2,000) or **$6,000**.

4. Schedule V controlled substances "48 hour violations". For violations based upon conduct described in Finding of Fact #9: **$3,000**.

5. Failure to have on file and available for inspection and copying controlled substances inventory records. For violations based upon conduct described in Findings of Fact #8 and 9: (2 x $1,000) or **$2,000**.

6. Other controlled substances record keeping violations. For violations based upon conduct described in Findings of Fact #8, 9 and 11: (3 x $1,000) or **$3,000**.

7. Providing false information to an investigative agent of the Board. For violations based upon conduct described in Finding of Fact #6: **$4,000**.

8. Allowing a non-pharmacist to dispense Schedule V controlled substances. For violations based upon conduct described in Finding of Fact #10: **$1,000**.

9. Keeping the pharmacy open and unsecured without a pharmacist present. For violations based upon conduct described in Finding of Fact #19: **$1,000**

Respondents' actions were numerous, flagrant, in total disregard of the law and resulted in substantial financial benefit. The violations cited in this case are precisely the type of violations which the Legislature intended to address in enacting the forfeiture provision in Ch. 450 Stats. The amount of forfeiture is reasonable given the number, type and severity of the violations, the culpability of DeIanni, R.Ph., and the economic benefit which accrued to Respondents. See, State v. Schmitt, 145 Wis. 2d 724 (1988).

Based upon the evidence presented and the discussions set forth herein, the Administrative Law Judge recommends that the Pharmacy Examining Board adopt as its final decision in this matter, the proposed Findings of Fact, Conclusions of Law and Order as set forth herein.

Dated at Madison, Wisconsin this 5th day of December, 1991.

Respectfully submitted,

Ruby Jefferson-Moore

Ruby Jefferson-Moore
Administrative Law Judge

NOTICE OF APPEAL INFORMATION

(Notice of Rights for Rehearing or Judicial Review, the times allowed for each, and the identification of the party to be named as respondent)

The following notice is served on you as part of the final decision:

1. Rehearing.

Any person aggrieved by this order may petition for a rehearing within 20 days of the service of this decision, as provided in section 227.49 of the Wisconsin Statutes, a copy of which is attached. The 20 day period commences the day after personal service or mailing of this decision. (The date of mailing of this decision is shown below.) The petition for rehearing should be filed with the State of Wisconsin Pharmacy Examining Board.

A petition for rehearing is not a prerequisite for appeal directly to circuit court through a petition for judicial review.

2. Judicial Review.

Any person aggrieved by this decision has a right to petition for judicial review of this decision as provided in section 227.53 of the Wisconsin Statutes, a copy of which is attached. The petition should be filed in circuit court and served upon the State of wisconsin Pharmacy Examining Board

within 30 days of service of this decision if there has been no petiti n for rehearing, or within 30 days of service of the order finally disposing of the petition for rehearing, or within 30 days after the final disposition by operation of law of any petition for rehearing.

The 30 day period commences the day after personal service or mailing of the decision or order, or the day after the final dispositi n by operation of the law of any petition for rehearing. (The date of mailing of this decision is shown below.) A petition for judicial review should be served upon, and name as the respondent, the following: the State of Wisconsin Pharmacy Examining Board.

The date of mailing of this decision is February 14,1992.