

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

In the Matter of the Accusation Against:

**L & S PHARMACY, INC. (dba VALLEY
PHARMACY OF SACRAMENTO), LELAND
KWONG MA, OWNER
7600 Hospital Drive, Suite A
Sacramento, CA 95823**

Pharmacy Permit No. PHY 49845,

**LEONARD KWONG MARR
7600 Hospital Drive, Suite A
Sacramento, CA 95823**

Pharmacist License No. RPH 36980

and

**LELAND KWONG MA
17215 Horst Avenue
Cerritos, CA 90703**

Pharmacist License No. RPH 32234

Case No. 5886

OAH No. 2017030485

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER AS TO:**

RESPONDENT LELAND KWONG MA

Respondents.

DECISION AND ORDER

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

This Decision shall become effective at 5:00 p.m. on January 12, 2018.

It is so ORDERED on December 13, 2017.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA



By

Amy Gutierrez, Pharm.D.
Board President

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Attorney General of California
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11 **STATE OF CALIFORNIA**

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17 **Sacramento, CA 95823**

18 **Pharmacy Permit No. PHY 49845,**

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22 **Pharmacist License No. RPH 36980,**

23 **and**

24 **LELAND KWONG MA**
25 **17215 Horst Avenue**
26 **Cerritos, CA 90703**

27 **Pharmacist License No. RPH 32234**

28 Respondents.

Case No. 5886

OAH No. 2017030485

STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER AS TO:

RESPONDENT LELAND KWONG MA
ONLY

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

PARTIES

1. Virginia Herold (Complainant) is the Executive Officer of the Board of Pharmacy

1 (Board). She brought this action solely in her official capacity and is represented in this matter by
2 Xavier Becerra, Attorney General of the State of California, by Daniel D. McGee, Deputy Attorney
3 General.

4 2. Respondent Leonard Kwong Marr (Respondent) is represented in this proceeding by
5 attorney Tony J. Park, Pharm.D, J.D., whose address is:

6 California Pharmacy Lawyers
7 49 Discovery, Suite 240
8 Irvine, CA 92618-6713

9 3. On or about August 7, 1978, the Board issued Pharmacist License No. RPH 32234 to
10 Leland Kwong Ma (Respondent). The Pharmacist License was in full force and effect at all times
11 relevant to the charges brought in Accusation No. 5886, and will expire on February 28, 2018,
12 unless renewed.

12 JURISDICTION

13 4. Accusation No. 5886 was filed before the Board, and is currently pending against
14 Respondent. The Accusation and all other statutorily required documents were properly served on
15 Respondent on December 19, 2016. Respondent timely filed his Notice of Defense contesting the
16 Accusation.

17 5. A copy of Accusation No. 5886 is attached as Exhibit A and incorporated herein by
18 reference.

19 ADVISEMENT AND WAIVERS

20 6. Respondent has carefully read, fully discussed with counsel, and understands the
21 charges and allegations in Accusation No. 5886. Respondent has also carefully read, fully
22 discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary
23 Order.

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

1 accorded by the California Administrative Procedure Act and other applicable laws.

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

4 CULPABILITY

5 9. Respondent understands and agrees that the charges and allegations in Accusation No.
6 5886, if proven at a hearing, constitute cause for imposing discipline upon his Pharmacist License.

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

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

13 CONTINGENCY

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

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

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

1 negotiations, and commitments (written or oral). This Stipulated Settlement and Disciplinary Order
2 may not be altered, amended, modified, supplemented, or otherwise changed except by a writing
3 executed by an authorized representative of each of the parties.

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

7 **DISCIPLINARY ORDER**

8 IT IS HEREBY ORDERED that Pharmacist License No. RPH 32234 issued to Respondent
9 Leland Kwong Ma is revoked. However, the revocation is stayed and Respondent is placed on
10 probation for four (4) years on the following terms and conditions.

11 **1. Obey All Laws**

12 Respondent shall obey all state and federal laws and regulations.

13 Respondent shall report any of the following occurrences to the Board, in writing, within
14 seventy-two (72) hours of such occurrence:

- 15 • An arrest or issuance of a criminal complaint for violation of any provision of the
16 Pharmacy Law, state and federal food and drug laws, or state and federal controlled
17 substances laws;
- 18 • A plea of guilty or nolo contendere in any state or federal criminal proceeding to any
19 criminal complaint, information or indictment;
- 20 • A conviction of any crime; and,
- 21 • Discipline, citation, or other administrative action filed by any state or federal agency
22 which involves Respondent's Pharmacist License or which is related to the practice of
23 pharmacy or the manufacturing, obtaining, handling, distributing, billing, or charging
24 for any drug, device or controlled substance.

25 Failure to timely report such occurrence shall be considered a violation of probation.

26 **2. Report to the Board**

27 Respondent shall report to the Board quarterly, on a schedule as directed by the Board or its
28 designee. The report shall be made either in person or in writing, as directed. Among other

1 requirements, Respondent shall state in each report under penalty of perjury whether there has been
2 compliance with all the terms and conditions of probation. Failure to submit timely reports in a
3 form as directed shall be considered a violation of probation. Any period(s) of delinquency in
4 submission of reports as directed may be added to the total period of probation. Moreover, if the
5 final probation report is not made as directed, probation shall be automatically extended until such
6 time as the final report is made and accepted by the Board.

7 **3. Interview with the Board**

8 Upon receipt of reasonable prior notice, Respondent shall appear in person for interviews
9 with the Board or its designee, at such intervals and locations as are determined by the Board or its
10 designee. Failure to appear for any scheduled interview without prior notification to Board staff,
11 or failure to appear for two (2) or more scheduled interviews with the Board or its designee during
12 the period of probation, shall be considered a violation of probation.

13 **4. Cooperate with Board Staff**

14 Respondent shall cooperate with the Board's inspection program and with the Board's
15 monitoring and investigation of Respondent's compliance with the terms and conditions of his
16 probation. Failure to cooperate shall be considered a violation of probation.

17 **5. Continuing Education**

18 Respondent shall provide evidence of efforts to maintain skill and knowledge as a pharmacist
19 as directed by the Board or its designee.

20 **6. Notice to Employers**

21 During the period of probation, Respondent shall notify all present and prospective employers
22 of the decision in case number 5886 and the terms, conditions and restrictions imposed on
23 Respondent by the decision, as follows:

24 Within thirty (30) days of the effective date of this decision, and within fifteen (15) days of
25 Respondent undertaking any new employment, Respondent shall cause his direct supervisor,
26 pharmacist-in-charge (including each new pharmacist-in-charge employed during Respondent's
27 tenure of employment) and owner to report to the Board in writing acknowledging that the listed
28 individual(s) has/have read the decision in case number 5886, and terms and conditions imposed

1 thereby. It shall be Respondent's responsibility to ensure that his employer(s) and/or supervisor(s)
2 submit timely acknowledgment(s) to the Board.

3 If Respondent works for or is employed by or through a pharmacy employment service,
4 Respondent must notify his direct supervisor, pharmacist-in-charge, and owner at every entity
5 licensed by the Board of the terms and conditions of the decision in case number 5886 in advance
6 of Respondent commencing work at each licensed entity. A record of this notification must be
7 provided to the Board upon request.

8 Furthermore, within thirty (30) days of the effective date of this decision, and within fifteen
9 (15) days of Respondent undertaking any new employment by or through a pharmacy employment
10 service, Respondent shall cause his direct supervisor with the pharmacy employment service to
11 report to the Board in writing acknowledging that he/she has read the decision in case number 5886
12 and the terms and conditions imposed thereby. It shall be Respondent's responsibility to ensure
13 that his employer(s) and/or supervisor(s) submit timely acknowledgment(s) to the Board.

14 Failure to timely notify present or prospective employer(s) or to cause that/those employer(s)
15 to submit timely acknowledgments to the Board shall be considered a violation of probation.

16 ~~"Employment" within the meaning of this provision shall include any full-time, part-time,~~
17 ~~temporary, relief or pharmacy management service as a pharmacist or any position for which a~~
18 ~~pharmacist license is a requirement or criterion for employment, whether Respondent is an~~
19 ~~employee, independent contractor or volunteer.~~

20 **7. No Supervision of Interns, Serving as Pharmacist-in-Charge (PIC), Serving as**
21 **Designated Representative-in-Charge, or Serving as a Consultant**

22 During the period of probation, Respondent shall not supervise any intern pharmacist, be the
23 pharmacist-in-charge or designated representative-in-charge of any entity licensed by the Board
24 nor serve as a consultant unless otherwise specified in this order. Assumption of any such
25 unauthorized supervision responsibilities shall be considered a violation of probation.

26 **8. Reimbursement of Board Costs**

27 As a condition precedent to successful completion of probation, Respondent, jointly and
28 severally with Respondents L&S Pharmacy, Inc. (dba Valley Pharmacy of Sacramento) and

1 Leonard Kwong Marr, shall pay to the Board its costs of investigation and prosecution in the
2 amount of \$20,000.00. Respondent(s) shall be permitted to pay these costs in a payment plan
3 approved by the Board or its designee. There shall be no deviation from this schedule absent prior
4 written approval by the Board or its designee. Failure to pay costs by the deadline(s) as directed
5 shall be considered a violation of probation.

6 The filing of bankruptcy by Respondent shall not relieve Respondent of his responsibility to
7 reimburse the Board its costs of investigation and prosecution.

8 **9. Probation Monitoring Costs**

9 Respondent shall pay any costs associated with probation monitoring as determined by the
10 board each and every year of probation. Such costs shall be payable to the Board on a schedule as
11 directed by the Board or its designee. Failure to pay such costs by the deadline(s) as directed shall
12 be considered a violation of probation.

13 **10. Status of License**

14 Respondent shall, at all times while on probation, maintain an active, current license with the
15 Board, including any period during which suspension or probation is tolled. Failure to maintain an
16 active, current license shall be considered a violation of probation.

17 If Respondent's license expires or is cancelled by operation of law or otherwise at any time
18 during the period of probation, including any extensions thereof due to tolling or otherwise, upon
19 renewal or reapplication Respondent's license shall be subject to all terms and conditions of this
20 probation not previously satisfied.

21 **11. License Surrender While on Probation/Suspension**

22 Following the effective date of this decision, should Respondent cease practice due to
23 retirement or health, or be otherwise unable to satisfy the terms and conditions of probation,
24 Respondent may tender his license to the Board for surrender. The Board or its designee shall have
25 the discretion whether to grant the request for surrender or take any other action it deems
26 appropriate and reasonable. Upon formal acceptance of the surrender of the license, Respondent
27 will no longer be subject to the terms and conditions of probation. This surrender constitutes a
28 record of discipline and shall become a part of the Respondent's license history with the Board.

1 Upon acceptance of the surrender, Respondent shall relinquish his pocket and wall license to
2 the Board within ten (10) days of notification by the Board that the surrender is accepted.
3 Respondent may not reapply for any license from the board for three (3) years from the effective
4 date of the surrender. Respondent shall meet all requirements applicable to the license sought as
5 of the date the application for that license is submitted to the Board, including any outstanding
6 costs.

7 **12. Notification of a Change in Name, Residence Address, Mailing Address or**
8 **Employment**

9 Respondent shall notify the Board in writing within ten (10) days of any change of
10 employment. Said notification shall include the reasons for leaving, the address of the new
11 employer, the name of the supervisor and owner, and the work schedule if known. Respondent
12 shall further notify the Board in writing within ten (10) days of a change in name, residence address,
13 mailing address, or phone number.

14 Failure to timely notify the Board of any change in employer(s), name(s), address(es), or
15 phone number(s) shall be considered a violation of probation.

16 **13. Tolling of Probation**

17 Except during periods of suspension, Respondent shall, at all times while on probation, be
18 employed as a pharmacist in California for a minimum of 40 hours per calendar month. Any month
19 during which this minimum is not met shall toll the period of probation, i.e., the period of probation
20 shall be extended by one month for each month during which this minimum is not met. During any
21 such period of tolling of probation, Respondent must nonetheless comply with all terms and
22 conditions of probation.

23 Should Respondent, regardless of residency, for any reason (including vacation) cease
24 practicing as a pharmacist for a minimum of 40 hours per calendar month in California, Respondent
25 must notify the Board in writing within ten (10) days of the cessation of practice, and must further
26 notify the Board in writing within ten (10) days of the resumption of practice. Any failure to
27 provide such notification(s) shall be considered a violation of probation.

28 It is a violation of probation for Respondent's probation to remain tolled pursuant to the

1 provisions of this condition for a total period, counting consecutive and non-consecutive months,
2 exceeding thirty-six (36) months.

3 "Cessation of practice" means any calendar month during which Respondent is not practicing
4 as a pharmacist for at least 40 hours, as defined by Business and Professions Code section 4000, *et*
5 *seq.* "Resumption of practice" means any calendar month during which Respondent is practicing
6 as a pharmacist for at least 40 hours as a pharmacist as defined by Business and Professions Code
7 section 4000, *et seq.*

8 14. Violation of Probation

9 If Respondent has not complied with any term or condition of probation, the Board shall have
10 continuing jurisdiction over Respondent, and probation shall automatically be extended, until all
11 terms and conditions have been satisfied or the Board has taken other action as deemed appropriate
12 to treat the failure to comply as a violation of probation, to terminate probation, and to impose the
13 penalty that was stayed.

14 If Respondent violates probation in any respect, the Board, after giving Respondent notice
15 and an opportunity to be heard, may revoke probation and carry out the disciplinary order that was
16 stayed. ~~Notice and opportunity to be heard are not required for those provisions stating that a~~
17 violation thereof may lead to automatic termination of the stay and/or revocation of the license. If
18 a petition to revoke probation or an accusation is filed against Respondent during probation, the
19 Board shall have continuing jurisdiction and the period of probation shall be automatically extended
20 until the petition to revoke probation or accusation is heard and decided.

21 15. Completion of Probation

22 Upon written notice by the Board or its designee indicating successful completion of
23 probation, Respondent's license will be fully restored.

24 16. Remedial Education

25 Within thirty (30) days of the effective date of this decision, Respondent shall submit to the
26 Board or its designee, for prior approval, an appropriate program of remedial education. The
27 program of remedial education shall consist of at least six unit hours to be completed in the first
28 year of probation, with 50% to be in-person, in the areas of (i) pharmacy security; and (ii)

1 corresponding responsibility and prescription drug abuse. Respondent is to receive credit for
2 satisfactory education credits obtained within the six (6) months prior to September 29, 2017.

3 The remedial education shall be completed at Respondent's own expense. All remedial
4 education shall be in addition to, and shall not be credited toward, continuing education (CE)
5 courses used for license renewal purposes.

6 Failure to timely submit or complete the approved remedial education shall be considered a
7 violation of probation. The period of probation will be automatically extended until such remedial
8 education is successfully completed and written proof, in a form acceptable to the Board, is
9 provided to the Board or its designee.

10 Following the completion of each course, the Board or its designee may require Respondent,
11 at his own expense, to take an approved examination to test the Respondent's knowledge of the
12 course. If Respondent does not achieve a passing score on the examination, this failure shall be
13 considered a violation of probation. Any such examination failure shall require Respondent to take
14 another course approved by the Board in the same subject area.

15 **17. No New Ownership.**

16 Respondent shall not acquire any new ownership, legal or beneficial interest nor serve as a
17 manager, administrator, member, officer, director, trustee, associate, or partner of any additional
18 business, firm, partnership, or corporation licensed by the Board. If Respondent currently owns or
19 has any legal or beneficial interest in, or serves as a manager, administrator, member, officer,
20 director, trustee, associate, or partner of any business, firm, partnership, or corporation currently or
21 hereinafter licensed by the Board, Respondent may continue to serve in such capacity or hold that
22 interest, but only to the extent of that position or interest as of the effective date of this decision.
23 Violation of this restriction shall be considered a violation of probation

24 **18. Ethics Course**

25 Within sixty (60) calendar days of the effective date of this decision, Respondent shall enroll
26 in a course in ethics, at Respondent's expense, approved in advance by the Board or its designee.
27 Failure to initiate the course during the first year of probation, and complete it within the second
28 year of probation, is a violation of probation.

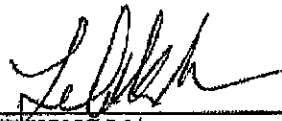
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Respondent shall submit a certificate of completion to the board or its designee within five days after completing the course.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Tony J. Park, Pharm.D., J.D. 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: 10-9-2017



LELAND KWONG MA
Respondent

I have read and fully discussed with Respondent Leland Kwong Ma the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 10/09/2017



TONY J. PARK, PHARM.D., J.D.
Attorney for Respondent

ENDORSEMENT

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

Dated: 10/13/2017

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JANICE K. LACHMAN
Supervising Deputy Attorney General



DANIEL D. MCGEE
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 5886

1 KAMALA D. HARRIS
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Supervising Deputy Attorney General
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Attorneys for Complainant

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A C C U S A T I O N

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18 Pharmacist License No. RPH 36980,

19 and

20 **LELAND KWONG MA**
21 17215 Horst Avenue
Cerritos, CA 90703

22 Pharmacist License No. RPH 32234

23 Respondents.
24

25 Complainant alleges:

26 **PARTIES**

27 1. Virginia Herold (Complainant) brings this Accusation solely in her official capacity
28 as the Executive Officer of the California State Board of Pharmacy ("Board"), Department of

1 Consumer Affairs.

2 2. On or about April 1, 2009, the Board issued Pharmacy Permit Number PHY 49845
3 to L & S Pharmacy, Inc. to do business as Valley Pharmacy of Sacramento ("Valley Pharmacy")
4 with Leland Kwong Ma as President and 100% shareholder and Leonard Kwong Marr designated
5 as the Pharmacist-in-Charge (PIC) since April 1, 2009. The Pharmacy Permit was in full force
6 and effect at all times relevant to the charges brought herein and will expire on April 1, 2017,
7 unless renewed.

8 3. On or about August 18, 1982, the Board issued Original Pharmacist License Number
9 RPH 36980 to Leonard Kwong Marr ("Marr"). The pharmacist license was in full force and
10 effect at all times relevant to the charges brought herein and will expire on June 30, 2018, unless
11 renewed. As alleged, Marr is Valley Pharmacy's PIC.

12 4. On or about August 7, 1978, the Board issued Original Pharmacist License Number
13 RPH 32234 to Leland Kwong Ma ("Ma"). The pharmacist license was in full force and effect at
14 all times relevant to the charges brought herein and will expire on February 28, 2018, unless
15 renewed. As alleged, Ma is President and 100% shareholder of Valley Pharmacy.

16 **JURISDICTION**

17 5. This Accusation is brought before the Board under the authority of the following
18 laws. All section references are to the Business and Professions Code ("Code") unless otherwise
19 indicated.

20 6. Code section 4011 provides that the Board shall administer and enforce both the
21 Pharmacy Law [Bus. & Prof. Code §§ 4000, *et seq.*] and the Uniform Controlled Substances Act
22 [Health & Safety Code §§ 11000, *et seq.*].

23 7. Code section 4300 states, in pertinent part:

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

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

28 (1) Suspending judgment.

1 (2) Placing him or her upon probation.

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

4 (4) Revoking his or her license.

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

7 8. Code section 4300.1 states:

8 The expiration, cancellation, forfeiture, or suspension of a board-issued
9 license by operation of law or by order or decision of the board or a court
10 of law, the placement of a license on a retired status, or the voluntary
11 surrender of a license by a licensee shall not deprive the board of
12 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.

13 **STATUTORY PROVISIONS**

14 9. Code section 4307(a) states:

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

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

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

27 10. Code section 4156 provides that "[a] pharmacy corporation shall not do, or fail to do,
28 any act where doing or failing to do the act would constitute unprofessional conduct under any

1 statute or regulation. In the conduct of its practice, a pharmacy corporation shall observe and be
2 bound by the laws and regulations that apply to a person licensed under this chapter.”

3 11. Code Section 4301 states, in pertinent part:

4
5 The board shall take action against any holder of a license who is guilty of
6 unprofessional conduct...Unprofessional conduct shall include, but is not
7 limited to, any of the following:

8 (b) Incompetence.

9 (c) Gross negligence.

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

12 ...

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

15 ...

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

21 12. Code section 4306.5 provides, in pertinent part:

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

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

28 (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

1 appropriate patient, prescription, and other records pertaining to the
2 performance of any pharmacy function...

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

6 13. Code section 4113 provides, in pertinent part, that every pharmacy shall designate a
7 pharmacist-in-charge who shall be responsible for the pharmacy's compliance with all state and
8 federal laws and regulations pertaining to the practice of pharmacy.

9 14. Code section 4081 provides:

10 (a) All records of manufacture and of sale, acquisition, receipt,
11 shipment, or disposition of dangerous drugs or dangerous devices
12 shall be at all times during business hours open to inspection by
13 authorized officers of the law, and shall be preserved for at least
14 three years from the date of making. A current inventory shall be
15 kept by every... pharmacy...[maintaining] a stock of dangerous
16 drugs or dangerous devices.

17 (b) The owner, officer, and partner of a pharmacy...shall be jointly
18 responsible, with the pharmacist-in-charge, responsible manager, or
19 designated representative-in-charge, for maintaining the records and
20 inventory described in this section...

21 15. Code Section 4333 states, in pertinent part, that all prescriptions filled by a pharmacy
22 and all other records required by Section 4081 shall be maintained on the premises and available
23 for inspection by authorized officers of the law for a period of at least three years.

24 16. Code Section 4105 states, in pertinent part:

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

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

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

(d)(1) Any records that are maintained electronically shall be maintained so
that the pharmacist-in-charge, or the pharmacist on duty if the pharmacist-
in-charge is not on duty, shall, at all times during which the licensed

1 premises are open for business, be able to produce a hardcopy and
2 electronic copy of all records of acquisition or disposition or other drug or
dispensing-related records maintained electronically.

3
4 (f) When requested by an authorized officer of the law or by an authorized
5 representative of the board, the owner, corporate officer, or manager of an
entity licensed by the board shall provide the board with the requested
records within three business days of the time the request was made....

6 17. Health & Safety Code section 11153, subsection (a), provides:

7
8 (a) A prescription for a controlled substance shall only be issued for a
9 legitimate medical purpose by an individual practitioner acting in the usual
10 course of his or her professional practice. The responsibility for the proper
11 prescribing and dispensing of controlled substances is upon the prescribing
12 practitioner, but a corresponding responsibility rests with the pharmacist
13 who fills the prescription. Except as authorized by this division, the
14 following are not legal prescriptions: (1) an order purporting to be a
15 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.

16 18. Health and Safety Code section 11162.1, subsection (a), provides:

17
18 (a) The prescription forms for controlled substances shall be printed with
the following features:

19 (1) A latent, repetitive "void" pattern shall be printed across the entire front
20 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
21 prescription.

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

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

25 (4) A feature printed in thermochromic ink.

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

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

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

- 4 1-24
5 25-49
6 50-74
7 75-100
8 101-150
9 151 and over.

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

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

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

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

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

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

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

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

27 (B) Each prescriber who signs the prescription form shall identify himself
28 or herself as the prescriber by checking the box by his or her name.

19. Health and Safety Code section 11164, provides, 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...

1 (f) The pharmacy shall have written policies and procedures regarding the
2 operations of the pharmacy during the temporary absence of the pharmacist
3 for breaks and meal periods...The policies and procedures shall be open to
inspection by the board or its designee at all times during business hours...

4 24. CCR, title 16, section 1714, provides, in pertinent part:

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

8 (d) Each pharmacist while on duty shall be responsible for the security of
9 the prescription department, including provisions for effective control
10 against theft or diversion of dangerous drugs and devices, and records for
such drugs and devices....

11 25. CCR, title 16, section 1711, provides, in pertinent part:

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

15 (b) For purposes of this section, "medication error" means any variation
16 from a prescription or drug order not authorized by the prescriber....

17 (c)(1) Each quality assurance program shall be managed in accordance
18 with written policies and procedures maintained in the pharmacy in an
immediately retrievable form.
....

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

23 (e) ... A record of the quality assurance review shall be immediately
24 retrievable in the pharmacy. The record shall contain at least the following:

- 25 1. the date, location, and participants in the quality assurance review;
- 26 2. the pertinent data and other information relating to the medication
27 error(s) reviewed and documentation of any patient contact required by
subdivision (c);
- 28 3. the findings and determinations generated by the quality assurance
review; and,

1 4. recommend changes to pharmacy policy, procedure, systems, or
2 processes, if any.

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

6 (f) The record of the quality assurance review, as provided in subdivision
7 (e), shall be immediately retrievable in the pharmacy for at least one year
8 from the date the record was created.

9 26. CCR, title 16, section 1735, provides, in pertinent part:

10 (a) "Compounding" means any of the following activities occurring in
11 a licensed pharmacy, by or under the supervision of a licensed pharmacist,
12 pursuant to a prescription:

- 13 (1) Altering the dosage form or delivery system of a drug
- 14 (2) Altering the strength of a drug
- 15 (3) Combining components or active ingredients
- 16 (4) Preparing a drug product from chemicals or bulk drug substances
- 17 ...

18 (d) The parameters and requirements stated by this Article 4.5 (Section
19 1735 et seq.) apply to all compounding practices....

20 27. CCR, title 16, section 1735.2, subsection (d), provides:

21 (d) A drug product shall not be compounded until the pharmacy has first
22 prepared a written master formula record that includes at least the
23 following elements:

- 24 (1) Active ingredients to be used.
- 25 (2) Equipment to be used.
- 26 (3) Expiration dating requirements.
- 27 (4) Inactive ingredients to be used.
- 28 (5) Process and/or procedure used to prepare the drug.
- (6) Quality reviews required at each step in preparation of the drug.
- (7) Post-compounding process or procedures required, if any.

29 28. CCR, title 16, section 1735.3, provides, in pertinent part:

30 (a) For each compounded drug product, the pharmacy records shall

include:

- (1) The master formula record.
- (2) The date the drug product was compounded.
- (3) The identity of the pharmacy personnel who compounded the drug product.
- (4) The identity of the pharmacist reviewing the final drug product.
- (5) The quantity of each component used in compounding the drug product.
- (6) The manufacturer, expiration date and lot number of each component....
- (7) A pharmacy assigned reference or lot number for the compounded drug product.
- (8) The expiration date of the final compounded drug product.
- (9) The quantity or amount of drug product compounded.

....

(d) Pharmacies shall maintain and retain all records required by this article in the pharmacy in a readily retrievable form for at least three years from the date the record was created.

29. CCR, title 16, section 1735.4, subsection (a), provides that “[i]n addition to the labeling information required under Business and Professions Code section 4076, the label of a compounded drug product shall contain the generic name(s) of the principal active ingredient(s).”

30. CCR, title 16, section 1735.6, subsection (a), provides that “[a]ny pharmacy engaged in compounding shall maintain written documentation regarding the facilities and equipment necessary for safe and accurate compounded drug products. Where applicable, this shall include records of certification(s) of facilities or equipment.”

31. CCR, title 16, section 1735.7, subsection (a), provides that “[a]ny pharmacy engaged in compounding shall maintain written documentation sufficient to demonstrate that pharmacy personnel have the skills and training required to properly and accurately perform their assigned responsibilities relating to compounding.”

32. CCR, title 16, section 1716, provides, in pertinent part, that “[p]harmacists shall not deviate from the requirements of a prescription except upon the prior consent of the prescriber

1 or to select the drug product in accordance with Section 4073 of the Business and Professions
2 Code....”

3 33. CCR, title 16, section 1761, provides:

4 (a) No pharmacist shall compound or dispense any prescription which
5 contains any significant error, omission, irregularity, uncertainty,
6 ambiguity or alteration. Upon receipt of any such prescription, the
7 pharmacist shall contact the prescriber to obtain the information needed to
8 validate the prescription.

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

13 FEDERAL REGULATIONS

14 34. Code of Federal Regulations (“CFR”), title 21, section 1301.75, subsection (b),
15 provides that “[c]ontrolled substances listed in Schedules II, III, IV, and V shall be stored in a
16 securely locked, substantially constructed cabinet. However, pharmacies and institutional
17 practitioners may disperse such substances throughout the stock of noncontrolled substances in
18 such a manner as to obstruct the theft or diversion of the controlled substances.”

19 35. CFR, title 21, section 1306.04, subsection (a), provides:

20 A prescription for a controlled substance to be effective must be issued for
21 a legitimate medical purpose by an individual practitioner acting in the
22 usual course of his professional practice. The responsibility for the proper
23 prescribing and dispensing of controlled substances is upon the prescribing
24 practitioner, but a corresponding responsibility rests with the pharmacist
25 who fills the prescription. An order purporting to be a prescription issued
26 not in the usual course of professional treatment or in legitimate and
27 authorized research is not a prescription within the meaning and intent of
28 section 309 of the Act (21 U.S.C. 829) and the person knowingly filling
such a purported prescription, as well as the person issuing it, shall be
subject to the penalties provided for violations of the provisions of law
relating to controlled substances.

29 COST RECOVERY

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

1 **DRUG CLASSIFICATIONS**

2 37. Promethazine with Codeine is a Schedule V controlled substance pursuant to Health
3 and Safety Code section 11058, subsection (c)(1).

4 38. "Lioresal" is a brand name for baclofen, a muscle relaxant.

5 39. "Norco" is a brand name for hydrocodone/acetaminophen (APAP), used in the
6 treatment of pain management. Hydrocodone/acetaminophen is a Schedule III controlled
7 substance under Health and Safety Code section 11056, subsection (e)(5), and a Schedule II
8 controlled substance under CFR, title 21, section 1308.12.

9 40. "Dolophine" is a brand name for methadone, used in the treatment of pain
10 management. Methadone is a Schedule II controlled substance under Health and Safety Code
11 section 11055, subsection (d)(2).

12 41. "MS Contin" is a brand name for morphine sulfate, used in the treatment of pain
13 management. Morphine sulfate is a Schedule II controlled substance under Health and Safety
14 Code section 11055, subsection (b)(1)(L).

15 42. "Mycostatin" is a brand name for nystatin, used in the treatment of fungal infection.

16 43. "Ditropan" is a brand name for oxybutynin, used in the treatment of bladder spasms.

17 44. "OxyContin" and "Roxicodone" are brand names for oxycodone, used in the
18 treatment of pain management. Oxycodone is a Schedule II controlled substance under Health
19 and Safety Code section 11055, subsection (b)(1)(M).

20 45. "Percocet" is a brand name for oxycodone/acetaminophen (APAP), used in the
21 treatment of pain management. Oxycodone/acetaminophen is a Schedule II controlled substance
22 under Health and Safety Code section 11055, subsection (b)(1)(M).

23 46. "Xanax" is a brand name for alprazolam, used in the treatment of anxiety.
24 Alprazolam is a Schedule IV controlled substance under Health and Safety Code section 11057,
25 subsection (d)(1).

26 47. All the aforementioned drugs are dangerous drugs under Code section 4022.

27 **FACTUAL BACKGROUND**

28 48. An audit of controlled substance purchases found that Valley Pharmacy had ordered

1 high quantities of promethazine/codeine liquid, a commonly abused Schedule V ("CV")
2 controlled substance. The Board therefore further investigated Valley Pharmacy's practices.

3 49. Dispensers of controlled substances are not required to report CV controlled
4 substances to the CURES database. Since promethazine/codeine is a CV substance, a review of
5 Valley Pharmacy's CURES data did not show its reported usage. The Board therefore reviewed
6 other areas of Valley Pharmacy's controlled substance practices. Based on this review, the Board
7 found indications of possible trends of early refills of controlled substances, and of dispensing
8 controlled substances with possible irregularities and "red flags" of abuse or misuse.

9 **November 12, 2015 Inspection and Subsequent Investigation:**

10 50. On November 12, 2015, Board inspector SK ("SK") went to Valley Pharmacy to
11 conduct an onsite inspection. Upon arrival, Valley Pharmacy's PIC, Respondent Marr, was
12 identified among other pharmacy personnel consisting of three pharmacy technicians, TCH EM,
13 TCH SX, and TCH TK. Inspector SK proceeded to observe the workflow and work patterns of
14 the pharmacy. SK made the following observations during the 11/12/15 inspection and
15 subsequent investigation thereon.

16 **Patient Consultation:**

17 51. SK observed that the pharmacy had prescriptions bagged for delivery. When SK
18 asked what paperwork was given to patients upon prescription delivery, TCH EM pulled a paper
19 out of one bag and verified that it was the only information given with deliveries. PIC Marr
20 verified these circumstances. The form did not notify patients of their right to receive a
21 consultation as required by CCR, title 16, section 1707.2, subsection (b)(2).

22 52. SK also monitored new prescription consultation activities by PIC Marr and staff. In
23 so doing, SK observed three new prescriptions (nos. 8039052-8039054) for oxycodone,
24 oxybutynin and baclofen being dispensed to patient PB without any oral consultation. This
25 violated CCR, title 16, section 1707.2.

26 **Medication Record Review:**

27 53. SK observed that PIC Marr had failed to perform any medication record review
28 before the new prescriptions were dispensed to patient PB. Also, that PIC Marr had failed to

1 access the pharmacy computer to review medication records when filling other prescriptions and
2 conducting occasional consultations. This violated CCR, title 16, section 1707.3.

3 **Absence of Pharmacist Policy:**

4 54. SK asked to review the pharmacy's policies and procedures regarding operations
5 during pharmacist absence. Those policies and procedures stated that a patient could pick up new
6 prescriptions in the absence of the pharmacist, and consultation would be provided upon the
7 pharmacist's return. This violated CCR, title 16, section 1714.1.

8 **Record Storage:**

9 55. Under Code section 4333, subsection (a), Valley Pharmacy was required to maintain,
10 onsite, at least three years' records of dangerous drug/device acquisition and disposition. At the
11 time of the 11/12/15 inspection, Valley Pharmacy was therefore required to have records for the
12 period of 11/12/12-11/12/15. The oldest original prescription document records available for
13 SK's inspection were located in a box labeled January 18, 2013. PIC Marr admitted that Valley
14 Pharmacy did not have a full three years of records onsite due to insufficient space and that he
15 kept some of the records at his personal residence. This violated Code section 4333(a) since
16 Valley Pharmacy did not have any waiver from the Board for such off-site storage.

17 **Pharmacy and Controlled Substance Security:**

18 56. SK reviewed Valley Pharmacy's storage and security of controlled substances. PIC
19 Marr showed SK controlled substances stored on drug stock shelves generally in alphabetical
20 order. PIC Marr also showed SK three drawers containing CII-V controlled substances in no
21 particular order. The top drawer appeared to have a lock, but was unlocked. The bottom drawer
22 did not have any locking devices. PIC Marr stated he did not want to lock the controlled
23 substances in case he was robbed. This violated CFR, title 21, section 1301.75, subdivision (b).

24 **Quality Assurance Program (Prescription Errors):**

25 57. SK reviewed Valley Pharmacy's records related to medication errors. In so doing,
26 PIC Marr gave SK a binder containing the pharmacy's Quality and Assurance Program policies
27 and procedures, incident reporting form, and a copy of the quality assurance law. There were no
28 completed reports or reviews of prescription errors.

1 58. When SK questioned PIC Marr regarding these circumstances, PIC Marr admitted
2 that at least one prescription error had occurred within the last year and that he did not document
3 the same. This violated CCR, title 16, section 1711. PIC Marr also admitted that he had never
4 documented any medication errors during his six-year tenure as Valley Pharmacy's PIC.

5 **Dispensing Records:**

6 59. In issuing his inspection report on November 12, 2015, SK directed PIC Marr and
7 Valley Pharmacy to e-mail, in excel format, and within seven days, complete records of all drugs
8 acquired and disposed of during the period of 10/1/12-11/12/15.

9 60. Between 11/25/15 and 1/3/16, PIC Marr sent the requested dispensing records at least
10 five times on 11/25/15, 12/21/15, 12/28/15, 12/30/15 and 1/4/16. None of the records so
11 forwarded were complete or accurate since they were inconsistent with both Valley Pharmacy's
12 stated prescription volume (300 prescriptions per day) and prescription volume as listed on the
13 pharmacy's CURES report. PIC Marr, in turn, blamed third parties for the perceived errors.

14 61. On January 5, 2016, SK requested PIC Marr to arrange a conference call with the
15 pharmacy's software vendor to try and obtain complete and accurate records. PIC Marr failed to
16 do so.

17 62. On January 19, 2016, SK sent the pharmacy owner, Respondent Ma, a letter
18 requesting complete and accurate records. Ma did not send the records and instead suggested that
19 SK conduct a conference call with PIC Marr and the pharmacy's software vendor.

20 63. On February 3, 2016, SK received yet another USB drive from PIC Marr purporting
21 to contain the complete and accurate records. These records were also incomplete and inaccurate.
22 For example, many records were duplicates indicating that certain controlled substance
23 prescriptions had been filled up to 17 times.

24 **CURES Reporting:**

25 64. SK's review of Valley Pharmacy's CURES data found gaps of time where Valley
26 Pharmacy made no reports of dispensed controlled substance prescriptions as follows: 10/12/12-
27 10/22/12 (10 days); 1/4/13-1/12/13 (eight days); 1/19/13-1/28/13 (nine days); 8/2/13-8/12/13 (10
28 days); 11/7/14-11/17/14 (10 days); and 4/24/15-5/4/15 (10 days). Since Valley Pharmacy is

1 closed weekends, this amounted to a potential of 45 days during which controlled substance
2 activity went unreported. Meanwhile, although inaccurate and incomplete, the records alleged
3 above which PIC Marr provided documented controlled substances being dispensed during the
4 time periods in question.

5 **Drug Audits:**

6 65. Valley Pharmacy had past reports of controlled substances being stolen on 1/14/2014,
7 6/25/14 and 11/25/14, resulting in the following losses:

8 Total tablets/capsules	27,543
9 Total liquid (ml)	17,663
10 Total liquid 5 ml doses	3,532

11 66. In order to determine the effect of the improper security of controlled substances
12 observed during the 11/12/15 inspection, and to determine if records of controlled substances
13 were being properly maintained, SK conducted an audit of the selected controlled substances
14 referenced in paragraph 65 below. In performing the audit, SK utilized various information
15 received from PIC Marr (including a count of the pharmacy's stock on hand) in addition to data
16 received directly from Valley Pharmacy's drug wholesalers.¹

17 67. SK's audit indicated that Valley Pharmacy was significantly short the following
18 controlled substances: alprazolam 2 mg (-4,774 tablets); hydrocodone/APAP 10/325 mg (-14,239
19 tablets); promethazine/codeine 6.5/10 mg (-260,579 ml).² Meanwhile, the audit showed the
20 pharmacy was significantly over the following controlled substances: hydrocodone/APAP 5/325
21

22 ¹ In conducting controlled substances inventories, an estimate of quantities in open bottles of 1,000 units or less is
23 allowed for CIII-V controlled substances (e.g., alprazolam and promethazine/codeine). Meanwhile, CII controlled
24 substances (e.g., hydrocodone, oxycontin and oxycodone) require an exact count for each inventory, each dispensing,
25 and each instance of other occurrences which could affect the CII controlled substance inventory. While federal law
26 defined hydrocodone as a CIII controlled substance at the start of the audit period, it was changed to a CII on
27 10/6/14, before the end of the audit period. Hydrocodone remains classified as a CIII controlled substance under
28 California law.

² Regarding the promethazine/codeine specifically, this highly-abused CIV controlled substance is usually dosed in 5
ml increments. Its shortage amounted to over 52,000 doses of controlled substances for which Valley Pharmacy
could not account. Additionally, the missing quantity of promethazine/codeine syrup was over 542 pint-sized bottles,
which would total over 542 pounds of controlled substances, excluding bottle weight.

1 mg (+2,206 tablets); oxycodone 30 mg (+1,173 tablets); oxycodone 5 mg (+1,127 tablets);
2 oxycontin 20 mg (+165 tablets); and oxycontin 80 mg (+51 tablets).

3 68. PIC Marr was unable to account for these discrepancies. Instead, each time PIC Marr
4 provided audit responses, they included different delivered quantities for some drugs, reflecting
5 the pattern of Valley Pharmacy's failure to maintain complete and accurate records of the
6 acquisition and disposition of controlled substances.

7 **Compounding:**

8 69. During the 11/12/15 inspection, PIC Marr acknowledged that Valley Pharmacy
9 occasionally compounded non-sterile prescriptions. When SK requested all records Valley
10 Pharmacy had related to compounding, PIC Marr admitted the pharmacy kept no such records
11 separate, including master formulas or compounding formulas.

12 70. When SK requested an example of prescriptions that Valley Pharmacy had
13 compounded and dispensed, PIC Marr provided prescription no. 8037774. The prescription was
14 dispensed on 11/4/15, for a combination of liquid drugs (including the dangerous drug nyastin) to
15 be mixed by the pharmacy and used orally by the patient. There were no compounding records
16 for prescription no. 8037774 other than the notes made on the back of the original prescription
17 document.

18 71. PIC Marr confirmed that Valley Pharmacy had no other records related to the
19 prescription, and that the documentation on this prescription was typical of the procedure used on
20 all Valley Pharmacy compounded prescriptions. The prescription was therefore compounded
21 without a written master formula or record on the prescription document that included each the:

- 22 • Inactive ingredients to be used;
- 23 • Process and/or procedures used to prepare the drug;
- 24 • Quality reviews required at each step in preparation of the drug;
- 25 • Post-compounding process or procedures required; and
- 26 • Expiration dating requirements.

27 72. Likewise, Valley Pharmacy did not maintain records of the compounded prescription
28 preparation that included the:

- 1 • Master formula record;
- 2 • Date the drug product was compounded;
- 3 • Identity of the pharmacy personnel who compounded the drug product;
- 4 • Manufacturer, lot number, and expiration date of each component;
- 5 • Equipment used in compounding the drug product; and
- 6 • Expiration date of the final compounded drug product.

7 73. Valley Pharmacy had a completed compounding self-assessment on file outlining
8 applicable laws and regulations related to prescription compounding. PIC Marr had completed
9 and signed the document indicating Valley Pharmacy was in compliance. Contrary to PIC Marr's
10 representation, SK determined that Valley Pharmacy compounded prescription preparations
11 without:

- 12 • Labels setting forth the generic name(s) of the principal active ingredient(s) and the
13 strength(s) of the products;
- 14 • Written documentation regarding the facilities and equipment necessary for safe and
15 accurate compounded drug products; and
- 16 • Written documentation sufficient to demonstrate that pharmacy personnel had the
17 requisite skills and training.

18 **Corresponding Responsibility:**

19 74. During the 11/12/15 inspection and subsequent investigation thereon, SK found that
20 PIC Marr and Valley Pharmacy had grossly deviated from the standard of practice related to the
21 dispensing of controlled substances by dispensing controlled substances on prescriptions in the
22 presence of well-known "red flags" of abuse or misuse. These included at least the following
23 prescriptions:

24 **RF, MD Prescriptions:**

25 75. Prescription nos. 8014018, 8014327, 8014373 and 8014481 were purportedly written
26 by RF, MD. Each prescription was for high quantities of oxycodone (Roxicodone) in strengths
27 varying from 10 mg to 30 mg, and dispensed to patients new to Valley Pharmacy, paying cash for
28 the prescriptions – all red flags.

1 76. Further, each prescription was written on an invalid prescription form missing the
2 following features mandated by Health and Safety Code section 11162.1:

- 3 • Six quantity check-off boxes;
- 4 • A watermark printed on the bottom of the prescription blank stating "California
5 Security Prescription;"
- 6 • A statement printed on the bottom of the prescription blank that the "Prescription is
7 void if the number of drugs prescribed is not noted;"
- 8 • The preprinted license number of the prescribing practitioner;
- 9 • Check boxes printed on the form so that the prescriber may indicate the number of
10 refills ordered;
- 11 • An identifying number assigned to the approved security printer by the Department of
12 Justice; and
- 13 • The lot number printed on the form and the form sequentially numbered.

14 77. Another irregularity was that three of the prescriptions had a written diagnosis of
15 "Goute, Goute arthritis." Gout is a common medical condition. Misspelling the word "gout" on a
16 medical prescription is also a red flag. So, too, is use of oxycodone in the treatment of gout.

17 78. Also, noted on the back of three of the prescription documents was "Phoney 5-14-
18 15," which was days after the prescriptions were actually dispensed. PIC Marr and Valley
19 Pharmacy had a duty to verify authenticity of the prescriptions before dispensing the same. PIC
20 Marr explained that some of Valley Pharmacy's patients look dangerous and that the pharmacy
21 tries to get them out as soon as possible.

22 79. Moreover, prescription no. 8014327 was for 100 tablets of "ROXICODONE 30
23 MG." The prescription was dispensed for 100 tablets of oxycodone 10 mg. This was a variation
24 from the purported prescription (*i.e.*, a medication error) since there was no indication on the
25 prescription document of any authorization for this change in strength.

26 **HC, NP Prescriptions:**

27 80. Prescription nos. 8010806, 8010807, 8011298, 8011299, 8011301, 8013443 and
28 8013445 were purportedly written by HC, NP, for three different patients. Each prescription was

1 dispensed on invalid prescription forms lacking the following mandated features:

2 • A watermark printed on the bottom of the prescription blank stating "California
3 Security Prescription;"

4 • An identifying number assigned to the approved security printer by the Department
5 of Justice; and

6 • The lot number printed on the form.

7 Valley Pharmacy dispensed the six prescriptions without verifying authenticity despite the red
8 flags of non-compliant prescription forms and new patients paying cash for the prescriptions.
9 This supplied 300 tablets of hydrocodone/APAP 10/325 mg and over 1,000 ml's of
10 promethazine/codeine syrup pursuant to invalid prescription documents.

11 **TM, MD Prescription:**

12 81. Prescription no. 8002498 was purportedly written by TM, MD. The name of the
13 prescribing doctor (which was in Valley Pharmacy's database) as preprinted on the top of the
14 prescription form was misspelled. Also, the form did not contain the following required features:

15 • A watermark printed on the bottom of the prescription blank stating "California
16 Security Prescription;"

17 • An identifying number assigned to the approved security printer by the Department
18 of Justice; and

19 • The lot number printed on the form.

20 Valley Pharmacy dispensed the prescription without verifying authenticity despite the red flags of
21 a non-compliant prescription form, the preprinted doctor's name being misspelled, and a new
22 patient paying cash for the prescription.

23 **DK, DDS Prescriptions:**

24 82. Prescription nos. 7940930, 7943672, 7946251 and 7960075 were purportedly written
25 by DK, DDS. Each prescription was for a high dose (30 mg) and high quantity (180-240 tablets)
26 of oxycodone. Oxycodone is unusual in dental treatment, especially in such high quantities and
27 doses. Valley Pharmacy dispensed the four prescriptions (a total of 840 tablets) despite the red
28 flags of new patients paying cash, an unusual medication for dental treatment, high dose and high

1 quantity. DK, DDS has since confirmed that the prescriptions were fake and that he has never
2 prescribed oxycodone in connection with his dental practice.

3 **AE, MD Prescription:**

4 83. Prescription no. 8014312 was purportedly written by AE, MD for the hydrocodone
5 containing controlled substance Lortab. The prescription document was on a controlled substance
6 form that appeared to meet all of the requirements, but was incomplete since there was no
7 quantity written on the prescription document other than the box checked indicating that the
8 quantity was for "151+" units. Since the prescription was written to be taken as needed, the total
9 dose prescribed could not be calculated. Valley Pharmacy dispensed the prescription for one 473
10 ml bottle without verifying the total quantity actually prescribed and despite the red flags of a
11 new patient paying \$240 cash.

12 **HK, MD Prescriptions:**

13 84. Prescription nos. 8038515, 8038513, 8038577, 8038903 were purportedly written by
14 HK, MD. Each prescription was for the CII controlled substance hydrocodone/APAP 10/325 mg.
15 Under Health and Safety Code section 11164, an original prescription form signed and dated in
16 ink by the prescriber is required for such prescriptions to be filled; they may not be faxed. Here,
17 each prescription was an electronic "computer-to-fax" prescription, and therefore invalid.
18 Notwithstanding, Valley Pharmacy filled them.

19 **NS, MD Prescriptions:**

20 85. Prescription nos. 8038620, 8038599, 8038778 and 8038766 were purportedly written
21 by NS, MD, a doctor who was placed on probation following an accusation that he had prescribed
22 controlled substances (including promethazine/codeine syrup) without proper record keeping or
23 exams. These prescriptions – to four separate patients (each of whom were an African-American
24 male born between 1990 and 1994) – were also for promethazine/codeine 240 ml, with directions
25 to take two teaspoons once daily at bedtime for severe cough and headache. The non-prescription
26 antihistamine loratadine 10 mg was also prescribed to each of the four patients. Further, each
27 prescription was filled between 11/10/15 and 11/11/15.

28 86. Headache is not an indication for promethazine/codeine. Also, the presentation of

1 prescriptions to Valley Pharmacy of such similar prescriptions (patients, drugs, quantities, stated
2 unapproved treatments) within such a short timeframe should have been red flags that the drugs
3 may have been sought for abuse. Another red flag was the public record of NS, MD's probation
4 status. Valley Pharmacy dispensed the prescriptions without verification.

5 **Patient BB:**

6 87. On 12/2/12, Valley Pharmacy filled two prescriptions for new patient BB, namely,
7 prescription nos. 7924592 (for 240 tablets of oxycodone 30 mg) and 7924593 (for 480 ml of
8 promethazine/codeine). BB paid cash for the prescriptions.

9 88. These prescriptions also had the following irregularities and ambiguities:

- 10 • The prescribed dose of oxycodone was a total of 240 mg per day – eight times the
11 starting dose PIC Marr stated as being appropriate;
- 12 • The highly-abused controlled substance promethazine/codeine was prescribed in a
13 full pint-sized bottle together with oxycodone in high dose.

14 89. Despite these red flags, Valley Pharmacy filled the prescriptions without verification.
15 Meanwhile, SK's review of CURES revealed that patient BB had received 120 tablets of
16 oxycodone 30 mg from another pharmacy just four days prior.

17 90. On 2/20/13, Valley Pharmacy filled two other prescriptions for BB, namely, nos.
18 7930983 (for 240 tablets of methadone 10 mg) and 7930984 (for 480 ml of
19 promethazine/codeine). Valley Pharmacy dispensed these controlled substance prescriptions
20 without verification despite the red flags of cash payment for high medication quantities.

21 **Patient MW:**

22 91. On 11/14/12, Valley Pharmacy dispensed to patient MW prescription nos. 7923296
23 (for 100 tablets of oxycodone 30 mg) and 7923295 (for 480 ml of promethazine/codeine).
24 Valley Pharmacy did so without verification despite the red flags of oxycodone and
25 promethazine/codeine being prescribed together in high doses and quantities to a new patient
26 paying cash.

27 **Patient JC:**

28 92. On 2/8/12, Valley Pharmacy dispensed to patient JC prescription nos. 7930031 (for

1 240 tablets of oxycodone 30 mg) and 7930030 (for 480 ml promethazine/codeine). Valley
2 Pharmacy did so without verification despite the red flags of oxycodone and
3 promethazine/codeine (480 ml) being prescribed in high doses and quantities at the same time to a
4 new patient paying cash.

5 **Patient RM:**

6 93. On 9/5/13, Valley Pharmacy dispensed to patient RM prescription no. 7947920,
7 consisting of hydrocodone/APAP 10/325 mg (180 tablets). This prescription was a verbal order
8 ostensibly taken as a transfer from an out-of-state pharmacy for a new patient paying cash – all
9 red flags. Again, Valley Pharmacy did so without verification.

10 94. SK's review of patient RM's CURES record revealed that RM had obtained
11 hydrocodone/APAP 10/325 mg at least 19 times in a 99-day period (5/23/13-8/30/13) prior to
12 Valley Pharmacy's 9/5/13 fill. This was evidence of "doctor shopping," and supplied RM with a
13 332-day supply of hydrocodone/APAP.

14 **Patient HP:**

15 95. On 5/8/15, Valley Pharmacy dispensed to patient HP prescription nos. 8014372 (for
16 60 tablets of morphine sulfate ER 15 mg) and 8014374 (for 150 ml of morphine sulfate 100 mg/5
17 ml solution). The 100 mg/5 ml morphine oral solution was dispensed with the following
18 directions:

- 19 • 10 ml (200 mg) every four hours for moderate pain;
20 • 20 ml (400 mg) every four hours for severe pain.

21 This dosing was unusual and irregular since it amounted to 10-20 times the recommended dosing
22 for morphine, necessitating verification. Further, patient HP was 65 years old. Morphine
23 prescribing information specifies that elderly patients generally should be started on low doses of
24 morphine and observed closely.

25 96. Again, there was no indication on the prescriptions of any inquiry or verification by
26 Valley Pharmacy to resolve these irregularities that could lead to patient harm. Instead, Valley
27 Pharmacy dispensed these prescriptions notwithstanding the dosing red flags.

28 //

1 **Patient RJ:**

2 97. On 11/29/12, Valley Pharmacy dispensed to patient RJ prescription no. 7924314 for
3 240 tablets of methadone 10 mg. The prescription had a notation that the amount to be taken by
4 the patient was not to exceed eight tablets per day. RJ was also a new patient paying cash for a
5 high quantity of controlled substance. Again, Valley Pharmacy dispensed the prescription
6 without verification despite the existence of red flags.

7 98. Further, SK's review of RJ's CURES report showed that a different pharmacy had
8 filled an identical quantity of methadone 10 mg just 17 days prior, and that another pharmacy had
9 filled a prescription for hydrocodone/APAP 10/325 mg just 14 days prior.

10 **Early Refills:**

11 99. In evaluating Valley Pharmacy's refilling practices, SK found that PIC Marr/Valley
12 Pharmacy had filled 276 controlled substance prescriptions more than five days before previously
13 dispensed supplies were exhausted. Many prescriptions were filled more than seven days early,
14 which was the standard PIC Marr stated he used. SK determined that this, too, constituted a
15 failure in corresponding responsibility.

16 **FIRST CAUSE FOR DISCIPLINE**

17 **(Failure to Provide Oral Consultation to Patients)**

18 100. Respondents PIC Marr and Valley Pharmacy are subject to disciplinary action under
19 Code section 4301, subdivision (o), in that Respondents violated CCR, title 16, section 1707,
20 subdivisions(b)(1)(A) and (B)(2), as follows:

21 a. On November 12, 2015, Respondents dispensed to Patient PB prescriptions that were
22 new without providing oral consultation, as set forth in paragraph 52 above.

23 b. On November 12, 2015, Respondents failed to provide patients who received their
24 medications by delivery service with a written notice of their right to request an oral consultation
25 from a pharmacist, as set forth in paragraph 51 above.

26 **SECOND CAUSE FOR DISCIPLINE**

27 **(Failure to Perform Medication Record Review Prior to Patient Consultation)**

28 101. Respondents PIC Marr and Valley Pharmacy are subject to disciplinary action under

1 Code Section 4301, subdivision (o), in that Respondents violated CCR, title 16, section 1707.3,
2 by failing to perform medication record review before dispensing prescriptions, including to
3 patient PB, as set forth in paragraph 53 above.

4 **THIRD CAUSE FOR DISCIPLINE**

5 **(Improper Absence of Pharmacist Policy)**

6 102. Respondents PIC Marr and Valley Pharmacy are subject to disciplinary action under
7 Code section 4301, subdivision (o), in that Respondents violated CCR, title 16, section 1714.1,
8 subdivision (b), by maintaining a policy that allowed new prescriptions requiring consultation to
9 be dispensed to patients in the absence of a pharmacist, as set forth in paragraph 54 above.

10 **FOURTH CAUSE FOR DISCIPLINE**

11 **(Failure to Maintain Records of Dangerous Drugs on Premises)**

12 103. Respondents PIC Marr and Valley Pharmacy are subject to disciplinary action under
13 Code section 4301, subdivision (o), in that Respondents violated Code section 4333,
14 subdivision(a), by failing to maintain on the premises, and make available for inspection, all
15 records of prescriptions filled by the pharmacy for three years, as set forth in paragraph 55 above.
16 Further, records earlier than January 8, 2013, were removed from the pharmacy, without a waiver
17 from the Board, and stored at the residence of PIC Marr, in violation of pharmacy law.

18 **FIFTH CAUSE FOR DISCIPLINE**

19 **(Failure to Maintain Pharmacy, Fixtures, and Equipment so that Drugs were Safely and**
20 **Properly Secured)**

21 104. Respondents PIC Marr and Valley Pharmacy are subject to disciplinary action under
22 Code section 4301, subdivisions (o) and (j), and CCR, title 16, section 1714, subdivision (b), and
23 CFR, title 21, section 1301.75, subdivision (b), in that Respondents failed to safely and properly
24 secure controlled substances in a securely locked, substantially constructed cabinet, or otherwise
25 by dispersing the controlled substances throughout the pharmacy's stock of non-controlled
26 substances, as set forth in paragraph 56 above.

27 105. Meanwhile, drug audits of controlled substances between May 1, 2013 and November
28 12, 2015, found significant shortages of controlled substances, for which Respondents failed to

1 account, as set forth in paragraph 66 through 68 above.

2 **SIXTH CAUSE FOR DISCIPLINE**

3 **(Failure to Comply with Quality Assurance Program)**

4 106. Respondents PIC Marr and Valley Pharmacy are subject to disciplinary action under
5 Code section 4301, subdivision (o), and CCR, title 16, section 1711, subdivisions (e) and (f), in
6 that Respondents failed to document medication errors when at least one error had occurred
7 within the year prior to the 11/12/15 inspection, as set forth in paragraphs 57 and 58 above.
8 Respondents failed to engage in a Quality Assurance Program in a manner to advance error
9 prevention by analyzing, individually and collectively, investigative and other pertinent data
10 collected in response to medication errors to assess the cause and any contributing factor(s) such
11 as system or process failure(s).

12 107. Further, Respondents did not keep all of the following records in an immediately
13 retrievable form in the pharmacy:

- 14 • Date, location, and participants in the quality assurance review;
- 15 • Pertinent data and other information relating to the medication error(s) reviewed
16 and documentation of any patient contact;
- 17 • Findings and determinations generated by the quality assurance review; and
- 18 • Recommended changes to pharmacy policy, procedure, systems, or processes.

19 **SEVENTH CAUSE FOR DISCIPLINE**

20 **(Failure to Report Controlled Substance Prescriptions to CURES)**

21 108. Respondents PIC Marr and Valley Pharmacy are subject to disciplinary action under
22 Code section 4301, subdivision (o), and Health and Safety Code section 11165, subdivision (d),
23 in that Respondents did not report to CURES Schedule II-IV controlled substances that were
24 dispensed, as set forth in paragraph 64 above.

25 **EIGHTH CAUSE FOR DISCIPLINE**

26 **(Failure to Maintain a Current Inventory of All Dangerous Drugs)**

27 109. Respondents PIC Marr and Valley Pharmacy are subject to disciplinary action under
28 Code section 4301, subdivision (o), in that Respondents violated Code sections 4081, subdivision

1 (a), and 4105, subdivision (d)(1). As set forth in paragraphs 65 through 68 above, Respondents
2 failed to maintain an accurate current inventory of all dangerous drugs, and significant shortages
3 and overages of controlled substances were discovered, as set forth in paragraph 65.
4 Additionally, Respondents were unable to produce accurate prescription records, which they
5 maintained electronically. Despite several attempts, Respondents were unable to produce a
6 complete and accurate electronic copy of all records of drug acquisition and disposition, as set
7 forth in paragraphs 59 through 63 above.

8 **NINTH CAUSE FOR DISCIPLINE**

9 **(Compounding of Drug Products Without Master Formula Records and Other Information**
10 **Required by Law)**

11 110. Respondents PIC Marr and Valley Pharmacy are subject to disciplinary action under
12 Code section 4301, subdivision (o), in that Respondents violated CCR, title 16, section 1735.2,
13 subdivision (d), as set forth in paragraphs 69 through 71 above. The extent of Respondents'
14 compounding activity could not be determined due to a lack of compounding records.

15 **TENTH CAUSE FOR DISCIPLINE**

16 **(Failure to Comply with Compounding Record Requirements)**

17 111. Respondents PIC Marr and Valley Pharmacy are subject to disciplinary action under
18 Code section 4301, subdivision (o), in that Respondents violated CCR, title 16, section 1735.3,
19 subdivisions (a) and (d), as set forth in paragraph 72 above.

20 **ELEVENTH CAUSE FOR DISCIPLINE**

21 **(Failure to Comply with Compounding Facilities and Equipment Requirements)**

22 112. Respondents PIC Marr and Valley Pharmacy are subject to disciplinary action under
23 Code section 4301, subdivision (o), in that Respondents violated CCR, title 16, section 1735.6,
24 subdivision (a), because Respondents dispensed compounded prescription no. 8037774 without
25 maintaining written documentation regarding the facilities and equipment necessary for safe and
26 accurate compounded drug products, as set forth in paragraph 73 above.

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1 **TWELFTH CAUSE FOR DISCIPLINE**

2 **(Failure to Maintain Training Records of Pharmacy Personnel Involved in Compounding)**

3 113. Respondents PIC Marr and Valley Pharmacy are subject to disciplinary action under
4 Code section 4301, subdivision (o), in that Respondents violated CCR, title 16, section 1735.7,
5 subdivision (a), because Respondents dispensed compounded prescription no. 8037774 without
6 maintaining written documentation sufficient to demonstrate pharmacy personnel had the skills
7 and training required to properly and accurately perform their assigned responsibilities relating to
8 compounding, as set forth in paragraph 73 above.

9 **THIRTEENTH CAUSE FOR DISCIPLINE**

10 **(Dispensing Medication in Variance from Prescription)**

11 114. Respondents PIC Marr and Valley Pharmacy are subject to disciplinary action under
12 Code section 4301, subdivision (o), in that Respondents violated CCR, title 16, section 1716,
13 when they dispensed prescription no. 8014327 for 100 tablets of oxycodone 10 mg when the
14 purported prescription document was for oxycodone 30 mg, as set forth in paragraph 79 above.

15 **FOURTEENTH CAUSE FOR DISCIPLINE**

16 **(Failure to Exercise Corresponding Responsibility with Regard to the Dispensing or**
17 **Furnishing of Controlled Substances)**

18 115. Respondents PIC Marr and Valley Pharmacy are subject to disciplinary action under
19 Code sections 4301, subdivisions (j) and (o), and 4306.5, subdivisions (c), for unprofessional
20 conduct in that Respondents dispensed controlled substances without ensuring the prescriptions
21 were issued for a legitimate medical purpose and in the usual course of professional practice,
22 leading to the excessive furnishing of Schedule II-V controlled substances. In so doing,
23 Respondents violated Health and Safety Code sections 11153, subdivision (a), and 11164,
24 subdivision (a)(1), CFR, title 21, section 1306.04, subdivision (a), and CCR, title 16, section
25 1761, subdivisions (a) and (b).

26 116. As set forth in greater detail in paragraphs 74 through 98 above, Respondents
27 dispensed, without verification and/or adequate consultation of appropriate patient, prescription
28 and like records, controlled substances on prescriptions with red flags of abuse or misuse,

1 including forged prescriptions, non-compliant controlled substance forms, and prescriptions
2 having factors of irregularity. Such factors of irregularity included prescriptions written outside
3 of the prescriber's scope of practice, cash payment for prescriptions by new patients, high doses
4 and/or quantities, and prescriptions for similar patients dispensed in a short time period which did
5 not match the drug's usual use.

6 117. Additionally, Respondents dispensed at least 276 controlled substance prescriptions
7 more than five days before previous supplies were exhausted, without ensuring their use was for a
8 legitimate medical purpose, as set forth in paragraph 99 above.

9 118. PIC Marr had the training, education and experience to evaluate prescriptions in order
10 to make informed dispensing decisions. PIC Marr either failed to utilize or otherwise ignored this
11 training, education and experience, and along with Valley Pharmacy, furnished excessive
12 controlled substances on forged, non-compliant and irregular prescriptions, in violation of Code
13 section 4306.5, subdivision (a). Respondents therefore also failed to exercise or implement their
14 best professional judgment or corresponding responsibility with regard to the dispensing or
15 furnishing of controlled substances and dangerous drugs, directly leading to patients receiving
16 excessive controlled substances, in violation of Code section 4306.5, subdivision (b).

17 **FIFTEENTH CAUSE FOR DISCIPLINE**

18 **(Excessive Furnishing of Controlled Substances)**

19 119. Respondents PIC Marr and Valley Pharmacy are subject to disciplinary action under
20 Code Sections 4301, subdivisions (d) and (o), for unprofessional conduct in that Respondents
21 clearly excessively furnished controlled substances in violation of Health and Safety Code
22 sections 11153, subdivision (a), and 11164, subdivision (a)(1), CFR, title 21, section 1306.04,
23 subdivision (a), and CCR, title 16, section 1761, subdivisions (a) and (b), as set forth in
24 paragraphs 74 through 99 above.

25 **SIXTEENTH CAUSE FOR DISCIPLINE**

26 **(Gross Negligence)**

27 120. Respondents PIC Marr and Valley Pharmacy are subject to disciplinary action under
28 Code sections 4301, subdivision (c), for unprofessional conduct in that Respondents were grossly

1 negligent in dispensing controlled substances, as set forth in paragraphs 74 through 99 above.

2 121. Further, as alleged in greater detail throughout this accusation, Respondents were
3 grossly negligent in that they violated several statutes and regulations governing the practice of
4 pharmacy as follows:

- 5 • Code sections 4333, 4081 and 4104;
- 6 • Health and Safety Code sections 11165 and 11153;
- 7 • CCR, title 16, sections 1707.2, 1707.3, 1714, 1714.1, 1711, 1735.2, 1735.3, 1735.4,
8 1735.6, 1735.7, and 1716; and,
- 9 • CFR, title 21, sections 1301.75 and 1306.04.

10 **SEVENTEENTH CAUSE FOR DISCIPLINE**

11 **(Incompetence)**

12 122. Respondents PIC Marr and Valley Pharmacy are subject to disciplinary action under
13 Code Sections 4301, subdivision (b), for unprofessional conduct in that Respondents were
14 incompetent in dispensing controlled substances, as set forth in paragraphs 74 through 99 above.

15 123. Further, as alleged in greater detail throughout this accusation, Respondents were
16 incompetent in that they violated several statutes and regulations governing the practice of
17 pharmacy as follows:

- 18 • Code sections 4333, 4081 and 4104;
- 19 • Health and Safety Code sections 11165 and 11153;
- 20 • CCR, title 16, sections 1707.2, 1707.3, 1714, 1714.1, 1711, 1735.2, 1735.3, 1735.4,
21 1735.6, 1735.7, and 1716; and,
- 22 • CFR, title 21, sections 1301.75 and 1306.04.

23 **EIGHTEENTH CAUSE FOR DISCIPLINE**

24 **(Owner/Officer's Failure to Maintain a Current Inventory of All Dangerous Drugs)**

25 124. Respondent Ma is subject to disciplinary action under Code section 4301, subdivision
26 (o), for unprofessional conduct in that Ma, as Valley Pharmacy's President and 100%
27 shareholder, did not maintain an accurate current inventory of all dangerous drugs, as set forth in
28 paragraphs 59 through 63 and 65 through 68 above, in violation of Code section 4081,

1 subdivision (b).

2 **NINETEENTH CAUSE FOR DISCIPLINE**

3 **(Owner/Officer's Failure to Provide Requested Records of Dangerous Drugs)**

4 125. Respondent Ma is subject to disciplinary action under Code section 4301, subdivision
5 (o), for unprofessional conduct in that Respondent, as Valley Pharmacy's President and 100%
6 shareholder, did not provide records of dangerous drugs when requested, as set forth in paragraph
7 62 above, in violation of Code section 4105, subdivision (f).

8 **TWENTIETH CAUSE FOR DISCIPLINE**

9 **(Unprofessional Conduct as to Respondent Ma)**

10 126. Respondent Ma is subject to disciplinary action under Code sections 4301,
11 subdivision (o), and 4306.5, subdivision (a), for unprofessional conduct in that Respondent failed
12 to exercise his education, training, and/or experience as a pharmacist, in the course of ownership
13 of Valley Pharmacy, to prevent the pharmacy's gross deviation from the standards of pharmacy
14 practice.

15 127. As set forth in paragraphs 74 through 98 above, controlled substance prescriptions
16 were dispensed in a gross deviation from the standards of pharmacy practice by not resolving
17 and/or ignoring red flags of abuse or misuse. These actions and omissions led directly to patients
18 receiving excessive controlled substances.

19 128. Further, as alleged in greater detail throughout this accusation, Respondents violated
20 several statutes and regulations governing the practice of pharmacy as follows:

- 21 • Code sections 4333, 4081 and 4104;
22 • Health and Safety Code sections 11165 and 11153;
23 • CCR, title 16, sections 1707.2, 1707.3, 1714, 1714.1, 1711, 1735.2, 1735.3, 1735.4,
24 1735.6, 1735.7, and 1716; and,
25 • CFR, title 21, sections 1301.75 and 1306.04.

26 **OTHER MATTERS**

27 129. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number
28 PHY 49845 issued to L & S Pharmacy, Inc., L & S Pharmacy, Inc. shall be prohibited from

1 serving as a manager, administrator, owner, member, officer, director, associate, or partner of a
2 licensee for five years if Pharmacy Permit Number 49845 is placed on probation or until
3 Pharmacy Permit Number 49845 is reinstated if it is revoked.

4 130. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number
5 PHY 49845 issued to L & S Pharmacy, Inc. while Leland Kwong Ma has been an officer and/or
6 owner and had knowledge of or knowingly participated in any conduct for which the licensee was
7 disciplined, Ma shall be prohibited from serving as a manager, administrator, owner, member,
8 officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number
9 PHY 49845 is placed on probation or until Pharmacy Permit Number 49845 is reinstated if it is
10 revoked.

11 **PRAYER**

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

14 1. Revoking or suspending Pharmacy Permit Number PHY 49845, issued to L & S
15 Pharmacy, Inc. dba Valley Pharmacy of Sacramento;

16 2. Revoking or suspending Original Pharmacist License Number RPH 36980, issued to
17 Leonard Kwong Marr;

18 3. Revoking or suspending Original Pharmacist License Number RPH 32234, issued to
19 Leland Kwong Ma;

20 4. Prohibiting L & S Pharmacy, Inc. from serving as a manager, administrator, owner,
21 member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit
22 Number PHY 49845 is placed on probation or until Pharmacy Permit Number 49845 is reinstated
23 if it is revoked;

24 5. Prohibiting Leland Kwong Ma from serving as a manager, administrator, owner,
25 member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit
26 Number 49845 is placed on probation or until Pharmacy Permit Number 49845 is reinstated if it
27 is revoked;

28 6. Ordering L & S Pharmacy, Inc. dba Valley Pharmacy of Sacramento, Leonard

1 Kwong Marr and Leland Kwong Ma to pay the Board of Pharmacy the reasonable costs of the
2 investigation and enforcement of this case, pursuant to Business and Professions Code section
3 125.3; and,

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

5
6 DATED: 11/30/16

Virginia Herold

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

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