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

In the Matter of the Accusation Against:

ANITA BIROSEL-MCQUIGG, Respondent

Pharmacist License No. RPH 42446

Agency Case No. 6992

OAH No. 2020110142

DECISION AND ORDER

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Pharmacy, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective at 5:00 p.m. on August 18, 2021.

It is so ORDERED on July 19, 2021.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By 

Seung W. Oh, PharmD.
Board President

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PROPOSED DECISION

Adam L. Berg, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, heard this matter on March 17, March 18, and May 4, 2021. The hearing was conducted by telephone/videoconference due to the ongoing public health emergency.

Nicole R. Trama, Deputy Attorney General, Department of Justice, State of California, represented complainant, Anne Sodergren, Executive Officer, Board of Pharmacy (board), Department of Consumer Affairs, State of California.

Benjamin Fenton, Attorney at Law, represented respondent Anita Birosel-McQuigg.

Oral and documentary evidence was received. The matter was submitted on May 4, 2021.

SUMMARY

During an inspection of Phantastic Pharmacy on November 7, 2019, the inspector conducted an audit of promethazine/codeine, a Schedule V controlled substance, and determined there was a shortage of 4032 ml. In response to this finding, respondent, who was the pharmacy's pharmacist-in-charge, provided the board's inspector with false documentation in an attempt to show that 6 prescriptions, totaling 11 fills, had been legally dispensed but not accounted for in the records the inspector originally obtained. In addition, in response to the inspector's request for original documentation to support these additional six prescriptions, respondent directed the pharmacy technician to create false telephone prescriptions to make it appear that these six prescriptions were legitimate.

Clear and convincing evidence established respondent created false documentation, attempted to subvert the board's investigation, failed to secure controlled substances, and committed unprofessional conduct. At hearing, respondent's testimony was pervasively false and misleading. In addition to her dishonesty, respondent demonstrated global incompetence in her knowledge of pharmacy law, such that revocation is the only discipline sufficient for public protection.

FACTUAL FINDINGS

Background

1. On March 13, 1989, the board issued Pharmacist License Number RPH 42446 to respondent. There is no history of discipline imposed against the license. However, as a disciplinary consideration, on June 1, 2017, the board issued respondent a citation assessing a $100 civil penalty for falsely representing on her renewal application that she completed 30 hours of required continuing education, but in response to the board's audit, respondent only provided documentation establishing completion of 27 hours.

2. On September 4, 2020, complainant signed the accusation alleging respondent, as Pharmacist-in-Charge (PIC) of Phantastic Pharmacy located in Sherman Oaks, provided a board inspector with false dispensing records after an inspection revealed a discrepancy in the pharmacy's accounting of promethazine/codeine. As causes for discipline, complainant alleges respondent knowingly made a document falsely representing a state of facts, subverted or attempted to subvert a board investigation, failed to secure dangerous drugs, and committed unprofessional conduct. Complainant seeks the revocation of respondent's license and recovery of investigation and enforcement costs.

3. Respondent timely filed a notice of defense; this hearing followed.

Complainant's Evidence

TESTIMONY AND REPORT BY INSPECTOR JULIA KRUMER

4. Julia Krumer is a board inspector who prepared an investigation report dated April 3, 2020. Her testimony and the report are summarized as follows: Krumer obtained her Doctor of Pharmacy from the University of Southern California (USC) in 2006 and became licensed as a pharmacist in California. She worked at retail and compounding pharmacies until she was hired by the board as an inspector in 2016. During her time at the board, she has conducted over 300 investigations. As an inspector, she conducts routine inspections of pharmacies and investigates alleged violations of state and federal law as it relates to the practice of pharmacy.

5. On November 7, 2019,[1] Krumer and her supervisor conducted an inspection of Phantastic Pharmacy. Predicating this inspection, on February 26, 2019, Phantastic Pharmacy's PIC, Kenneth Asarch, notified the board and Drug Enforcement Administration (DEA) of a drug loss of three Schedule II controlled substances. In response to the drug losses, Asarch notified the board of his plans to correct security deficiencies. Asarch left employment with Phantastic Pharmacy in May. The purpose of Krumer's November inspection was to review the security procedures in place at the pharmacy.

6. During the inspection, pharmacist Katty Vu was the only pharmacist on-site. Krumer asked Vu who the pharmacy's PIC was, since Asarch had left in May. Vu identified respondent as having been hired as the PIC in August. She provided Krumer a copy of the board's application for a change in PIC, identifying respondent as the

[1] All future references to dates are in 2019 unless otherwise specified.

new PIC, with an effective start date of August 5. The form was signed by respondent on October 15.

7. Krumer reviewed the pharmacy's Schedule II inventory logs. She also selected promethazine/codeine[2] for audit. Krumer selected this drug because it is commonly diverted and has a high street value. She instructed Vu to conduct a "stock-on-hand" count of all promethazine/codeine in the pharmacy, which showed 946 ml of the drug in two sealed bottles (473 ml each). Krumer reviewed a drug inventory report, completed by Asarch on May 16, which was Asarch's last day at the pharmacy.[3] The report provided Asarch's hand-count of all controlled substances in the pharmacy. For promethazine/codeine, the report indicated 909 mL on-hand.[4] Krumer requested Vu print drug utilization reports for promethazine/codeine. The drug utilization report is generated by the pharmacy's software program and shows the dispensing history of drugs. Vu did not know how to print the reports, so Krumer had her call the pharmacy's software vendor to receive assistance. Krumer listened over speaker phone as Vu received technical assistance with printing the reports. Krumer provided the

[2] Promethazine/codeine (trade name Phenergan/codeine) is a cough syrup containing an antihistamine (promethazine) and opioid cough suppressant (codeine). It is a Schedule V controlled substance (Health & Saf. Code, § 11058, subd. (c)(1)) and a dangerous drug (Bus. & Prof. Code, § 4022).

[3] A board certification of records indicates that Asarch was Phantastic Pharmacy's PIC from January 4, 2018, until May 16, 2019.

[4] The report indicated two different National Drug Code (NDC) numbers, which is a universal product identifier for drugs. The two NDC numbers indicated the promethazine/codeine came from two different manufacturers.

relevant data she wished to obtain in the report. Vu printed and provided Krumer with multiple drug utilization reports, including two for promethazine/codeine for different time frames.

8. Krumer left an inspection report with Vu outlining her findings. She requested certain records be submitted, including that respondent, as PIC, provide a statement explaining what measures were taken to prevent future controlled substance losses. Krumer also left a receipt showing what documents she took from the pharmacy.

9. Following the inspection, Krumer contacted Cardinal Health (Cardinal), one of the pharmacy's wholesale drug distributors, and requested purchasing records for Phantastic Pharmacy. According to the certified records, from May 17, through November 7, Phantastic Pharmacy acquired 6149 ml of promethazine/codeine. She also obtained acquisition records for promethazine/codeine from February 20, 2018, through May 16, 2019, which showed the pharmacy acquired 4257 ml. Krumer noted that in the six months before the inspection, the pharmacy acquired 1892 ml more of the drug than it had the entire previous 15 months.

10. On November 19, respondent emailed Krumer with a list of changes she would be implementing regarding controlled substance security, including the installation of cameras and limiting narcotic key access. Respondent also wrote, "Also there was a pharmacist in charge during the transition period, a check was cashed. Is the cash receipt adequate?"

11. On November 20, Krumer spoke to respondent and requested that she provide a copy of the cashed check that was purportedly sent to the board to change

the PIC after Asarch's departure in May. Krumer also requested respondent provide information on the pharmacy's current ownership.

12. Krumer next conducted an audit of the promethazine/codeine. Krumer used two audit periods. The first was from February 20, 2018, to May 16, 2019, which were periods that Asarch had conducted controlled substance inventories at the pharmacy. Based on the acquisition and disposition records, the pharmacy had a shortage of 498 ml (1 bottle), which was an 11.7 percent variance from the pharmacy's acquisition of the drug. Next, Krumer conducted an audit for the period of May 17, 2019 (Asarch's last day as PIC) to November 7, 2019 (the date of her inspection). Krumer determined a shortage 4032 ml, equivalent to 8.5 bottles of 473 ml, which was a 65.6 percent variance from the pharmacy's total acquisition of 13 bottles. In her experience, the variance was significant because during a short timeframe, the equivalent of 1.4 bottles went missing each month. Krumer noted that respondent had not conducted a hand-count inventory of promethazine/codeine when she started as PIC, which is standard practice for a new PIC.

13. Next, Krumer contacted Cardinal Health and requested delivery receipts for promethazine/codeine to Phantastic Pharmacy. The receipts showed that following Asarch's departure, Vu signed for three bottles on June 7 and three bottles on June 27, and respondent signed for four bottles on September 11 and three bottles on October 21, 2019. Krumer noted that the delivery records for Cardinal were consistent with Phantastic Pharmacy's acquisition records. Put another way, Phantastic Pharmacy had accounted for all the bottles received by its wholesale distributor.

14. On December 9, Krumer spoke to respondent and notified her about the discrepancies in promethazine/codeine. Respondent said she did not know anything about it because she had just started working at the pharmacy in August. Krumer

asked respondent if she did a physical count of the Schedule III through V controlled substances when she started at the pharmacy. Respondent said she had not.

Later that day, Krumer sent respondent and Vu emails with an attached letter, advising that there was a discrepancy in promethazine/codeine, and requesting that if they had any information regarding the discrepancy, to complete an attached form under the penalty of perjury.

15. On December 11, respondent emailed Krumer stating that she faxed information regarding the variance reports for promethazine/codeine, and said she found additional invoices for promethazine/codeine purchased from Cardinal. Respondent provided invoices from Cardinal, which were the same as the invoices Krumer had received from Cardinal. The delivery receipts confirmed the pharmacy's receipt of 13 bottles from May 17 to November 7. Thus, there was no difference in what respondent reported the pharmacy had received than what Krumer had identified the pharmacy as receiving.

16. Respondent also provided a signed "variance report" showing that of the 6149 ml acquired, 5440 ml was dispensed, a difference of 709 ml. She also provided a current inventory of 593 ml (473 ml plus 120 ml). Subtracting the stock on hand of 593 ml from 709 ml, there was a variance of 116 ml (the amount unaccounted for). The report attempted to explain the variance by noting that if 10 ml of syrup was lost for each of the 23 prescriptions, there should be a 230 ml variance, which is greater than the 116 ml variance actually observed. Thus, the report indicated that respondent had accounted for all the promethazine/codeine.

Krumer found the variance report to be irregular. The report claimed that 5440 ml was dispensed, which differed from the 2080 ml shown dispensed in the

pharmacy's dispensing report Krumer received during the inspection. Respondent noted 593 ml in current inventory of promethazine/codeine as of December 11, 2019, and additional fills of 240 ml on November 26 and December 9, occurring after the audit. However, the pharmacy received no additional shipments of promethazine/codeine after the audit date. Since Krumer observed the pharmacy to have 946 ml on-hand at the time of her audit, with two additional fills totaling 480 ml after the audit date, the pharmacy should have only had 466 ml on hand – not 593 ml indicated in the variance report.

Krumer was also skeptical of respondent's claim that there was a justifiable loss of 10 mL for every prescription filled, which is equivalent to two teaspoons. She did not believe that it was within the standard of practice for a pharmacist to lose two teaspoons for every prescription filled.

17. Finally, respondent submitted a new dispensing report showing 6 prescriptions with 11 additional fills of 240 ml each that had not been included in the pharmacy's dispensing report Krumer obtained during the audit.[5] The report indicated the following:

- Patient A.L. had an initial fill on June 2 (Rx No. 124110), another fill on July 5 (Rx No. 124113), and refills on July 29, and August 5;

- Patient M.G. had an initial fill on June 17 (Rx No. 124108), with refills on June 24, and October 22;

[5] Krumer excluded prescriptions filled after the November 7 inspection, the end-date of her audit.

- Patient S.P. had an initial fill on August 13 (Rx. No. 124117) and a refill on October 25;

- Patient A.D. had a fill on August 12 (Rx No. 124114); and

- Patient J.G. had a fill on August 26 (Rx No. 124118).

None of these patients had been listed in the drug dispensing reports Krumer obtained from the pharmacy during the inspection. In other words, none of these patients had ever been dispensed promethazine/codeine as of February 20, 2018, but respondent was now claiming they had been dispensed promethazine/codeine during the audit period.

Krumer noted several irregularities in the information respondent provided. The first related to the prescription numbers for the six new prescriptions. A pharmacy's computer system will typically generate a sequential prescription number when the prescription is entered into the system. All six prescriptions had sequential prescription numbers even though they had fill dates differing months apart. Thus, prescriptions processed in one month would have a different numerical sequence than those processed in another month. Here, all the prescriptions, which were filled from June through October, had sequential prescription numbers indicating they were created in December.

18. The next day, Krumer spoke to respondent and inquired about the discrepancies in the dispensing record respondent had just emailed compared to the dispensing record provided during the inspection. Respondent said the original dispensing record was not correct because Vu did not know how to pull the correct dispensing records and was nervous during the inspection. This explanation made little sense to Krumer, who was with Vu the entire time Vu was on the phone with the

software vendor; Krumer had no reason to believe that the report Vu printed was inaccurate. Respondent said the prescription numbers were different because the pharmacy does out-of-state dispensing. This was also suspicious to Krumer, because she had never received any information that the pharmacy did out-of-state prescriptions, and regardless, there was no reason why an out-of-state prescription would affect the numerical sequence of the promethazine/codeine prescriptions.

Krumer requested respondent to provide copies of the six prescriptions that were included in respondent's new report by the close of business. She also requested respondent complete a statement, under the penalty of perjury, stating that the dispensing report Krumer received from Vu was not accurate. Krumer also advised respondent that it was a cause for disciplinary action to provide misleading statements. Krumer never received the signed statement as requested.

19. On December 12, Krumer spoke to Phantastic Pharmacy owner Rouben Davtyan and his attorney, Tony Park. Park inquired about what information Krumer needed from the owners. Krumer requested information on ownership and a copy of the cashed check to the board for the interim PIC that respondent claimed had been submitted. On December 16, Park provided Krumer with notice of representation of Phantastic Pharmacy, respondent, and Vu.

20. Krumer obtained a Controlled Substance Utilization Review and Evaluation System (CURES) for Phantastic Pharmacy. Although pharmacies were not required to report Schedule V controlled substances at the time, Phantastic Pharmacy had been submitting data for promethazine/codeine dispensing. The CURES report showed the same prescriptions were dispensed in the original dispensing report Krumer obtained at the time of the inspection, with the addition of two prescriptions on October 22 and 25, which were not in the original dispensing report.

21. Over a month later, on January 22, 2020, Krumer received a letter and attached documents from Luis Vizcocho, Park's associate.[6] In the letter, Vizcocho provided a list of all the fills for promethazine/codeine from June 2 through December 9, for a total of 5440 ml, indicating a shortage of 116 ml. This was the same list and information respondent provided to Krumer on December 9. Vizcocho reiterated respondent's claim that there was a justifiable loss of 230 ml for each of the 23 prescriptions filled.

Vizcocho also submitted prescription documents in support of the additional prescriptions contained in the dispensing report provided by respondent. This included "telephone prescriptions" for five patients. He also submitted signed "attestation letters" from three of the four physicians who were responsible for ordering the prescriptions in question.

Vizcocho wrote that while they agree that the prescription numbers assigned to the six suspect prescriptions were inconsistent with the purported date of process, respondent created those records with the "good faith" intention to accurately post-account for all the prescriptions that were dispensed from the pharmacy, and not to "trifle" with the investigation or tamper with records. He wrote that respondent informed "us" that she conducted a follow-up investigation after receiving the board's notice letter regarding the discrepancies. During her investigation, respondent found the hardcopy for six prescriptions, which she determined to have been dispensed but not properly recorded in the pharmacy's computer system. With these findings, respondent processed these prescriptions into the computer system to reflect the

[6] The letter was sent as an email attachment and copied to what is listed as respondent's email address. The letter also indicated respondent had been copied.

correct dispensing numbers for the drug. However, respondent did not realize the adverse implications of her actions until Park's law firm was retained. Respondent is now aware of her errors, but the mistake did not change the fact that the suspect prescriptions were legitimately ordered by the prescribers, as documented in the attestation letter. Finally, respondent tried to ascertain why the suspect prescriptions were not processed in the pharmacy's computer system when the orders were created, however a root cause could not be established because the pharmacy came into possession of the prescription orders after the previous PIC left the pharmacy, and the pharmacy had no PIC of record until August 2019, when respondent became PIC.

22. Krumer reviewed the six telephone prescriptions that Vizcocho provided. All were telephonic prescriptions written for the same quantity and with four refills. Four of the prescriptions were written with the same directions, "10 ml bid prn." All prescriptions were written in similar handwriting. Two of the prescriptions were in June, one in July, and three in August. One of the prescriptions was on a Sunday, when the pharmacy was closed. Finally, all the prescriptions were written with four refills. This was also very unusual because promethazine/codeine is not a maintenance medication so it would be irregular for a prescriber to provide four refills.

Affixed to the telephone prescriptions were printed labels, also known as the back tag, which is essentially a duplicate of the label affixed to the medication bottle and shows the date dispensed. Affixing the back tag indicates that the prescriptions had been filled. All the prescriptions were processed with the same NDC number, which the pharmacy acquisition invoices showed had not been delivered to the pharmacy until October, after which most of the prescriptions were supposedly dispensed.

Krumer reviewed the signed attestation letters, which were the same except for the names of the doctors signing the document. The letters did not list specific patient names, specific prescription numbers, or dates the prescriptions were authorized. The letters stated that the prescriptions in the "attached dispensing report" were prescribed by the doctors, but no dispensing report was attached to the letters.

23. On February 12, 2020, Krumer emailed Vizcocho and requested additional documentation regarding the six prescriptions including identity of the pharmacist who took the phone order and filled/refilled the prescriptions; duplicate copies of the prescription labels on the dispensed medication; an explanation of how the medication was labelled if the prescriptions had not been processed in the pharmacy computer system; copies of the controlled substance refill logs for the refills; and patient dispensing history for the patients for the six prescriptions.

24. In response, on February 26, 2020, Vizcocho emailed Krumer a letter from Davtyan stating, "We were shocked and disappointed when we discovered that yesterday (February 25, 2020) from [respondent] our pharmacist, that she did not, in fact, have any documents related to those 6 prescriptions in question." Davtyan wrote that when he pressed respondent for details surrounding those prescriptions, she said they were based on her recall memory and not any documentation. She said that this error in judgment was triggered by panic and anxiety over not being able to account for controlled substance inventories. Davtyan wrote that respondent would no longer be working at the pharmacy.

25. Krumer noted that four of the prescriptions had written dates prior to respondent's employment at the pharmacy in August, and thus could not have been based on her memory. Krumer left a voicemail for respondent on March 12, 2020. The next day, respondent called and said she was trying to gather additional documents.

Krumer returned the call and again asked respondent to contact her before she provided any documents. On March 18, 2020, the two spoke and Krumer advised respondent about the information she received from the pharmacy owner. Respondent said the owner lied, and she had done nothing wrong. She said the pharmacy's technician told respondent about the telephone prescriptions respondent provided. She said she was very upset with the owner and quit working at the pharmacy.

26. Krumer provided respondent an additional notice of possible violations related to unprofessional conduct and a blank statement for respondent to provide a sworn statement. Although respondent said she was trying to obtain additional documents, respondent never provided Krumer with the requested statement.

27. On February 9, 2021, respondent emailed another board inspector, Ben Rustia, printed copies of labels and back tags for eight of the suspect prescriptions. Her email is reprinted in its entirety [all errors in original]:

> These are some key documents that were issues by the inspector. One of the sheets show that I emailed Digital RX that previous reports by digital could be even accurate by Ken cause drugs were not recalibrated into the system which you can tell by the email. They sent me email though on the proper process, more of a training email. They didn't want to take any responsibility but again I know the previous Pharmacist Ken did not even keep up on inventory that was received into the system. Even his first report sent to the board was probably inaccurate. I can forward the email they sent me for proof. Again another letter should be coming and Rouben is to get the sign MD signatures for

direct prescriptions. Also Who is going to be in the settlement conference?

TESTIMONY OF KATTY VU

28. Vu obtained her Doctor of Pharmacy from USC and worked at Phantastic Pharmacy intermittently from May 2019 until February 2020. Until respondent joined the pharmacy in August, Vu was the only pharmacist in addition to a pharmacy technician. Vu testified that the pharmacy filled 10 to 20 bags per day, with 5 to 15 prescriptions per bag. It was rare for the pharmacy to receive new phone prescriptions. Most of the prescriptions were received by fax, and refill requests phoned-in by the nurses. Vu never took any phone prescriptions by doctors while she worked there. Once a prescription was received, the technician would immediately enter the information into the computer system. The technician would then print a label and pull the medication. If everything was accurate, Vu would fill and bag the prescription. There were never any occasions where a prescription was not entered into the computer system right away. The computer system auto-generates a prescription number for new prescriptions. The technician was able to process refills phoned in by a nurse. Vu never dispensed any prescriptions that had not been entered into the computer system because there would be no way to print a label.

29. After Krumer's inspection, Vu left a note for respondent indicating she found a discrepancy in promethazine/codeine. Respondent said she would contact Cardinal Health to see if the records matched what the pharmacy had received. Respondent asked Vu how to run reports, which Vu showed her.

30. Vu testified that it is unusual to see a prescription for promethazine/codeine with four refills. She never saw scripts filled at the pharmacy

without being processed in the computer system. In fact, she did not believe it possible to fill a prescription if it were not entered into the system. Respondent never asked Vu if Vu had filled the "missing" scripts. Respondent never told Vu she was entering the scripts retroactively. It is not the usual practice in pharmacy to enter scripts retroactively after they had been filled. Vu never observed the technician reprinting old labels and putting them on new prescriptions.

31. When Vu started at the pharmacy there was not a PIC. She had never worked at a pharmacy where there was not a PIC. In mid-June, Davtyan asked Vu if she wanted to be the PIC. Vu declined because she did not feel she had enough experience. Vu was never told that the previous PIC, Asarch, had discovered missing controlled substances.

TESTIMONY OF ROUBEN DAVTYAN

32. Davtyan is the part owner of Phantastic Pharmacy. He has no pharmacy training and relies entirely on the PIC to run the pharmacy. After the board's inspection, Davtyan had several conversations with respondent. At first respondent claimed she had memory recall of the prescriptions that were not in the original report. Later, respondent said it was actually the technician, Lilia Gharakhanian (referred to in testimony as "Lilly") who remembered the prescriptions. After he learned this, he realized respondent could not continue working for the pharmacy, and she resigned soon after. Davtyan did not know anything about the documents submitted to the inspector. Davtyan asked respondent about them, and she replied that they were valid prescriptions. Davtyan then followed-up with the doctors to make sure they were valid prescriptions. Davtyan initially believed respondent that she had recalled filling the prescriptions. However, when he looked at some of the documentation, he realized some of the fills pre-dated her employment. When he

spoke to respondent again, she told him that Lilly had remembered filling the prescriptions. Davtyan denied any involvement in preparing the documentation, except for obtaining letters from the doctors. He contacted the doctors and asked them if they had authorized the prescriptions. He provided them attestation letters to sign, but he did not include a dispensing report indicated in the letter. Davtyan rehired respondent in April 2020 because he found issues with Lilly and needed someone to keep an eye on her. He later fired Lilly at the end of 2020. Lilly was the only full-time employee. The pharmacy had a lot of Armenian patients and Lilly spoke Armenian. Davtyan also owns a hospice, and the pharmacy would sometimes dispense medications to the hospice patients.

33. Asarch left as PIC in May 2019. Asarch did inform him that Asarch had reported missing Schedule II drugs to the board. Davtyan does not believe he informed respondent of this. After Asarch left, Davtyan discovered that he had been reprinting labels without entering a new prescription into the system. Because they were not in the system, the pharmacy could not bill. However, these were usually cash payments.

TESTIMONY OF TSOVINAR TEKKELIAN, M.D.

34. Tsovinar Tekkelian, M.D., testified at hearing and submitted a sworn declaration. Tekkelian has been licensed by the Medical Board of California (Medical Board) since 1993. He is board certified in internal medicine and has a practice in Los Angeles County.

35. He testified that he sometimes prescribes promethazine/codeine, but he never authorizes refills on medication containing codeine. He would never authorize four refills in a prescription. Tekkelian reviewed the telephone prescription for M.G. for

promethazine/codeine issued on June 17, 2019, with four refills. Although M.G. was his patient, he never authorized a prescription for her. It is his custom and practice to document prescriptions in the patient's chart. He reviewed the patient's records and determined he never prescribed promethazine/codeine to her. Additionally, he did not believe he was able to phone in prescriptions containing codeine because an original prescription is required.

TESTIMONY OF DOMINGO BARRIENTOS, M.D.

36. Domingo Barrientos, M.D., has been licensed to practice medicine since 1996. Although he does prescribe promethazine/codeine, he never issues four refills. This is because it is a dangerous medication susceptible to addiction. Barrientos reviewed a telephone prescription for promethazine/codeine for patient A.L. allegedly prescribed on June 2. The phone prescription contained the notation, "Ok by Dynina." Barrientos said Dynina was the director of nursing at a palliative care center in Van Nuys. He denied ever giving refills on controlled substances and said a patient would need to be seen. He did not authorize her to call in a prescription for this patient. There are no records in the patient chart showing that it was prescribed. Similarly, he did not authorize a prescription for this patient on July 5.

37. Barrientos also reviewed a telephonic prescription for A.D. he supposedly prescribed on August 12. Although A.D. was his patient, he never authorized a prescription for promethazine/codeine, and there is not documentation of this in the patient's records.

38. Phantastic Pharmacy's owner Davtyan did contact him and asked him to sign a letter regarding the prescriptions. He signed the letter because Davtyan told him there was an issue with a hospice patient and he needed to verify the prescription

was valid. Barrientos said he made a mistake signing the document without verifying he had issued the prescription.

TESTIMONY OF IRAJ ZAMANIAN, M.D.

39. Iraj Zamanian, M.D., has been licensed by the Medical Board since 1985. Patient S.P. was his patient, but he did not prescribe her promethazine/codeine. He had never seen the December 17, 2019, letter submitted to the board by respondent's attorney. He noted that he legally changed his name several years before, and no longer has the first name "Alexander," which is written in the stamp next to the signature. He said this was likely an old stamp maintained by the receptionist. He was not aware of who signed the letter and never authozied it being signed on his behalf. Although there was a progress note for the patient, written by one of his staff members, he never authorized his staff to phone in a prescription for promethazine/codeine.

Respondent's Evidence

RESPONDENT'S TESTIMONY

40. Respondent's testimony is summarized as follows:[7] Respondent received her Doctor of Pharmacy from the University of California, San Francisco in 1987. She

[7] Respondent's testimony was often very difficult to follow, was occasionally non-sensical, and throughout direct and cross-examination, respondent frequently answered with non-responsive narratives. Multiple admonitions to listen to the question and provide answers to that question were ignored. For this reason, it often difficult to summarize in a logical or coherent manner. Accordingly, her testimony is

worked as a staff pharmacist and pharmacy manager in home infusion and inpatient pharmacies for most of her career. Most of her experience is in long term and acute care. From 2008 to 2017, she was a part-time staff pharmacist at Indian Health Pharmacy, doing medical patient management. Respondent then worked for two staffing agencies, one of which sent her to work at Phantastic Pharmacy. Respondent denied ever being terminated from a position, although admitted to leaving "at least a couple" positions because of "political strain," which she admitted were "unfavorable circumstances."

41. Respondent started at Phantastic Pharmacy on August 19. When she started, she was not clear on her role. She believed she was there on a trial period to see how the relationship worked. Phantastic Pharmacy was the most difficult pharmacy she worked at in her 30-year career. Nothing was being followed in accordance with pharmacy laws. She was not expecting to walk into a pharmacy so badly run.

42. Respondent worked at the pharmacy three days per week. Respondent kept finding issues that she had to fix. One example was that the narcotic key was available for anyone in the pharmacy to use. She secured it in a lockbox where only the pharmacists would know the code. There were no records to track drug wastage. There was also storage of drugs in a cheap refrigerator, which she replaced. She found empty Schedule II narcotics containers in a drawer, which she addressed. She created a separate log for Schedule II prescriptions.

43. Respondent testified on multiple occasions how pharmacy records were "inconsistent." She was asked to be specific about what exactly was inconsistent but

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mostly summarized in chronological order, and direct quotes are used extensively where a coherent summary is simply not possible.

would not provide an answer. However, she noted that after the audit, she implemented additional changes. She claimed to be unaware that the previous PIC, Asarch, had reported drug losses.

44. Phantastic Pharmacy primarily serviced hospice facilities. The nurses would notify the pharmacy they needed a medication and there is "a regulation that you can send medications out in cases of emergency and they would also notify the doctor." The pharmacy staff interacted more with the hospice nurses than doctors, approximately three or four times per day. The pharmacy would also receive a sheet from the hospice showing new prescriptions, but most were refills. Respondent was asked to address the doctors' testimony that they did not do refills for promethazine/codeine. Respondent first answered, "If the doctor did a refill, we would check with the nurse before sending it out." When again asked the same question, she responded, "The fact we are in daily contact with the nurse and they send us a weekly updated list; since they're hospice they do expire and we don't want to be sending drugs out unless we need to." Respondent never did address the question.

45. Lilly had a "major role" in the pharmacy. She talked to people because of language difficulties. She talked to the nurses, and they "really relied on her and would text her." Lilly had worked in the pharmacy over a year. She was the only full-time employee.

46. After Krumer inspected the pharmacy, respondent created a log for promethazine/codeine. Respondent did this because she said she found the reports were not "necessarily that accurate." Respondent believed the reports were not accurate because of the discrepancies in the promethazine/codeine identified by Krumer. When asked why reports were not accurate, respondent answered, "when you run certain reports you get three different numbers and actually one report did not

include a different patient's name .....Depending on the report you run, it will include people or not." She claimed to have addressed this with "Digital [the software vendor]." When asked why she did not notice this before the inspection, she answered, "Because at the time I was still learning the system and the daily reports does [*sic*] not really show some of, like, the daily reports would probably have been more accurate since shows less numbers."

47. Respondent learned of the inspection when Vu called her and informed her the inspector was there. Vu told respondent she did not need to come to the pharmacy. Respondent learned of the promethazine/codeine discrepancy when she received a handwritten note from Vu stating that something was "off." Respondent started running reports to see "what was really going on." The reports showed that "none of the numbers were matching, the Cardinal invoices weren't matching, the Cardinal reports weren't matching, and overall nothing was matching. I had three different numbers." She said Vu's numbers were different, the inspector's numbers were different, and she "was trying to figure out what was going on." When asked to provide specifics about what exactly was not matching by referring to the hearing exhibits, respondent did not provide a clear answer and repeatedly referred to the Cardinal invoices. She reiterated that certain reports were inaccurate but would not provide any details explaining why she believed the report was inaccurate, even when the ALJ repeated the question multiple times. She also repeatedly referred to events occurring during the tenure of the previous PIC, Asarch, who left in May.

48. Respondent learned that that not all prescriptions that were dispensed were entered into the system, which is why the records were not reliable. She explained that if a prescription label had been reprinted, then it would not be included in the report. "If the promethazine/codeine was not even in the system, then if it's not

even really in the system, then the report is based on a drug or an NDC number that would not actually be there at the time." She confirmed with the software vendor that "unless you make sure the entire system is accurate from the beginning, most reports are not going to be accurate generated in reality." Thus, rather than a discrepancy, respondent concluded that the reports were not reliable.

49. She then conducted an investigation to determine the issues. Respondent felt it her responsibility to investigate the discrepancy because it was a controlled substance, people rely on the pharmacy for good records, the pharmacy has to ensure the drug profile is accurate, and the pharmacy is frequently called to verify if the person is on a medication. It is important for the patient that the pharmacy has a record of dispensing the drug to the patient. Also, Krumer instructed respondent to "look into the discrepancy," and respondent knew it "needed to be looked at closely." She looked for the "hand invoices" from the distributors, which showed receipt of the drugs. Respondent said they were "poor records" because they did not have invoices for drugs actually received. She said you could run a report from Cardinal Health and see that they sent promethazine/codeine, but the pharmacy did not have a copy of the invoice. Respondent made sure Krumer knew respondent had found extra invoices. The invoices Krumer received during the inspection were not complete, as respondent found additional invoices when she went to the wholesaler's website.[8]

[8] According to Krumer's investigation report and official receipt of documents she took from the pharmacy during her inspection, Krumer did not take any invoices from the pharmacy. Rather, Krumer obtained copies of the invoices through a request to Cardinal Health directly. As previously noted, the invoices respondent provided to Krumer were exactly the same as the ones Krumer obtained from Cardinal.

50. Respondent then ran a report that "shows drugs dispensed for that particular drug." She ran a drug utilization report to show the drugs received to show inventory in the pharmacy. She tried to find the hard copy of the prescriptions, which could show that prescriptions had not been entered in the system. She looked in the pharmacy but could not find records.

She asked Vu, but Vu only worked two days per week. Respondent then checked with Lilly, who was there during the time period, was full-time, spoke to patients daily, spoke to nurses, and has an "exceptional" memory. Respondent asked Lilly if she recalled any records that would explain "what was really going on with the promethazine/codeine." "Lilly remembered certain patients that should have been in the system." Respondent believed Lilly because "they were existing hospice patients, and there were other indications that they needed the medication." When asked why respondent felt she could rely on what Lilly was telling, respondent's non-responsive reply was, "it is important to maintain a drug profile for a patient," and "it is the law to maintain proper records" because nurses and doctors rely upon them. When asked what considerations made respondent believe Lilly was credible such that respondent could use her memory to create records, respondent replied that Lilly was there five days per week, knew all the patients, spoke the language, spoke to the nurses, and had positive relationships with everyone. Respondent asked Lilly more than once, and Lilly said she has the prescriptions. When asked what steps respondent took to update the records after Lilly told her about these prescriptions, respondent answered, "She originally told me yes, she remembered, she started giving me prescriptions, and I checked like three different ways and make sure, and we also get hard copies from the nurses that are faxed over too. So between one, two, three, four ways, I could see I could rely on this information."

Respondent was asked to review one of the five handwritten telephone prescriptions that attorney Vizcocho submitted to Krumer in January 2019.[9] Respondent said she provided these telephone prescriptions to the lawyers. When asked what the documents were, she replied, "It is just for documentation to show and make sure the records were updated and the profile." When asked if respondent instructed Lilly to create these documents, respondent answered, "She also gave me printed copies too . . . from the hardcopy prescription too . . . because I felt I needed a system, it looked like a real prescription too, but we also get faxed prescriptions from the doctors too, that she assured me we had." Respondent told Lilly, "If it was a verbal, we should probably put it down as a verbal too, so that is why we did that." When asked how respondent determined the appropriate date for the prescription, respondent said she "relied on Lilly as well," and added, "but it was filling in the records." The following colloquy then transpired:

> Attorney Fenton: Were you trying to make it seem that this existed back on this date?
>
> Respondent: Yes.
>
> Attorney Fenton: Ok, well, was that your understanding?

[9] The specific document (Exhibit 31, p. A235) is on a form titled "Telephone Prescription." The handwritten prescription is for patient M.G., dated June 17, for 240 ml of Phenergan/codeine, by Dr. Tekkelian, with the notation "OK by Anna." Below the prescription is an affixed prescription label, also known as the "back tag" or "auxiliary label." The label indicates the prescription was dispensed on June 17 and filled by respondent. There is a handwritten "x" across the label.

Respondent: My understanding is that I needed to make sure there were records.

Attorney Fenton: Ok, so what is this sticker that is crossed out?

Respondent: It doesn't mean anything that she put labels on there, it really doesn't mean anything. That's just an accidental label being put on there. It doesn't mean anything.

ALJ: An accidental label?

Respondent: Yes, it happens, but she just crossed it off and I said ok.

ALJ: Ok, wait, wait. A235, whose handwriting is that?

Respondent: That's Lilly's.

ALJ: When did she create this document?

Respondent: About the time I was doing the audit, I was instructed to do this audit.

ALJ: You told her to write this?

Respondent: No, she actually gave a printed, she gave me a combination of things.

ALJ: What did she give you?

Respondent: She gave me a hard copy, she gave me . . .

ALJ: A hard copy of what?

Respondent: A printed hard copy prescription but at the time I didn't know if it was the actual hard copy.

ALJ: What do you mean you didn't know if it was the actual hard copy?

Respondent: Because we also get a faxed order from the doctors too. A list of faxed orders too.

ALJ: She gave you a hard copy of the prescription, a handwritten prescription written by a doctor?

Respondent: No, she gave three documents, a hard copy, and so I said was it verbal? A hard copy like an electronic.

ALJ: What document did she provide you?

Respondent: Like an electronic prescription.

ALJ: She provided you with an electronic prescription? What was on that document?

Respondent: It's like an electronic prescription that looks exactly like an electronic prescription and we do use them because we can take that like a verbal order and then she also gave me . . .

ALJ: Ok, stop, where is this electronic prescription that she gave you?

Respondent's attorney then referred to Exhibit B[10] and asked if that was what Lilly gave her. The questioning continued:

Respondent: Those [Exhibit B] are like it too.

ALJ: Like it, or they are? These are the documents she gave you? With Tony Park listed on it . . . that was created in December?

Respondent: Right, that is an added note you add later so a reprint of this that I gave you it will show up no matter what. On reprints, even if I have to print it later, comments will show up on a copy like this.

ALJ: Where is the original hard copy she gave you?

Respondent: I don't have that because to me it was the original hand prescriptions that was the actual true document.

ALJ: A hand prescription form the physician?

[10] This document, titled "Hard Copy" for patient A.L, is for promethazine/codeine 240 ml, issued by Dr. Barrientos, filled on June 2, and lists respondent's initials as the pharmacist. Under "Rx Notes" is the following entry: "D/C Date 12/16/2019" and "TONY PARK -BOARD."

Respondent: Mmm hmm.

ALJ: But you have no record of that now?

Respondent: Because it's in the system too. It's retrievable.

ALJ: This is absolutely making no sense. You're accused of fabricating prescriptions and you're saying you have a handwritten prescription from the doctor but you've not submitted it.

Respondent: It's for post-documentation.

ALJ: Post . . .

Respondent: It's for after the fact to show records.

ALJ: After the fact to show a record of what? What did the doctor write?

Respondent: According to her [Lilly] this is what the doctor wrote. Ok. So I said technically did you take an oral-type prescription. Yes. Ok, but she also printed off, which she tended to do is also printed a hard copy. Those comments were not there at the time. She gave me the written and the hard copy and also told me there were going to be faxed orders.

ALJ: What is the written copy? You keep saying the written prescription? What is the written prescription for A.L. that

Lilly supposedly gave you in December when you were looking at this?

Respondent then referenced the telephonic prescription documents (Exhibit 31) "and a hard copy that is readily retrievable in the computer." Respondent then admitted that the handwritten telephonic prescriptions were created by Lilly in December at respondent's instruction. The questioning resumed:

ALJ: What original documents from this June prescription did she provide you, not that were created in December. What were the original documentation?

Respondent: She was supposed to have . . .

ALJ: What was the original documentation that she provided you? You said, you testified that she provided you with three things, what were those original things?

Respondent: It's supposed to be a faxed . . .

ALJ: What were the original documents that she provided you? I'm going to ask you the last time, I find your testimony to by highly incredible. Listen to the question and answer the question. What were the three documents she provided you?

Respondent: I don't find him respectful. And I mean it. I have to take a break.

51. Following a short break and explanation by the ALJ as to why he was asking these questions, questioning resumed by respondent's attorney, who asked respondent to identify the original documentation Lilly provided her. Respondent said Lilly told her there were prescriptions for these patients. She gave respondent a hard copy and a handwritten telephone prescription. Respondent asked Lilly three times for the original documents, but respondent "never really got it from her." Because it was "a busy time of year and things were disorganized," she accepted Lilly's representation that she had original records and that the prescriptions were dispensed. Lilly was "adamant" that they were dispensed, and respondent had no reason to believe this was not true. Respondent gave the written telephone prescriptions to her attorneys. Respondent denied she was trying to mislead the inspector when she had Lilly create these records to fill in the gaps in the records. She thought it was important to create a record for these prescriptions because she knew that labels were just reprinted and there were no records. Respondent believed that the current prescription numbers would show that this was "post-documentation."

52. Respondent was asked about the printed labels she sent to the board on February 9, 2021. Respondent said she printed the labels because Davtyan asked for a copy of them. She just "reprinted the label" which was already in the system. Respondent had no involvement with the request to verify the prescriptions with the prescriber. That was done by Davtyan and the attorneys.

53. Post-documentation is done all the time "to create accurate records to show and help to evaluate overall therapy, and pharmacists are really relied on what the accurate record of a drug profile is. We always have the best records." This is what she attempted when she worked with Lilly to create these records. She did not believe that any records that she ordered created falsely represented a state of facts because

"Lilly was adamant that they were correct." Respondent denied trying to subvert the board's investigation and insisted she was "just trying to create a record to show proper information and also for reliance on the pharmacy for medication therapies."

54. When asked if respondent could have handled her post-documentation in a better way, and what she could have done to improve her transparency, she responded, "Well, the numbers speak for themselves you can tell it's post-documentation. You see that on CURES all the time. The one thing you could have done was to add an additional note." When asked what the note would contain, she responded, "It's all on the label, the only thing is the record, I could add that, but to me, it's, I could have told the inspector more clearly, but to me it was quite obvious, so I apologize for that." When asked what she would have told the inspector had the inspector ever asked how she got these additional records, respondent stated, "I would have told her that its already backdated to 6/2, it's a little, it's very obvious."

55. Respondent denied she was fired from Phantastic Pharmacy. She said after Davtyan sent the letter to Krumer (falsely stating they fired respondent) she resigned and gave two weeks' notice. She had another job opportunity at a pharmacy closer to her residence but that "didn't work out," so she asked Davtyan if she could return. She is still employed at Phantastic Pharmacy and "still has a key." On later questioning, she testified that the pharmacy has been closed since January 2021 when the permit expired and her application to become PIC had been denied.

56. Respondent addressed her prior citation by the board. She said she was going through a divorce and did not intend to falsely certify she completed all her continuing education when she was in fact three hours short.

57. Respondent's testimony during cross-examination is summarized as follows: Respondent was asked whether a pharmacy technician can perform discretionary tasks, respondent answered, "What do you mean by discretionary? They do make decisions but are supposed to run it past the pharmacist . . . They are supposed to check with you."

58. Respondent admitted that she signed and submitted an application to be designated as PIC, retroactive to August 5. When asked why she agreed to become the PIC of such a "sloppy and disorganized" pharmacy, respondent said when she agreed to come, she did not know how bad it was because "you would not think a two-person operation would be such a mess." When she did know how bad things were, she made sure changes were implemented. She was constantly having difficulty with the staff and she went to Davtyan to implement changes.

59. At the beginning of the week, the pharmacy would get a list of all the hospice patients, then they send over the orders for medications. They did not fill any prescriptions without an order, "so in reality, we were really doing extra steps to ensure we were sending medications out properly." These lists include both original prescriptions and refills, similar to a hospital where orders are faxed down.

60. Except for counting the Schedule II controlled substances, respondent did not conduct an inventory of the other schedules when she started at the pharmacy because she was returning to management and had managed more IV medications. However, she was concerned about the security of all the controlled substance and ensured that they were locked up. When asked if it was the standard for a PIC to conduct an inventory of all controlled substances upon the start of the position, respondent said she was "trying to get to it," but had to take care of major problems

first. Respondent admitted in hindsight that she should have, but she had to take the acute problems first.

When asked if she performed an inventory of promethazine/codeine in August when she started, respondent said she did a "limited inventory of big bottles." She said she saw a half a bottle of promethazine/codeine. When asked if she made a record of her inventory, she referenced "daily reports," but then said she had not made a record of her inventory. When asked if she ever did an inventory of promethazine/codeine, respondent said, "they had Schedule III to V reports" and they made sure "to monitor it but did not per se write it down." When asked if she ever did an inventory of promethazine/codeine prior to the inspection, she responded, "You can do a daily report, which gives you a feel," to tell if anything was "off", and the daily report "is a form of inventory control too." When asked if she did an on-hand count, she said she did not "because you can do an inventory report and can tell immediately if a bottle is missing, because I would fill and was hands-on with the drugs." She added that Vu should have been doing it too, but because respondent locked up the promethazine/codeine, and because only the pharmacist has a key, she could tell by reports on a regular basis how many prescriptions were dispensed. Respondent was then asked if this were the case, how come she did not discover the discrepancies with the promethazine/codeine, she responded, "Those were prior recordkeeping problems. I got there on 8/5 and was still learning the entire system, all those discrepancies are from the past." When it was noted that some of the unaccounted promethazine/codeine occurred during her tenure, respondent said, "I was just starting and still trying to figure out what the heck they were doing." Respondent repeated that they filled narcotics daily and from the reports she could tell if anything was "off." She repeated that the daily report was a form of recordkeeping and she locked the promethazine/codeine up too. When she figured out what was going on, she did

everything she was supposed to do, especially since she did not know if she was "per se" the PIC. She did not submit the PIC application until October 15, because "in reality I was not really the pharmacist-in-charge and I did not really have authorization to move stuff around so that was a grey area."

61. Respondent was questioned about her statements related to the Cardinal Health invoices, and the fact that the invoices provided by respondent to Krumer were the same as the invoices Krumer had received directly from Cardinal. Respondent would not admit that the invoices accurately reflected the amount of promethazine/codeine received by the pharmacy, and asserted, without any evidence, that the invoices could have been inaccurate as to what was actually delivered.[11]

62. After respondent learned of the discrepancy from the inspector, she spoke to Vu, who "did not know anything." She then asked Lilly, who remembered all the details of all 6 prescriptions totaling 11 fills because, "she is good." Respondent believed that the prescriptions were dispensed but not entered in the system because "they're constantly doing things wrong." When asked who "they" were, she blamed the previous PIC Asarch, who "did not do things right." When it was noted that the period of the discrepancy was following Asarch's departure, respondent said that most of the prescriptions were actually refills, "they just had new prescription numbers." When questioned about the actual process of this, respondent explained that others enter the prescriptions into the system on "file," and they can just reprint a label. She stated,

[11] Her testimony in this regard was hard to follow, and more importantly, conflicts with her testimony that the drug was actually dispensed to patients but not recorded in their system.

> The problem is you put it in and type it in earlier, so when you're in a rush, you don't have to have the pressure of putting the drug in right then, right, so you type it in the system but the day it's actually dispensed it's just a reprinted label, but in actuality, it's really hard to keep records of it unless you have to implement and make sure nobody does it like that, and get a hard copy, and that happens all the time, but it's even worse with hospice.

63. Complainant's attorney attempted to clarify this process. Respondent confirmed that when a prescription is entered into the system, it automatically generates a prescription number. If a new prescription arrived for an old medication, if "they" were in a rush, they would sometimes just print the old prescription label with the old prescription number and the original prescription date by doctor. Respondent personally observed Lilly dispensing prescriptions with old labels. Respondent admitted to personally filling prescriptions with old labels and said it was a "legal" prescription. When asked why she did it, she answered, the prescription was still legal because she made sure the documentation on the auxiliary label (back tag) would show the actual date it was dispensed. She said it was legal so long as there was documentation showing the date the prescription was dispensed. When it was noted that the dispensed date on the back tag would reflect the date the label was first printed (and not the current date), respondent said it does not matter because it is "post-documentation." Respondent maintained that the prescription was legal because "the label required the required information." When it was noted that a reprinted label would have old information, she repeated, "It's post-documentation. It's just to show records. All it is, is recordkeeping." When pressed how it was legal to print an old label in lieu of entering a new prescription, respondent said it was a "grey area" and she did

not like doing it. When it was noted that respondent still did it and testified that it was a legal practice, she answered,

> The date is still the date it represents is the date of the prescription, you also send out information that shows the date of the, of the medication, but in reality what the technician is trying to do is show the date of how legal the prescription really is and that's where I was getting in arguments with her where it is a grey area. But you do have trackable records. This allows a person to see, ok, on 6/2/19 if they have four refills that prescription is only good up to five, five months, five times, and that's the date that the date that its dispensed is really the date of the prescription and that's where we have other records to show the date of the prescription and again that is something that I wanted to change too. But in this situation, it is clearly, it's recordkeeping . . .

When asked if the label would have false or misleading information on it because it would have the old prescription date and not the new date, respondent said, "You write it in by hand." When she filled a prescription by printing an old label, she put the new date "in parentheses or something so people will understand." With regard to ensuring the NDC matched the actual medication dispensed, she claimed that it was never an issue because they ordered the same brand. When it was noted there were different NDC numbers for the promethazine/codeine ordered by Phantastic Pharmacy, respondent then said, "You just correct it. I think all of us are very good at changing the NDC codes, that's very important for billing. That's one

thing all of us look for." When asked if she did this by hand, respondent said she gave it back to the technician who can "edit" the NDC code. When asked why not just ask the technician to enter the new script correctly, respondent said it was usually a "rush situation" where "she" (the technician) was trying to get prescriptions out for hospice patients. She said it was very quick to edit the date and NDC code. When asked what record the pharmacy would maintain that the prescription was filled (and thus be able to bill for it) she said that is why the pharmacy was losing money because there were no records, and "another challenge I had to deal with."

Respondent said that although she engaged in this practice, she maintained proper records because the information was correct on the auxiliary label. When it was noted that some of the prescription documents she sent Krumer had an NDC for a promethazine/codeine produced by a manufacturer that had not been ordered by the pharmacy, respondent maintained that it is "just recordkeeping" and the NDC code that was pulled up when the record was created was "probably wrong." When asked if respondent bears any responsibility for this, she said, "I will bear responsibility absolutely when it's necessary."

64. When asked if the old prescriptions would show up in the patient's history report to corroborate her claim that the 6 prescriptions (and 11 fills) were the result of labels being reprinted, respondent said they would be in the record. When asked if she looked in the patients' history report if there were old prescriptions for promethazine/codeine where the reprinting of labels occurred, "I did see some and did follow the trend, but like I said, I was relying on Lilly to make sure this was appropriate." As evidence, respondent submitted prescription history reports (Exhibit

B) for three of the patients in question listing a total of five fills of promethazine.[12] When respondent was asked to identify in the reports the old prescriptions that were used to print the labels, respondent said, "Lilly was supposed to get them to me, but I never got a chance to get them from her. Again, that is another issue I had with recordkeeping and the organization of the pharmacy."

65. When asked why she never told Krumer that the pharmacy had been reprinting labels, respondent said "she barely spoke to Krumer, nobody even asked, and at some point, she was told not to talk to Krumer." Regarding the conversation with Krumer on December 9, respondent was asked if she told Krumer about the reprinting of labels. Respondent said, "I wasn't aware of it then that much then, I did not know as well. But that's when I started doing research, and I was suspicious of this problem, and I reported to Rouben, but at the time when I spoke to her, I wasn't totally sure what was going on, I barely even knew the system."

66. Respondent reiterated that she did not reconstruct the six prescriptions solely based on Lilly's memory recall because Lilly told her she had records too. This exchange followed:

> DAG: Ok, but you never actually saw records at that point correct?

[12] The reports indicate all the fills for a particular patient for promethazine/codeine. All the fills were for prescriptions that respondent had Lilly enter in December, and thus contained new prescription numbers. There were no entries for any previous prescriptions for promethazine/codeine for any of the patients.

Respondent: She gave me a hard copy, she gave me records that indicated that there were a copy, and the hard copy looks like a record too, that hard copy prescription. And she was also going to get faxed orders from the nurse. She said she had those but again, it was a mess of pharmacy at that time, so I made the administrative decision, ok let's allow it because she was adamant those did go out. So on all the stuff I made an administrative decision. I go ok.

DAG: So, my understanding is that none of this documentation existed prior to December 9, is that correct?

Respondent: Yes.

DAG: Ok, so none of this documentation existed prior to December 9, so you had to rely on her memory, is that right?

Respondent: Yes, she was the best person to rely on.

DAG: Ok, it was based on her memory of events that occurred months prior?

Respondent: Yes.

DAG: And you didn't think it was unusual that a tech could remember such specifics about prescriptions that were filled and dispensed months prior?

> Respondent: She talks to them regularly, they are not, they have been patients on our service for awhile, and no, she has an exquisite memory, she is only 31 years old, she is way above the curve.

67. Respondent confirmed that the pharmacy filled between 100 to 150 prescriptions per day. Respondent admitted that she did not call any of the prescribers to verify that they had actually prescribed the medication to a particular patient before entering them into the system. She asked Vu if she filled any of these prescriptions but Vu did not know.

68. When respondent was asked if she had any personal memory of having dispensed any of these prescriptions she answered, "No, not really. I was in reference with her and she spoke to the nurses too and could speak the language." When the question was repeated, she said, "Only the few that I did, yes." When asked which ones she recalled, and when directed to refer to the prescriptions in the exhibits, she said, "Probably more like the 10/22 one but I still, they were mostly refills, almost all were refills, maybe."

69. Respondent admitted that her name is on multiple prescriptions that were filled prior to her starting work at Phantastic Pharmacy. When asked who filled those prescriptions, such as one in June, respondent said Asarch or Vu. When it was noted that Asarch left in May, respondent said she was not sure when Asarch left. Respondent said her name is on the prescription because when Lilly entered the prescription, respondent's name was in the system and she put it in to show "post-documentation." When asked if respondent dispensed the prescriptions for the fills after she started working at the pharmacy, respondent said she probably had. However, "The only way you can really tell what was dispensed on a date, you have to

have initials and an actual date it was dispensed, and that's the problem I've been struggling with that I've corrected. Now I'm the only one there I made sure all of that is correct because it helps with audits."

70. When it was noted that one of the prescriptions was filled on a Sunday, when the pharmacy was closed, she said Lilly made a "mistake" on the date it was filled, which is "quite common." She said mistakes happen and Lilly was 97 or 98 percent accurate. "She might have just put a date she meant for Monday, because when she did things in advance . . . probably that's what it is about, it is not something to show diversion." Respondent became agitated and said "everyone" was accusing her of diversion. When asked where there was an allegation that respondent was accused of diversion, respondent said diversion means the same as "deceitful" in "layman's terms."

71. Respondent twice claimed she did not know if the labels she printed for the prescriptions that were entered into the system in December had ever been on a bottle dispensed to a patient. When asked how they could have possibly been on a bottle if they weren't created until December, she said they were post-documentation. When asked if it was her practice to retroactively enter prescriptions filled months prior, respondent said it happens all the time, occurred at every pharmacy she has worked, and is not out of the norm. She said it was "almost too obvious" that this prescription was newly created. When asked if she thought doing this during the middle of a board investigation was a bad idea, she said she was told to make sure things were correct, "so to me, it represents being honest, it also represents proper records, it also represents ethically that when the doctor calls or anybody calls us you want to make sure there is proper patient care." The medication can cause seizures, and she would not want someone to die because of a seizure that could have been

prevented, "so to me, I made an administrative decision this seems appropriate because technically and ethically those are two correct things." When asked if she would now retroactively enter prescriptions dispensed months prior, she said, "No, I probably wouldn't, if anything I would have made sure there's a note in there, but I think it's obvious."

72. Respondent confirmed she ran a new report after adding the 6 prescriptions and 11 fills. She gave this report to Krumer and told Krumer the report Vu gave her was incorrect. She did not tell Krumer about her conclusion about reprinting the labels because, "She never asked. I wasn't really, I don't even know. I just ran the report and turned it in and that's all. I thought it was taken care of." When asked why during the telephone call respondent did not think that was information that would have been helpful to Krumer's investigation, respondent said it was "obvious" that they were retroactively entered, and "I wasn't really in direct communication, I sent the report and it's obvious." The following colloquy transpired:

> DAG: Didn't the inspector have a telephone conversation about the report?
>
> Respondent: Yes.
>
> DAG: And you never told her, hey, this is my finding, this is what I found, there was a bunch of scripts I found that weren't into the system. You never told that to her, right?
>
> Respondent: All she did was ask me, when I was at the end of the day with 100 prescriptions, and asking me, and at the time, I didn't know the system. Also, we were starting out-

of-state prescriptions, but it's, it's like it's too obvious that it's post documentation.

DAG: Ok, and you didn't think you needed to tell her that because it was obvious?

Respondent: It's too obvious. It's an obvious question in pharmacy. It's so obvious when do CURES report. When you see numbers way out of sequence, which you do, you check and have to call the pharmacy, and also call the doctor, you do it all the time. It's too obvious.

73. Respondent refutes that she was trying to hide the fact she was retroactively entering scripts. However, respondent admitted that during the phone conversation, Krumer asked her about the sequence of the numbers being irregular, and responded:

Respondent: I did not know the system. The problem with the system when you copy a prescription they're way off. We were doing out-of-state prescriptions, and I even confirmed recently that Digital will cause glitches. So in reality, I didn't really know the system, but I wasn't trying to hide anything, it's just too obvious. It's so obvious that she told me, she told me to go back and look at the records. She told me to figure out the problem. I figured it out, I thought I figured out the problem. She specially told me to figure it out. I figured it out and it's too obvious what's going on. So why would I be trying to hide something she

instructed, I needed to go back and figure it out, and the numbers were off so how can you be hiding something, even when I gave her extra Cardinal invoices, I made sure there was an email if you want me to submit it to show what's going on. It doesn't even make sense, I apologize but that does not make sense to me. It's too obvious, a straightforward obvious situation.

DAG: When she asked you why the numerical sequence for the scripts that was being used in December 2019, you told her the reason the sequencing was off was because the pharmacy was doing fills of out-of-state prescriptions?

Respondent: We were, we were doing. We have five licenses out of state. I didn't know the system well enough. I didn't know what was going on. I'm still learning the system because the technician would not let me touch the computer, so there's no way of trying to hide something you don't even know how to hide.

DAG: So, are you telling me now, sitting here, testifying under oath, that the reason why the numerical sequence of these scripts being used in Dec 2019 is off, is because you guys were filling out-of-state prescriptions?

Respondent: No, I'm not saying that. I'm saying it did cause confusion for me.

DAG: The reason the scrips were off was because they were entered in December 19, correct?

Respondent: Yes.

DAG: It had nothing to do with out-of-state prescriptions?

Respondent: I didn't know that at the time because there's out-of-state prescriptions putting in at the same time. So I didn't know enough to be even able to tell her correctly. But I do know it's too obvious that it's post documentation.

74. Respondent denied that she ordered Lilly to create the telephonic prescription records for the purpose of submitting to the board. She said she created these for "recordkeeping" because "you have to have a hard copy in pharmacy no matter what." She added, "I didn't know what was going on. Nobody consulted me."

75. She claimed not to have been aware of what her attorneys sent Krumer. When it was noted that she was copied on all correspondence, she claimed she did not read it.

76. When asked why the board might have had a concern about her, she answered,

I think things have been presented in a way that are not proper so I can see why they would have concern, but clearly I've had a 30-year record. If it had been done appropriately, all they would have had to do was really call me, and I gave my personal cell phone on every email I sent, so I find it unlikely that somebody who is responsible

would not be going around giving their personal cell phone. So somebody who has a 30-year record, with zero problems except for the CE, which I did call the board and ask if I could extent it, but then they told me later I couldn't, but I did have records showing I was going through a personal hard time and that is allowed. So, I can see the board having some issues, but if the proper research or even questions were asked me, we wouldn't be sitting here.

77. As the hearing was not completed within the allotted time, an additional day of hearing was scheduled. Respondent was recalled for additional examination. The ALJ asked respondent if she admitted that her statement to Krumer in the November 19 email stating that during the transition period there was a PIC and the "check was cashed" was in fact false. Respondent said she thought Vu was supposed to be the PIC during that time and a check was cashed. When asked if she had any personal knowledge of this, she said, "All I can go by was what the owner told me." Respondent maintained that there was a check and that Vu had been the PIC. When it was noted that there is no evidence, including Vu's own testimony, that she was the PIC, respondent maintained that her statement to Krumer was true because that is what she had been told. Even now, respondent does not know whether Vu was the PIC.

78. Respondent did not provide a coherent response when questioned why she did not present documentation showing the original prescriptions for the patients that supposedly had labels reprinted, thus accounting for the 11 additional fills. Respondent asserted that the pharmacy could have printed a label for Promethazine DM, and then crossed out the DM and added codeine by hand. Again, respondent presented no evidence in support of this claim. She then testified that it was possible

that instead of dispensing one bottle of 240 ml, the pharmacy dispensed two bottles without recording that a second bottle went out. Respondent could not corroborate that this had occurred.

79. When asked why she did not subpoena Lilly to corroborate her testimony, respondent said the two of them fought at the end, and that Lilly "is really bull-headed." Respondent said she followed the letter of the law, but Lilly would not listen to respondent. As time went on, respondent realized that. Respondent added, "I am a stickler to laws."

80. Respondent's counsel again asked respondent whether Cardinal Health documentation was reliable. Respondent said it is widely known in the industry to be the weakest and not reliable. Respondent then reiterated an earlier claim that she looked at all the invoices from Cardinal and there were missing invoices. She then ran reports and looked at info and found one of the invoices showed there was no promethazine/codeine in stock, even though it was supposedly sent.

81. Respondent asserted that post-documentation is necessary in order to accurately update CURES. It is better to err on the side of reporting a prescription to CURES, even if it were not filled, because diversion is such a problem. Respondent believes by entering the prescriptions for these patients she was ensuring their CURES profiles were accurate and preventing potential doctor shopping or drug abuse.

82. When asked what other states Phantastic Pharmacy is licensed, respondent said only Arizona and Ohio, although they were applying in other states as well.

Testimony of Fred Weissman

83. Fred Weissman received his Doctor of Pharmacy from USC in 1963 and a Juris Doctor from Loyola Law School in 1989 He was a pharmacist in the Army for two years and worked in retail pharmacies until 1970. From 1975 to 1980 he was the director of pharmacy services at St. Mary's Medical Center in Long Beach. Beginning in 1969 he has held various clinical pharmacy teaching positions and dean positions at USC's pharmacy school. He has taught multiple pharmacy law courses as well as some clinical courses. He has extensive publications and memberships in professional organizations.

84. Weissman reviewed the investigation report and "some material" from Park's law firm. He also spoke to respondent. His testimony and report outlining his findings are summarized as follows:

85. Regarding the allegation that respondent provided the board with false and misleading information, Weissman testified that after talking with respondent, "my sense was she didn't intend to be deceitful or dishonest." Respondent has been a pharmacist for 30 years without any prior issues except for the continuing education, which indicates she has worked well as a pharmacist intending to follow the laws. When she was presented with the issue of the promethazine/codeine discrepancy, she was given limited time to put records together to show accountability of missed prescriptions. About half the prescriptions had been filled before she started working at the pharmacy. Respondent seemed to figure out the problem. She inquired with the technician and was able to determine something was wrong, or there was a computer glitch causing missing information from the computer system. Depending on what respondent, the other pharmacist, or the pharmacy technician could remember, respondent was able to put together a record. Respondent found patients that were

not reported in the system, respondent attempted to identify the doctor and approximate dates of the prescriptions, and respondent wanted to create a record to account for the missing prescriptions. Weissman believed that respondent's records were authenticated by three of the four prescribing physicians. He believed she acted in good faith in an attempt to identify both the patients and the physicians associated with the unaccounted-for prescriptions. Weissman wrote, "In order to create a record for the approximate 2,600 ml not accounted for and later identified, [respondent] created prescriptions for those 11 prescriptions on the pharmacy's prescription pads as she identified the patients and got confirmations that the prescriptions were probably called in on various past dates." Weissman believed that respondent simply wanted to create a record showing that the patient did get the drug and the drug could be accounted for, even if "the method of recording may not have been in accordance with what is expected in practice." He testified that the manner in which respondent created the records was "awkward" and not customary, but it was one way to reconcile the issue. Perhaps, if there was more time, she could have gone to the doctor to obtain additional records. However, it was her honest intent and best judgment to show "for the record" that the drug was given legally.

86. Weissman did not believe respondent acted dishonestly in an attempt to subvert the board's investigation. Instead, in good faith, she attempted to create records showing that the drug could be accounted for. He believed she did what she felt had to be done to put this information together.

87. Regarding the third cause for discipline, maintaining security of controlled substances, Weissman believed respondent maintained good operational standards and security for these drugs. In talking to her on issue, she indicated there were some "sloppy problems" in the pharmacy with recording information. He wrote:

> It was noted by Ms. McQuigg that the program that maintains the record of the dispensing of prescriptions was not recording a number of prescriptions in the manner such a system is expected to. She had complained to the owners about the recording problem of the computer failing to keep good recordkeeping accountability, Ms. McQuigg's [*sic*] decided to record

88. Finally, Weissman did not believe respondent acted unprofessionally. He felt respondent was presented with unusual circumstances as a new PIC, and she was tasked with accounting for the discrepancy. She was able to acquire as much information as she could as to the reason for the discrepancy. He believed respondent acted honestly and noted that if she had wanted to deceive the board, she could have created false prescription numbers to hide the fact they were recently entered.

89. On cross-examination Weissman said he was being paid approximately $2,200 for his testimony and time to review records. He spoke to respondent approximately three times for one-half to one hour each. The last time he practiced in a pharmacy was 15 or 16 years ago, but as associate dean at the pharmacy school, he indirectly oversaw operations of two pharmacies. When he worked in a pharmacy there was a computerized system, but he depended on a technician or another pharmacist to help navigate him through the system. Weissman testified that once a telephone prescription was received, it should be entered into the system when it is prepared. When asked if it was the standard of practice to enter a prescription three to six months later, he answered, that it was generally not an appropriate practice. He agreed that it was not permissible to dispense narcotic medications without writing a telephonic script. Nor is it the standard of practice to fill a prescription without

entering it into the computer system because a dispensed prescription must have a label. When asked if he was aware that respondent entered these prescriptions based solely on the memory recall of a technician, he was not aware if she used any other sources other than the technician. He believed respondent had contacted the physicians to verify the prescriptions. He had no knowledge of the nature of the computer glitch and based this information on his discussions with respondent. He believed she advised the owners that they needed to use a new computer system. He was not aware of respondent's claim that pharmacy staff, including respondent, had been reprinting old labels for new prescriptions. He admitted this would not be appropriate as it creates some confusion.

90. Weissman believed that the inspector should have been more focused on educating respondent. When asked if he would change his opinion if there was evidence that the doctors did not authorize these prescriptions, Weissman said, "It would create a problem." When asked if it was unusual to see four refills for promethazine/codeine, he said it may not be with this case. He agreed it is outside the standard of care for a new PIC not to do a complete controlled substance inventory. When asked if he ever asked respondent how the prescriptions were dispensed if not in the system, he was unsure, and believed they were dispensed based on her investigation. All he recalled was that she did have labels, but he did not recall that they were re-printed labels. This was the first time he had heard that. He did recall there was "some issue" with out-of-state prescriptions. Even after being presented with additional information about respondent's actions, he believed she used her best judgment, and would not categorize her actions as unprofessional.

Character References

91. Joanne Nelson testified at hearing as follows: She has been a pharmacy technician for approximately 25 years and is employed at the Indian Health Council. She has worked at the facility for 30 years and with respondent for approximately 10 years. They last worked together three or four years ago. They worked together daily. Respondent was "pretty precise" in everything she did. If we made a typing mistake, "she was right there correcting me." Nelson was not aware of disciplinary issues with respondent. Respondent was "fine" compared to other pharmacists. Nelson thought respondent was reliable and never doubted her honesty or integrity. Nelson believed that respondent had been fired from the company but was not aware of the specifics. Respondent said she was going to file something against the company. Nelson had not read the accusation in this matter. When respondent's lawyer asked Nelson to testify, the lawyer told her the board inspector was accusing respondent of a discrepancy.

92. Stephen Loy Chapin's testimony at hearing is summarized as follows: He has been a licensed pharmacist in California for over 35 years. He has worked in hospitals and home infusion over the last 17 years. He also worked at the Orange County Healthcare Agency at the jail. He has known respondent over 25 years. The two first met while working at the same home infusion pharmacy, although they worked at different branches. Over the years they worked at several other home care pharmacies, but mostly at different branches. They only worked side-by-side for approximately three months. Respondent also worked at the jail over 10 years ago. He told respondent he would be happy to provide a reference if she ever needed one, which he does not always do. He found her to be very precise in a highly technical field. She was very good at recordkeeping. Home infusion is higher level of pharmacy because of

calculations and recordkeeping. They also deal with a large amount of opiates and opioids. Respondent was known as being "by the book." Chapin skimmed the accusation in this matter and understands there is some question about count of promethazine/codeine. After seeing it was for a Schedule V liquid, he was surprised the board was taking disciplinary action. He has worked in the field for a long time and believes she is a good pharmacist. He has never known respondent to be dishonest.

93. Respondent submitted a letter from Holly O'Meara addressed to the board's "Human Resources Department", she has known respondent since 2017. The two are friends, and O'Meara, a retired teacher, wrote respondent is an attentive mother of her adult children and regularly attends church. O'Meara did not reference knowledge of the allegations of misconduct against respondent.

ADDITIONAL EVIDENCE

94. Respondent submitted continuing education certificates documenting completion of a pharmacy law ethics course, HIPPA, basics, and fraud, waste, and abuse in 2020.

Evaluation of the Evidence

95. The credibility of witnesses was evaluated considering the following factors: the demeanor and manner of the witness while testifying, the character of the testimony, the capacity to perceive at the time the events occurred, the character of the witness for honesty, the existence of bias or other motive, other statements of the witness which are consistent or inconsistent with the testimony, the existence or absence of any fact to which the witness testified, and the attitude of the witness toward the proceeding in which the testimony has been given. (Evid. Code, § 780.) A trier of fact may "accept part of the testimony of a witness and reject another part

even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co*. (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id*., at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal. App. 2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal. 3d 875, 890.)

96. Respondent's testimony was not credible based on both the nature of the testimony and substance of her statements on multiple levels. She was almost always non-responsive to questions, even by her own attorney, and would engage in long circular narratives. She repeatedly made broad generalizations and failed to provide specific answers when requested. One of the most frustrating aspects of her testimony was her continued implications that the reports Krumer obtained were inaccurate and the result of an error with the computer's software, or some other situation other than the supposed prescriptions were never entered. For example, on multiple occasions she testified that the reports that were being reviewed by Krumer were "inaccurate," but failed to provide any details as to what exactly was inaccurate. On one occasion, she testified that she ran three separate reports, which all had different "numbers." Respondent could not provide specifics of how her reports differed from those prepared by Vu (in Krumer's presence) or Cardinal Health. When pressed on specifics, she referred to reports prepared by Asarch in 2018 that had no bearing on this case. Similarly, she consistently dodged questions by blaming the former PIC Asarch, her fellow pharmacist Vu, the technician Lilly, the pharmacy owner Rouben, her previous attorneys, and the board's inspector Krumer. She frequently referenced the Cardinal Health invoices, even though there was no evidence that the

reports Krumer received from the company were incorrect or differed from the information produced by respondent herself. Moreover, any claim that the pharmacy did not actually receive the medication sent by Cardinal conflicted with her testimony that the pharmacy had legitimately issued the 11 prescriptions, an irony lost on respondent. Her answers were frequently hard to comprehend and laden with tautological repetitions. One of her most frequent responses to any questions about her actions was to repeat as a mantra, "It's post-documentation" and "It's too obvious."

97. Her testimony was replete with misrepresentations, red-herrings, and outright lies. Respondent lied to Krumer when she said the irregular prescription numbers were the result of out-of-state prescriptions. Respondent lied during her testimony when she claimed to have been confused about the system and whether the out-of-state fills were the cause of the irregular numbers. Even her testimony that they were filling prescriptions in five states was a lie, as she later admitted the pharmacy was only licensed in two other states. Ironically, respondent testified more than a dozen times that because the new prescription numbers were from December, it was "obvious" to anyone that they had just been created; yet she maintained that when she spoke to Krumer in December, she had been confused about the out-of-state prescriptions being the cause for the irregular prescription numbers.

98. Moreover, there is a certain "down the rabbit hole" quality to her repeated justifications that the documents she ordered Lilly to create retroactively could then serve as corroboration that the prescriptions had been legitimately dispensed. More than once she referred to these documents as a means of corroborating Lilly's memory, when in fact, these documents were created by Lilly at respondent's direction based on Lilly's memory *alone*. Rather than appreciating the

fallacy of her contentions, respondent repeatedly maintained her position, peppered with other red-herrings such as the Cardinal delivery receipts, Asarch's inattention to detail, and her unfamiliarity with the pharmacy's computer system and processes. It is absurd that a pharmacy technician would remember the patient's name, date, physician, directions, and refill number of six prescriptions, issued at various times over the preceding six months, in addition to remembering the exact dates of another five refills, without *any* supporting documentation. Respondent remained undaunted, and initially maintained that Lilly provided additional documentation to support what respondent described as her "exquisite memory." When asked what steps respondent took to update the records after Lilly supposedly told her about these prescriptions, respondent testified, "She originally told me yes, she remembered, she started giving me prescriptions, and I checked like three different ways and make sure, and we also get hard copies from the nurses that are faxed over too. So between one, two, three, four ways, I could see I could rely on this information." This statement is a lie, which respondent attempted to justify by citing the documents she herself ordered Lilly to create in December. Respondent initially maintained Lilly gave her original documentation of the prescription, which was also a lie, as she also testified that she asked Lilly multiple times for the documentation yet never received it. Respondent produced no reliable evidence to support her claims that these prescriptions had actually been dispensed; in fact, much of her evidence showed the exact opposite. Specifically, her testimony that the prescriptions were the result of pharmacy staff (and herself) reprinting old labels was belied by the fact that there were *no* other prescriptions for promethazine/codeine for any of these patients preceding the entries made by respondent in December. In other words, if these prescriptions were actually dispensed by reprinting of old labels for the same medication, there should be a record of the old label. While respondent offered alternative explanations, such as the

original prescriptions were for promethazine DM, or multiple bottles were dispensed, there was no corroborating evidence to support such claims. In sum, respondent's testimony regarding the circumstances of entering the 6 prescriptions and 11 fills into the pharmacy computer system is implausible, false, and misleading. To the extent that it conflicts with the testimony of Krumer, the doctors, and Vu, their testimony is far more credible.[13]

99. Regarding the testimony of respondent's expert, California courts repeatedly underscore that an expert's opinion is only as good as the facts and reason upon which that opinion is based: "Like a house built on sand, the expert's opinion is no better than the facts on which it is based .....[W]here the facts underlying the expert's opinion are proved to be false or nonexistent, not only is the expert's opinion destroyed but the falsity permeates his entire testimony." (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.) In this case, sand would provide far greater support for a house than the facts Weissman relied upon to base his opinion.

100. While Weissman presented as polite and well-intentioned, his evaluation was perfunctory and appeared to have rested solely on respondent's explanations. While he was not present for respondent's testimony, it was clear that he accepted

[13] Davtyan's testimony was given little weight. It is clear that he was at least grossly negligent in his supervision of respondent, if not complicit, up until the time that the pharmacy could not produce documentation to support respondent's claim that the prescriptions were legitimately dispensed. The fact that he re-hired respondent after he himself claimed she lied about having original documentation to support her records is shocking. The board should have grave concerns about Phantastic Pharmacy's continued operation.

respondent's explanations at face value, without any independent analysis to determine whether her explanations were credible. It was clear that he had not thoroughly reviewed the investigation report; had he, he would have realized that respondent's explanations made little sense. Despite this, Weissman maintained that because respondent exercised her best judgment, she had not acted unprofessionally or with an intent to deceive. Even on cross-examination, when told about respondent's testimony and claim about reprinting of labels (which he had not heard before), he refused to concede that respondent's actions were unprofessional – instead maintaining that she exercised her best judgement.

It is unfortunate that an expert, with such a long career, especially in academia, would agree to stake his reputation to defend respondent's actions in this case. Notwithstanding, having agreed to testify on respondent's behalf, and offering only a superficial evaluation of the evidence, he placed himself squarely in the position of having his testimony deemed to have no probative value and to be completely rejected.

101. In consideration of the witness testimony and documentary evidence, the following findings are made:

- On December 11, respondent knowingly made false documents when she provided Krumer with a variance report and dispensing report listing 11 fills of promethazine/codeine that were not contained in the original dispensing report Krumer obtained a month earlier.

- Respondent's claim that these 11 fills of promethazine/codeine were dispensed as lawful prescriptions is false and misleading.

- Respondent's claim that the patients identified in her report had received legitimate prescriptions for promethazine/codeine that had been filled on the dates indicated is false and misleading. Similarly, the claim that these prescriptions were issued as "reprints" from previous prescriptions is false. The documents were produced with the intent to deceive Krumer and subvert her investigation into the root cause of the discrepancy.

- Respondent's December 11 email to Krumer, stating, "attached are files that hopefully will clarify everything" is misleading and attempted to subvert the investigation because there was no reference as to the manner in which the information was added.

- During a telephone conversation with Krumer the following day, respondent made false and misleading statements by stating that the report produced by Vu was inaccurate (again failing to make any mention as to how the additional records came to be added) and further falsely stated, with the intent to deceive, that the irregular prescription numbers were because the pharmacy performed out-of-state-fills.

- Respondent lied during testimony that the pharmacy had permits to operate in five states, and that because the pharmacy was filling out of state prescriptions, she did not know enough about the system, and was confused (at the time she spoke to Krumer) as to why the new prescription numbers were irregular.

- Respondent ordered Lilly to create telephone prescription orders, which Krumer had requested. These documents were false and created solely with the intent to subvert the board's investigation. Respondent provided

these false documents to her attorneys, who submitted them to Krumer in order to satisfy Krumer's request for records. Respondent never indicated that the telephone prescriptions had been retroactively fabricated, but instead, tried to pass them off as original documentation. The January 22, 2019, letter by respondent's attorney, stating that respondent had located the hardcopy records of six prescriptions was also a lie, and as respondent was copied on the letter, is considered an adoptive admission. (Evid. Code, § 1221.) The above conduct was deceitful and attempted to subvert the board's investigation.

- Respondent authorized the submission of "hard copies" of the prescriptions in order to continue the charade that these were legitimate prescriptions. Respondent knew that these documents were false in that they were created to justify her previously tendered false documents and made with the intent to subvert the board's investigation. Respondent attempted to pass these documents off as original documentation of the prescriptions.

- Respondent's testimony contrary to these findings was false and misleading.

Cost Recovery

102. Complainant submitted certifications of costs and requested cost recovery pursuant to Business and Professions Code section 125.3. A certification by complainant and declarations by Krumer and her supervisor outlined the board's investigation costs in the amount of $11,583.50. A declaration by the deputy attorney general contained information related to services provided by the Office of the

Attorney General and included costs of prosecution in the amount of $14,288.75. The certifications of cost satisfied the requirements of California Code of Regulations, title 1, section 1042, subdivision (b), and the certifications support a finding that costs in the amount of $25,872.25 are reasonable in both the nature and extent of the work performed.

103. Respondent did not address her ability to pay costs.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. The standard of proof in an administrative action seeking to suspend or revoke a professional license is "clear and convincing evidence." (*Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; it requires sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Sup. Ct.* (2005) 130 Cal.App.4th 586, 594.) The burden of proof is on complainant.

Purpose of License Discipline

2. The business of compounding prescriptions and selling drugs is intimately connected with and has a vital relationship to the health, safety, and welfare of the public. Public safety must be regarded as superior to private rights. (*Brodsky v. California State Board of Pharmacy* (1959) 173 Cal.App.2d 680, 688-689.) Protection of the public is the board's highest priority in exercising its disciplinary functions; whenever the protection of the public is inconsistent with other interests sought to be

promoted, the protection of the public is paramount. (Bus. & Prof. Code, § 4001.1.) The main purpose of license discipline is protection of the public through the prevention of future harm and the improvement and rehabilitation of the licensee. It is far more desirable to impose discipline before a licensee harms any patient than after harm has occurred. (*Griffiths v. Sup. Ct.* (2002) 96 Cal.App.4th 757, 772.)

Relevant Statutory Authority

3. Business and Professions Code section 4113, subdivision (c), provides that the PIC is responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy.

4. Business and Professions Code section 4301 authorizes the board to take action against a license holder for unprofessional conduct which includes:

> (g) Knowingly making or signing any certificate or other document that falsely represents the existence or nonexistence of a state of facts.
>
> [¶] . . . [¶]
>
> (o) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any provision or term of this chapter or of the applicable federal and state laws and regulations governing pharmacy, including regulations established by the board or by any other state or federal regulatory agency.
>
> [¶] . . . [¶]

(q) Engaging in any conduct that subverts or attempts to subvert an investigation of the board.

5. Business and Professions Code section 4307, subdivision (a) provides that any person whose license has been revoked shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee until such license is reinstated.

6. California Code of Regulations, title 16, section 1714, subdivision (b), requires a pharmacy to "maintain its facilities, space, fixtures, and equipment so that drugs are safely and properly prepared, maintained, secured and distributed."

Cause Exists to Revoke Respondent's License

7. Cause exists to discipline respondent's pharmacist license pursuant to Business and Professions Code section 4301, subdivision (g). Clear and convincing evidence established respondent knowingly made or signed documents that falsely represents the existence or nonexistence of a state of facts. Respondent argued complainant failed to prove that respondent acted maliciously or with the intent to deceive. However, the provision is a general intent provision that only requires respondent acted "knowingly." To constitute general criminal intent, it is not necessary to prove the intent to violate the law. When a person intentionally does that which the law declares to be a crime, he or she acts with general criminal intent, even though the person may not know that his act is unlawful. The requirement of acting "knowingly" is satisfied when the person committing the act has knowledge of the facts. The word "knowing" imports only an awareness of the facts that bring the act within the terms of the statute. (*People v. Lonergan* (1990) 219 Cal.App.3d 82, 95.) Even if the statute

required specific intent, clear and convincing evidence established respondent's actions were not only knowing, but with the intent to deceive.

8. Cause exists to discipline respondent's pharmacist license pursuant to Business and Professions Code section 4301, subdivision (q). Clear and convincing evidence established respondent engaged in conduct that subverted or attempted to subvert the board's investigation.

9. Cause exists to discipline respondent's pharmacist license pursuant to Business and Professions Code section 4301, subdivision (o). Clear and convincing evidence established respondent violated California Code of Regulations, title 16, section 1714, subdivision (b), by failing to secure promethazine/codeine which could not be accounted for after she began working at Phantastic Pharmacy in August 2019.

10. Cause exists to discipline respondent's pharmacist license pursuant to Business and Professions Code section 4301 based on general unprofessional conduct. Unprofessional conduct has been defined in the health care context as "conduct which indicates an unfitness to practice medicine . . . conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession." (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575 and n.5.) Clear and convincing evidence established respondent's actions constituted unprofessional conduct.

Appropriate Discipline

11. California Code of Regulations, title 16, section 1760, provides that in reaching a decision in a disciplinary action under the Administrative Procedure Act, the board must consider its "Disciplinary Guidelines" (Rev. 2/2017).

The factors relevant to this matter that were considered in reaching a decision in this matter are: actual or potential harm to the public; actual or potential harm to any consumer; prior disciplinary record (including citations); number and/or variety of current violations; nature and severity of the acts under consideration; aggravating evidence; mitigating evidence; rehabilitation evidence; time passed since the acts; whether the conduct was intentional or negligent, demonstrated incompetence, or, if respondent is being held to account for conduct committed by another, respondent had knowledge of or knowingly participated in such conduct; and financial benefit to respondent from the misconduct.

The Guidelines identify four categories of violations and provide recommended minimum and maximum discipline. For each violation category, the board has given offense descriptions and examples where violations would typically merit the recommended range of minimum to maximum penalties for that category. These descriptions and examples are representative, and they are not intended to be comprehensive or exclusive. The violations in this matter most closely correspond to Category II violations, due to the disregard for public safety or for the laws or regulations pertaining to pharmacy and/or to dispensing of controlled substances, and violations that reflect on ethics, competence, or diligence. The minimum recommended discipline is a stayed revocation with three years' probation. The maximum discipline is revocation.

12. Respondent's multiple levels of deceit and indifference to the truth, under oath, are sufficient in themselves to justify revocation. In addition, respondent demonstrated global incompetence as it relates to her knowledge of pharmacy law. With the exception of having no official disciplinary record over the past 30 years, two professional references, and completing some continuing education (required for

renewal), there was no other evidence of rehabilitation or mitigation. Instead, respondent failed to appreciate the seriousness of her actions, which belies any argument of rehabilitation. Even if respondent were required to take substantial remedial education, pass the Pharmacy Law and Ethics Exam, and obtain a psychological evaluation as conditions precedent to probation, there is no indication in this record that respondent is capable of complying with the myriad of terms of probation due to her pervasive dishonesty. Accordingly, respondent poses a significant danger to the public if allowed to continue to practice. Public protection requires revocation of her license.

Cost Recovery

13. The California Supreme Court in *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, held that a regulation imposing costs for investigation and enforcement under California Code of Regulations, title 16, section 317.5, which is similar to Business and Professions Code section 125.3, did not violate due process. But it was incumbent on the board in that case to exercise discretion to reduce or eliminate cost awards in a manner such that costs imposed did not "deter [licensees] with potentially meritorious claims or defenses from exercising their right to a hearing." (*Ibid.*)

The Supreme Court set forth five factors to consider in deciding whether to reduce or eliminate costs: whether the licensee used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed; whether the licensee had a "subjective" good faith belief in the merits of his or her position; whether the licensee raised a "colorable challenge" to the proposed discipline; whether the licensee had the financial ability to make payments; and whether the scope of the investigation was appropriate in light of the alleged

misconduct. The reasoning of *Zuckerman* must be applied to Business and Professions Code section 125.3 since the language in the cost recovery regulation at issue in *Zuckerman* and section 125.3 are substantially the same.

Applying the *Zuckerman* criteria, the costs were reasonable, while she may have subjectively believed in the merits of her position, she did not raise a colorable challenge to the proposed discipline, which was not reduced in severity. She did not address the ability to pay costs. Respondent is ordered to pay full costs in the amount of $25,872.25.

ORDER

1. Pharmacist License number RPH 42446 issued to respondent Anita Birosel-McQuigg is revoked. Respondent shall relinquish her license, including any indicia of licensure issued by the board, to the board within 10 days of the effective date of this decision. Respondent may not reapply or petition the board for reinstatement of her revoked license for three years from the effective date of this decision.

2. Respondent shall pay to the board its costs of investigation and prosecution in the amount of $25,872.25 within 60 days of the effective date of this decision.

DATE: May 25, 2021

Adam Berg (May 25, 2021 12:25 PDT)

ADAM L. BERG
Administrative Law Judge
Office of Administrative Hearings

XAVIER BECERRA
Attorney General of California
JAMES M. LEDAKIS
Supervising Deputy Attorney General
NICOLE R. TRAMA
Deputy Attorney General
State Bar No. 263607
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9441
Facsimile: (619) 645-2061
Attorneys for Complainant

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

In the Matter of the Accusation Against**:** **ANITA BIROSEL-MCQUIGG** **20702 El Toro Road, #595** **Lake Forest, CA 92360** **Pharmacist License No. RPH 42446** Respondent.	Case No. 6992 **ACCUSATION**

PARTIES

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

2. On or about March 13, 1989, the Board of Pharmacy issued Pharmacist License Number RPH 42446 to Anita Birosel-McQuigg (Respondent). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2022, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Pharmacy (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 118, subdivision (b), of the Code provides that the suspension, expiration, surrender, cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

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

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

7. Section 4300.1 of the Code states:

> The expiration, cancellation, forfeiture, or suspension of a board-issued license by operation of law or by order or decision of the board or a court of law, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee shall not deprive the board of jurisdiction to commence or proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license.

STATUTORY PROVISIONS

8. Section 4113, subdivision (c) of the Code states:

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

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

> The board shall take action against any holder of a license who is guilty of unprofessional conduct or whose license has been issued by mistake. Unprofessional conduct shall include, but is not limited to, any of the following:
>
> …
>
> (g) Knowingly making or signing any certificate or other document that falsely represents the existence or nonexistence of a state of facts.

…

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

. . .

(q) Engaging in any conduct that subverts or attempts to subvert an investigation of the Board.

10. Section 4307, subdivision (a) of the Code states that:

Any person who has been denied a license or whose license has been revoked or is under suspension, or who has failed to renew his or her license while it was under suspension, or who has been a manager, administrator, owner member, officer, director, associate, or partner of any partnership, corporation, firm, or association whose application for a license has been denied or revoked, is under suspension or has been placed on probation, and while acting as the manger, administrator, owner, 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 manger, administrator, owner, member, officer, director, associate, or partner of a licensee as follows:

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

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

REGULATORY PROVISIONS

11. California Code of Regulations, title 16, section 1714, subdivision (b) states:

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

COST RECOVERY

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

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DRUGS

13. Promethazine with Codeine is a controlled substance pursuant to Health and Safety Code section 11058, subdivision (c) and a dangerous drug pursuant to section 4022 of the Code.

FACTUAL ALLEGATIONS

14. From August 5, 2019 through February 27, 2020, Respondent was the pharmacist-in-charge of Phantastic Pharmacy located in Sherman Oaks, California.

15. On November 7, 2019, Board of Pharmacy inspectors obtained dispensing records for Promethazine/Codeine from Phantastic Pharmacy for the period covering May 17, 2019 to November 7, 2019. On September 11, 2019 and October 21, 2019, Respondent received and signed for a total of 3311 ml of Promethazine/Codeine out of the 6149 ml received from May 17, 2019 to November 7, 2019.

16. An inspector conducted an audit for the period covering May 17, 2019 to November 7, 2019 for Promethazine/Codeine. That audit showed a shortage of 4032 ml (or approximately 8.5 bottles of 473 ml) of Promethazine/Codeine. On December 9, 2019, the inspector informed Respondent about the losses in the Promethazine/Codeine audit.

17. On or about December 11, 2019, Respondent provided the inspector with a pharmacy dispensing record for Promethazine/Codeine for May 1, 2019 through December 10, 2019. The new dispensing report provided by Respondent included eleven fills that were not included in the original report received by inspectors on November 7, 2019. Six of the prescription numbers in the new report had a numerical sequence that was representative of the current prescription numbers, and not the prescription numbers provided at the time of the inspection.[1] When the inspector inquired about the discrepancies in the Respondent's new dispensing record, Respondent stated the new record was the most accurate, and that pharmacy prescription numbers are different because the pharmacy performs out of state dispensing.

18. During the course of the investigation, inspectors learned that Respondent retroactively entered the six prescriptions containing about 11 fills of Promethazine/Codeine into

[1] In the usual pharmacy practice, prescription numbers get created as prescriptions are processed. Prescriptions processed in one month will have different numerical sequences versus prescriptions processed one or more months after that.

the pharmacy computer system after the audit discrepancy was identified and reported to her. As such, the six prescriptions had current prescription numbers because they had been recently entered and processed, and not for the reasons Respondent reported to the inspector. Respondent also claimed to have found the hardcopies of the six prescriptions in question for which she retroactively entered into the pharmacy computer system. Review of those prescriptions showed that they were all telephonic prescriptions written in similar handwriting for the same quantity (240 ml) of drug, with the same number of refills (4 refills). There were other discrepancies noted with these prescriptions.

19. When asked to provide additional documentation and information to explain and support these prescriptions, Phantastic Pharmacy's owner reported to the inspector that Respondent did not have any documents related to the six prescriptions, that they were based on Respondent's recall memory, and not based on any actual documentation.

FIRST CAUSE FOR DISCIPLINE

(Knowingly Making a Document that Falsely Represents a State of Facts)

20. Respondent is subject to disciplinary action under Code section 4301, subdivision (g), for knowingly making or signing any certificate or document that falsely represents the existence or nonexistence of a state of facts, as set forth in paragraphs 14 through 19 above, which are incorporated herein by reference.

SECOND CAUSE FOR DISCIPLINE

(Subverting or Attempting to Subvert a Board Investigation)

21. Respondent is subject to disciplinary action under Code section 4301, subdivision (q), for engaging in conduct that subverts or attempts to subvert an investigation of the Board by providing misleading documentation and/or information to the Board inspector, as set forth in paragraphs 14 through 19 above, which are incorporated herein by reference.

THIRD CAUSE FOR DISCIPLINE

(Operational Standards and Security)

22. Respondent is subject to disciplinary action under Code sections 4301, subdivision (o), for California Code of Regulations, title 16, section 1714, subdivision b, in that she failed to

secure dangerous drugs and devices, as set forth in paragraphs 14 through 19 above, which are incorporated herein by reference.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

23. Respondent is subject to disciplinary action under Code section 4301 for unprofessional conduct in that Respondent provided false or misleading records and/or information to the Board inspector as described in paragraphs 14 through 19 above, which are incorporated herein by reference.

DISCIPLINE CONSIDERATIONS

24. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about June 1, 2017, the Board of Pharmacy issued Citation Number CI 2016 74052 against Respondent for the following violations: Business and Professions Code section 4301, subdivision (g) for knowingly making or signing any certificate or other document that falsely represents the existence or nonexistence of a state of facts and for violating Business and Professions Code section 4231, subdivision (d) and California Code of Regulations, title 16, section 1732.5 for failing to provide documentation substantiating completion of continuing education requirements/renewal requirements for a pharmacist. Respondent paid the fine in full and that citation is now final.

OTHER MATTERS

25. Pursuant to Code section 4307, if discipline is imposed on Pharmacist License No. RPH 42446 issued to Anita Birosel-McQuigg, Anita Birosel-McQuigg shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacist License Number RPH 42446 is placed on probation or until Pharmacist License Number RPH 42446 is reinstated if it is revoked.

PRAYER

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

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1. Revoking or suspending Pharmacist License Number RPH 42446, issued to Anita Birosel-McQuigg;

2. Prohibiting Anita Birosel-McQuigg from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacist License Number RPH 42446 is placed on probation or until Pharmacist License Number RPH 42446 is reinstated if Pharmacist License Number RPH 42446 issued to Anita Birosel-McQuigg is revoked;

3. Ordering Anita Birosel-McQuigg to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

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

DATED: 9/4/2020

Anne Sodergren

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

SD2020800581