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

In the Matter of the Accusation Against: **FERRYS PHARMACY INC.,** **dba FERRYS PHARMACY** **DANIEL OWEN FERRY AND** **DOROTHY ANN FERRY, OWNERS** **2940 East Street** **Anderson, CA 96007** **Pharmacy Permit No. PHY 19913** **and** **DANIEL OWEN FERRY** **21316 Gaines Lane** **Anderson, CA 96007** **Pharmacist License No. RPH 24741** Respondents.	Case No. 5964 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about January 17, 1978, the Board issued Pharmacy Permit Number PHY 19913 to Ferrys Pharmacy, Inc., doing business as Ferrys Pharmacy ("Respondent Ferrys Pharmacy"), with Daniel Owen Ferry ("Respondent Ferry") as president and pharmacist-in-

charge and Dorothy Ann Ferry as secretary and treasurer. The pharmacy permit was in full force and effect at all times relevant to the charges brought in the Accusation and will expire on November 1, 2017, unless renewed.

3. On or about August 12, 1966, the Board issued Pharmacist License Number RPH 24741 to Respondent Ferry. The pharmacist license was in full force and effect at all times relevant to the charges brought in the Accusation and will expire on September 30, 2018, unless renewed.

JURISDICTION

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

5. Code section 4300 states, in pertinent part:

> (a) Every license issued may be suspended or revoked.
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> (b) The board shall discipline the holder of any license issued by the board, whose default has been entered or whose case has been heard by the board and found guilty, by any of the following methods:
>
> (1) Suspending judgment.
>
> (2) Placing him or her upon probation.
>
> (3) Suspending his or her right to practice for a period not exceeding one year.
>
> (4) Revoking his or her license.
>
> (5) Taking any other action in relation to disciplining him or her as the board in its discretion may deem proper . . .

6. Code section 4300.1 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.

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STATUTORY AND REGULATORY PROVISIONS

(Statutory Provisions)

7. Code section 4301 states, in pertinent part:

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

. . . .

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

. . . .

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

8. Code section 4073 states, in pertinent part:

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

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

9. Code section 4076 states, in pertinent part:

(a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:

(1) Except when the prescriber or the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure

described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6 orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

. . . .

(9) The expiration date of the effectiveness of the drug dispensed.

. . . .

(11)(A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules . . .

10. Code section 4077, subdivision (a), that "[e]xcept as provided in subdivisions (b) and (c), no person shall dispense any dangerous drug upon prescription except in a container correctly labeled with the information required by Section 4076."

11. Code section 4078, subdivision (a)(1), states that "[n]o person shall place a false or misleading label on a prescription."

12. Code section 4081, subdivision (a), states:

All records of manufacture and of sale, acquisition, or disposition of dangerous drugs or dangerous devices shall be at all times during business hours open to inspection by authorized officers of the law, and shall be preserved for at least three years from the date of making. A current inventory shall be kept by every manufacturer, wholesaler, pharmacy, veterinary food-animal drug retailer, physician, dentist, podiatrist, veterinarian, laboratory, clinic, hospital, institution, or establishment holding a currently valid and unrevoked certificate, license, permit, registration, or exemption under Division 2 (commencing with Section 1200) of the Health and Safety Code or under Part 4 (commencing with Section 16000) of Division 9 of the Welfare and Institutions Code who maintains a stock of dangerous drugs or dangerous devices.

13. Code section 4105 states, in pertinent part:

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

. . . .

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

(d) Any records that are maintained electronically shall be maintained so that the pharmacist-in-charge, the pharmacist on duty if the pharmacist-in-charge is not on duty, or, in the case of a veterinary food-animal drug retailer or wholesaler, the designated representative on duty, shall, at all times during which the licensed premises are open for business, be able to produce a hard copy and electronic copy of all records of acquisition or disposition or other drug or dispensing-related records maintained electronically . . .

14. Code section 4113, subdivision (c), states that "[t]he 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."

15. Code section 4307(a) states:

Any person who has been denied a license or whose license has been revoked or is under suspension, or who has failed to renew his or her license while it was under suspension, or who has been a manager, administrator, owner member, officer, director, associate, partner, or any other person with management or control of any partnership, corporation, 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, partner, or any other person with management or control 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, partner, or any other person with management or control of a licensee as follows:

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

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

16. Code section 4342, subdivision (a), states:

The board may institute any action or actions as may be provided by law and that, in its discretion, are necessary, to prevent the sale of pharmaceutical preparations and drugs that do not conform to the standard and tests as to quality and strength, provided in the latest edition of the United States Pharmacopoeia or the National Formulary, or that violate any provision of the Sherman Food, Drug and Cosmetic Law (Part 5 (commencing with Section 109875) of Division 104 of the Health and Safety Code).

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17. Health and Safety Code section 11162.1 states, in pertinent part:

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

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

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

. . . .

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

(7)(A) Six quantity check off boxes shall be printed on the form so that the prescriber may indicate the quantity by checking the applicable box . . .

. . . .

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

. . . .

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

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

. . . .

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

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

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

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

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

refill; and the name, quantity, strength, and directions for use of the controlled substance prescribed . . .

19. Health and Safety Code section 11165, subdivision (d), states:

For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy, clinic, or other dispenser shall report the following information to the Department of Justice as soon as reasonably possible, but not more than seven days after the date a controlled substance is dispensed, in a format specified by the Department of Justice:

(1) Full name, address, and, if available, telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.

(2) The prescriber's category of licensure, license number, national provider identifier (NPI) number, if applicable, the federal controlled substance registration number, and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

(3) Pharmacy prescription number, license number, NPI number, and federal controlled substance registration number.

(4) National Drug Code (NDC) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) International Statistical Classification of Diseases, 9th revision (ICD-9) or 10th revision (ICD-10) Code, if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

20. Health and Safety Code section 111330 states that "[a]ny drug or device is misbranded if its labeling is false or misleading in any particular."

21. Health and Safety Code section 111480 states, in pertinent part:

Any drug or device sold by filling or refilling a written or oral prescription of a practitioner licensed to prescribe the drug or device shall be exempt from the labeling requirements of Sections 111335, 111340, 111350, 111355, 111360, 111365, 111375, 111380, 111385, 111395, 111415, and 111420, if the drug or device bears a label displaying all the following:

(a) Except where the prescriber orders otherwise, either the manufacturer's trade name of the drug, or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

. . . .

(i) The expiration date of the effectiveness of the drug or device if the information is included on the original label of the manufacturer of the drug or device . . .

(Regulatory Provisions)

22. Title 21, Code of Federal Regulations ("CFR"), section 1301.75, subdivision (b), states:

Controlled substances listed in Schedules II, III, IV, and V shall be stored in a securely locked, substantially constructed cabinet. However, pharmacies and institutional practitioners may disperse such substances throughout the stock of noncontrolled substances in such a manner as to obstruct the theft or diversion of the controlled substances.

23. Title 21, CFR, section 1304.11 states, in pertinent part:

(a) General requirements. Each inventory shall contain a complete and accurate record of all controlled substances on hand on the date the inventory is taken, and shall be maintained in written, typewritten, or printed form at the registered location. An inventory taken by use of an oral recording device must be promptly transcribed. Controlled substances shall be deemed to be "on hand" if they are in the possession of or under the control of the registrant, including substances returned by a customer, ordered by a customer but not yet invoiced, stored in a warehouse on behalf of the registrant, and substances in the possession of employees of the registrant and intended for distribution as complimentary samples . . . The inventory may be taken either as of opening of business or as of the close of business on the inventory date and it shall be indicated on the inventory.

. . . .

(c) Biennial inventory date. After the initial inventory is taken, the registrant shall take a new inventory of all stocks of controlled substances on hand at least every two years. The biennial inventory may be taken on any date which is within two years of the previous biennial inventory date . . .

24. Title 16, California Code of Regulations ("CCR"), section 1707.5, subdivision (d), states:

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The pharmacy shall have policies and procedures in place to help patients with limited or no English proficiency understand the information on the label as specified in subdivision (a) in the patient's language. The pharmacy's policies and procedures shall be specified in writing and shall include, at minimum, the selected means to identify the patient's language and to provide interpretive services in the patient's language. The pharmacy shall, at minimum, provide interpretive services in the patient's language, if interpretive services in such language are available, during all hours that the pharmacy is open, either in person by pharmacy staff or by use of a third-party interpretive service available by telephone at or adjacent to the pharmacy counter.

25. Title 16, CCR, section 1711 states, in pertinent part:

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

(b) For purposes of this section, "medication error" means any variation from a prescription or drug order not authorized by the prescriber, as described in Section 1716. Medication error, as defined in the section, does not include any variation that is corrected prior to furnishing the drug to the patient or patient's agent or any variation allowed by law.

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

(2) When a pharmacist determines that a medication error has occurred, a pharmacist shall as soon as possible:

(A) Communicate to the patient or the patient's agent the fact that a medication error has occurred and the steps required to avoid injury or mitigate the error.

(B) Communicate to the prescriber the fact that a medication error has occurred.

. . . .

(3) The communication requirement in paragraph (2) of this subdivision shall only apply to medication errors if the drug was administered to or by the patient, or if the medication error resulted in a clinically significant delay in therapy.

. . . .

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

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(e) The primary purpose of the quality assurance review shall be to advance error prevention by analyzing, individually and collectively, investigative and other pertinent data collected in response to a medication error to assess the cause and any contributing factors such as system or process failures. A record of the quality assurance review shall be immediately retrievable in the pharmacy. The record shall contain at least the following:

1. the date, location, and participants in the quality assurance review;

2. the pertinent data and other information relating to the medication error(s) reviewed and documentation of any patient contact required by subdivision (c);

3. the findings and determinations generated by the quality assurance review; and,

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

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

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

26. Title 16, CCR, section 1714 states, in pertinent part:

. . . .

(b) 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.

. . . .

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

27. Title 16, CCR, section 1715, subdivision (a), states:

The pharmacist-in-charge of each pharmacy as defined under section 4029 or section 4037 of the Business and Professions Code shall complete a self-assessment of the pharmacy's compliance with federal and state pharmacy law. The assessment shall be performed before July 1 of every odd-numbered year. The primary purpose of the self-assessment is to promote compliance through self-examination and education.

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28. Title 16, CCR, section 1715.6 states that "[t]he owner shall report to the Board within thirty (30) days of discovery of any loss of the controlled substances, including their amounts and strengths."

29. Title 16, CCR, section 1718 states, in pertinent part:

> "Current Inventory" as used in Sections 4081 and 4332 of the Business and Professions Code shall be considered to include complete accountability for all dangerous drugs handled by every licensee enumerated in Sections 4081 and 4332 . . .

30. Title 16, CCR, section 1745, subdivision (d), states:

> A pharmacist may partially fill a prescription for a controlled substance listed in Schedule II, if the pharmacist is unable to supply the full quantity ordered by the prescriber. The pharmacist shall make a notation of the quantity supplied on the face of the written prescription. The remaining portion of the prescription may be filled within 72 hours of the first partial filling. If the remaining portion is not filled within the 72-hour period, the pharmacist shall notify the prescriber. The pharmacist may not supply the drug after 72 hour period has expired without a new prescription.

31. Title 16, CCR, section 1761, subdivision (a), states:

> No pharmacist shall compound or dispense any prescription which contains any significant error, omission, irregularity, uncertainty, ambiguity or alteration. Upon receipt of any such prescription, the pharmacist shall contact the prescriber to obtain the information needed to validate the prescription.

COST RECOVERY

32. Code section 125.3 provides, in pertinent part, that a 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.

DRUG CLASSIFICATIONS

33. Cyclobenzaprine is a dangerous drug pursuant to Code section 4022 and is indicated for use as a muscle relaxant. "Flexeril" is a brand name for cyclobenzaprine.

34. Morphine ER (extended release) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(L), and is used to treat chronic pain. Morphine ER is also a dangerous drug pursuant to Code section 4022. "MS Contin" is a brand name for morphine ER.

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35. Dexmethylphenidate ER is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d)(6), and is used to treat Attention Deficit Hyperactivity Disorder (ADHD). Dexmethylphenidate ER is also a dangerous drug pursuant to Code section 4022. "Focalin XR" is a brand name for dexmethylphenidate ER.

36. Methylphenidate is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d)(6), and is used to ADHD. Methylphenidate is also a dangerous drug pursuant to Code section 4022. "Ritalin" is a brand name for methylphenidate.

37. Levothyroxine is a dangerous drug pursuant to Code section 4022 and is used to treat hypothyroidism. "Synthroid" is a brand name for levothyroxine.

38. Clonazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(7), and is used to treat anxiety and restless legs. Clonazepam is also a dangerous drug pursuant to Code section 4022. "Klonopin" is a brand name for clonazepam.

39. Nabumetone is a dangerous drug pursuant to Code section 4022 and is used to treat inflammation and arthritis. "Relafen" is a brand name for nabumetone.

40. Zolpidem is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(32), and is used to treat insomnia. Zolpidem is also a dangerous drug pursuant to Code section 4022. "Ambien" is a brand name for zolpidem.

41. Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(14), and is used to treat pain. Methadone is also a dangerous drug pursuant to Code section 4022. "Dolophine" is a brand name for methadone.

42. "Norco" is a brand name for a combination drug containing hydrocodone and acetaminophen (APAP). Norco was previously designated as a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), but was reclassified as a Schedule II controlled substance pursuant to Title 21, CFR, section 1308.12, subdivision (b)(1)(vi), effective October 6, 2014. Norco is also a dangerous drug pursuant to Code section 4022 and is used to treat pain.

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43. "Percocet" is a brand name for a combination drug containing oxycodone and APAP. Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M). Oxycodone is also a dangerous drug pursuant to Code section 4022 and is used to treat pain.

44. Oxycodone is a Schedule II controlled substance and a dangerous drug as set forth in paragraph 42 above, and is used to treat pain. "Percolone" and "Roxicodone" are brand names for oxycodone.

45. Pravastatin is a dangerous drug pursuant to Code section 4022 and is used to treat hypercholesterolemia. "Pravachol" is a brand name for pravastatin.

46. "Suboxone" is a brand name for a combination drug containing buprenorphine and naloxone. Suboxone is a Schedule III controlled substance pursuant to Title 21, CFR, section 1308.13, subdivision (e)(2). Suboxone is also a dangerous drug pursuant to Code section 4022 and is used to treat opioid dependence.

47. Buprenorphine is a Schedule V controlled substance pursuant to Health and Safety Code section 11058, subdivision (d), and a Schedule III controlled substance pursuant to Title 21, CFR, section 1308.13, subdivision (e)(2). Buprenorphine is used to treat pain. "Subutex" is a brand name for buprenorphine.

48. Febuxostat is a dangerous drug pursuant to Code section 4022 and is used to treat gout. "Uloric" is a brand name for febuxostat.

49. Alprazolam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(1). Alprazolam is also a dangerous drug pursuant to Code section 4022 and is used to treat anxiety. "Xanax" is a brand name for alprazolam.

BOARD INSPECTION OF SEPTEMBER 8, 2014, AND INVESTIGATION

50. On or about September 8, 2014, Board Inspector P. went to Ferrys Pharmacy to conduct an inspection after the Board received a complaint from a confidential informant. The informant alleged that the pharmacist-in-charge, Respondent Ferry ("PIC Ferry"), often made medication errors and dispensed drugs in prescription bottles that were mislabeled.

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51. Staff pharmacist V. ("RPH V.") gave Inspector P. a tour of the pharmacy. Inspector P. noted that they had a Parata Automated Dispensing System (Parata) which counts prescription products, places them in prescription bottles, and affixes a prescription label to the bottles.

52. PIC Ferry arrived at the pharmacy about a half hour after the inspection commenced. Inspector P. obtained a copy of the pharmacy's biennial controlled substance inventory dated December 28, 2013, and noted that it was not in compliance with the law. Inspector P. asked PIC Ferry if he had any recent drug losses. PIC Ferry replied yes. PIC Ferry stated that he filled out a DEA 106 form and sent it to the DEA, but had forgotten to send a copy to the Board. Inspector P. obtained a copy of the DEA 106 form. The pharmacy had reported a loss of 103 tablets of methadone, 270 tablets of Oxycontin 20 mg, 90 tablets of Oxycontin 40 mg, 199 tablets of Oxycontin 60 mg, and 197 tablets of Oxycontin 80 mg tablets due to an armed robbery; the loss occurred on July 13, 2012. Inspector P. confirmed later that the Board had no record of this loss.

53. Inspector P. had PIC Ferry provide her with the pharmacy's Schedule II controlled substance bundles. Inspector P. reviewed the bundles and found several prescriptions that had been partially filled; the remaining portion of the drug was supplied beyond 72 hours without a new prescription issued by the prescriber. Inspector P. asked PIC Ferry about the partial fills. PIC Ferry told Inspector P. that they kept a partial fill binder. Inspector P. obtained a copy of one page in the binder, then requested and received the invoices showing the date each drug was received by the pharmacy. Later, Inspector P. asked RPH V. if he filled prescription number 6689501 for patient SJ. RPH V. replied yes. The prescription was written for Ritalin 20 mg – white tablet only. The partial fill documentation showed that the remaining drug was filled with a light yellow tablet. Inspector P. asked RPH V. if he called the prescriber before he changed the tablets. RPH V. admitted that he had not.

54. Inspector P. reviewed PIC Ferry's self-assessment dated June 1, 2013, and asked him if he had read the form. PIC Ferry admitted that one of his pharmacy technicians had filled out the self-assessment and that PIC Ferry had signed the form without reading it.

55. Inspector P. observed a lock sitting on a counter over a set of drawers. Inspector P. noted that no one re-locked the drawers for over an hour. Inspector P. asked PIC Ferry what was

in the drawers. PIC Ferry pulled open the drawers and showed Inspector P. various Schedule II controlled substances. PIC Ferry stated that he unlocked the drawers in the morning, left them unlocked, and re-locked them at night when the pharmacy closed.

56. Inspector P. reviewed prescriptions located in the will-call area and found 21 prescription bottles that were misbranded. The physical description of the pills on the prescription label did not match the tablets inside the bottles, the wrong drug manufacturer was listed on some of the labels, and some of the labels were missing the physical description of the pill or the drug manufacturer. Inspector P. placed the misbranded prescriptions into a red tote.

57. Inspector P. asked PIC Ferry if he had interpretive services. He admitted that he did not. Later, Inspector P. received documentation showing that the pharmacy obtained interpretive services on September 17, 2014.

58. Inspector P. observed during her inspection that the prescription labels produced by the Parata were defaulted to a one-year expiration date. Inspector P. confirmed with PIC Ferry that every label produced from the Parata on the day of the inspection would show an expiration date of September 8, 2015. At the conclusion of the inspection, Inspector P. asked PIC Ferry to provide her with a print out of the current cell details on the Parata through September 8, 2014.

59. On or about September 9, 2014, Inspector P. received an Inventory by Cell Parata report from the pharmacy which included the expiration date of each drug contained within the Parata. Inspector P. found in reviewing the report that a number of drugs had expiration dates prior to September 9, 2014. Inspector P. sent a fax to PIC Ferry requesting Drug Utilization Reports (DUR) for these medications.

60. On or about September 12, 2014, Inspector P. received various documents from the pharmacy, including a biennial inventory dated August 13, 2012, signed by RPH V. Inspector P. noted that it was not in compliance with the law. Later, Inspector P. spoke with consumer K. O. by phone regarding medications she had received from the pharmacy (K. O. was identified by the informant as one of the consumers who had received incorrect medications from the pharmacy).

61. On or about September 22, 2014, Inspector P. received a package from K. O. containing prescription bottles she had received from the pharmacy. Some of the prescription

labels did not identify the drug manufacturer or had the incorrect manufacturer.

62. On or about March 14, 2016, Inspector P. received copies of DUR's from the pharmacy. Inspector P. found in reviewing the DUR's that the pharmacy had dispensed approximately 843 prescriptions with an invalid expiration date.

FIRST CAUSE FOR DISCIPLINE

(Misbranded Drugs)

63. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (j) and (o), in that Respondent violated Code section 4342 and Health and Safety Code sections 111330 and 111480, as follows:

a. On and between April 1, 2014 and September 8, 2014, Respondent dispensed approximately 843 prescriptions with an invalid expiration date in that the prescription bottles were labeled with an expiration date of one year from the date the medications were dispensed by the Parata when, in fact, the drugs had an expiration date prior to the stated date on the label. Consequently, the drugs were misbranded.

b. On or about September 8, 2014, Respondent had 21 prescription in their will-call area that were misbranded in that the prescription labels either did not list the drug manufacturer or had the wrong drug manufacturer listed.

c. On and between March 26, 2014 and August 5, 2014, Respondent dispensed four (4) prescriptions to consumer K. O. that were misbranded in that the prescription labels either did not list the drug manufacturer or had the wrong drug manufacturer listed.

SECOND CAUSE FOR DISCIPLINE

(Incorrect Prescription Labels)

64. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent violated Code sections 4076, subdivisions (a)(1), (9), and (11)(A), and 4077, subdivision (a), as follows:

a. On and between April 1, 2014 and September 8, 2014, Respondent dispensed approximately 843 prescriptions with an invalid expiration date listed on the prescription label, as set forth in subparagraph 62 (a) above.

b. On or about September 8, 2014, Respondent had 21 prescription bottles in their will-call area that were incorrectly labeled in that the prescription labels had an invalid physical description of the dispensed medications, listed the wrong drug manufacturer, and/or did not include the physical description of the medication or the drug manufacturer.

c. On and between March 26, 2014 and August 5, 2014, Respondent dispensed four prescriptions to consumer K. O. that were misbranded in that the prescription labels either did not list the drug manufacturer or had the wrong drug manufacturer listed.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Pharmacy, Fixtures, and Equipment so that Drugs Were Safely and Properly Secured)

65. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (o) and (j), in that Respondent failed to maintain the pharmacy and its facilities, space, fixtures and/or equipment so that drugs were safely and properly secured, in violation of Title 16, CCR, section 1714, subdivision (b), and failed to store Schedule II Controlled Substances in securely locked, substantially constructed cabinets, in violation of Title 21, CFR, section 1301.75, subdivision (b), as follows: On or about September 8, 2014, Respondent kept Schedule II controlled substances in an unlocked cabinet and admitted that it was the pharmacy's practice to unlock the cabinet at the beginning of the day, to keep the cabinet unlocked during business hours, and lock the cabinet at the end of the day.

FOURTH CAUSE FOR DISCIPLINE

(Improper Biennial Inventories)

66. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (o) and (j), in that Respondent violated Title 16, CCR, section 1718, and Title 21, CFR, section 1304.11, by failing to complete proper biennial inventories, as follows:

a. Respondent's biennial inventory dated December 28, 2013, was started on November 20, 2013 and completed on December 28, 2013, rather than being completed in one day. Further, the inventory form was not signed by a pharmacist and did not indicate whether the inventory was

taken at the opening or close of business.

b. Respondent's biennial inventory dated August 13, 2012, was not completed at the opening or close of business, but was conducted throughout the day.

FIFTH FOR DISCIPLINE

(Partial Filling of Schedule II Controlled Substances Not in Compliance with the Law)

67. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (o) and (j), in that Respondent violated Title 16, CCR, section 1745, subdivision (d), as follows: Respondent partially filled the following prescriptions for Schedule II controlled substances with the remaining portion of the drugs having been supplied beyond 72 hours without a new prescription issued by the prescriber:

Rx No. on Rx Blank	**Drug/patient initials**	**Date filled**	**Partial dated or filled**	**Order for partial received**
2684618 for #90	morphine ER 60 mg/EJ	#27 on 7/25/14	#63 on 7/30/14	7/31/14 – received after partial fill date
2684672 for #30	Focalin XR 30 mg/AD	#15 on 7/25/14	#15 on 7/28/14; pharmacy could not verify receipt of order to fill	8/25/14 incorrect invoice
2684672 for #30 (should have been 2687989 for #30)	Focalin XR 30 mg/AD	#7 on 7/25/14 or #7 on 8/13/14	#23 on 8/28/14	8/25/14 invoice provided incorrect
Rx No. on Rx Blank	**Drug/patient initials**	**Date filled**	**Partial dated or filled**	**Order for partial received**
6689501 for #120	Ritalin 20 mg/SJ	#105 on 9/2/14	#15 on 9/8/14; per PIC Ferry, no balance date on any document	9/5/14
2684682 for #60	MS ER 60 mg/SJ	#12 on 7/25/14	#48 on 7/30/14	7/28/14

68. In addition to dispensing beyond 72 hours, the pharmacist erroneously documented when the partial fill was completed for RX No. 2684618. The partial fill for morphine sulfate ER 60mg was documented as completed on July 30, 2014, however the order to complete the partial fill did not arrive until July 31, 2014.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Report Loss of Controlled Substances)

69. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (j) and (o), in that Respondent violated Title 16, CCR, section 1715.6, as follows: Respondent failed to report to the Board the burglary or theft of controlled substances from the pharmacy on July 13, 2012, as set forth in paragraph 51 above.

SEVENTH CAUSE FOR DISCIPLINE

(Failure to Complete Self-Assessment)

70. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent violated Title 16, CCR, section 1715, by failing to complete a self assessment, as follows: Respondent's pharmacist-in-charge, Respondent Ferry, had a pharmacy technician complete the self-assessment and Respondent Ferry signed the form without reading it, as set forth in paragraph 53 above.

EIGHTH CAUSE FOR DISCIPLINE

(Dispensing Erroneous/Uncertain Prescription)

71. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent violated Title 16, CCR, section 1761, subdivision (a), by dispensing a prescription containing a significant error, omission, irregularity, uncertainty, ambiguity or alteration, as follows: On and between September 5, 2014 and September 8, 2014, Respondent's employee, RPH V., partially filled prescription number 6689501 for consumer SJ that was written for Ritalin 20 mg – white tablet only, but substituted or dispensed a light yellow tablet by a different manufacturer without contacting the prescriber.

NINTH CAUSE FOR DISCIPLINE

(Failure to Provide Interpretive Services)

72. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent violated Title 16,

CCR, section 1707.5, subdivision (d), as follows: On or about September 8, 2014, Respondent failed to provide interpretive services to consumers.

TENTH CAUSE FOR DISCIPLINE

(Misbranded Drugs)

73. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (j) and (o), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated Code section 4342 and Health and Safety Code sections 111330 and 111480, as follows:

a. On and between April 1, 2014 and September 8, 2014, Respondent dispensed approximately 843 prescriptions with an invalid expiration date in that the prescription bottles were labeled with an expiration date of one year from the date the medications were dispensed by the Parata when, in fact, the drugs had an expiration date prior to the stated date on the label. Consequently, the drugs were misbranded.

b. On or about September 8, 2014, Respondent had 21 prescription bottles in their will-call area that were misbranded in that the prescription labels either did not list the drug manufacturer or had the wrong drug manufacturer listed.

c. On and between March 26, 2014 and August 5, 2014, Respondent dispensed four prescriptions to consumer K. O. that were misbranded in that the prescription labels either did not list the drug manufacturer or had the wrong drug manufacturer listed.

ELEVENTH CAUSE FOR DISCIPLINE

(Incorrect Prescription Labels)

74. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated Code sections 4076, subdivisions (a)(1), (9), and (11)(A), and 4077, subdivision (a), as follows:

a. On and between April 1, 2014 and September 8, 2014, Respondent dispensed approximately 843 prescriptions with an invalid expiration date listed on the prescription label, as set forth in subparagraph 62 (a) above.

b. On or about September 8, 2014, Respondent had 21 prescription bottles in their will-call area that were incorrectly labeled in that the prescription labels had an invalid physical description of the dispensed medications, listed the wrong drug manufacturer, and/or did not include the physical description of the medication or the drug manufacturer.

c. On and between March 26, 2014 and August 5, 2014, Respondent dispensed four prescriptions to consumer K. O. that were misbranded in that the prescription labels either did not list the drug manufacturer or had the wrong drug manufacturer listed.

TWELFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Pharmacy, Fixtures, and Equipment so that Drugs Were Safely and Properly Secured)

75. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (o) and (j), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, failed to maintain the pharmacy and its facilities, space, fixtures and/or equipment so that drugs were safely and properly secured, in violation of Title 16, CCR, section 1714, subdivision (b), and failed to store Schedule II Controlled Substances in securely locked, substantially constructed cabinets, in violation of Title 21, CFR, section 1301.75, subdivision (b), as follows: On or about September 8, 2014, Respondent kept Schedule II controlled substances in an unlocked cabinet; admitted that it was his practice to unlock the cabinet at the beginning of the day, keep the cabinet unlocked during business hours, and lock the cabinet at the end of the day.

THIRTEENTH CAUSE FOR DISCIPLINE

(Improper Biennial Inventories)

76. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (o) and (j), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated Title 16, CCR, section 1718 and Title 21, CFR, section 1304.11, by failing to complete proper biennial inventories, as follows:

a. Respondent's biennial inventory dated December 28, 2013, was started on November 20, 2013 and completed on December 28, 2013, rather than being completed in one day as required. Further, the inventory form was not signed by a pharmacist and did not indicate

whether the inventory was taken at the opening or close of business.

b. Respondent's biennial inventory dated August 13, 2012, was not completed at the opening or close of business, but was conducted throughout the day.

FOURTEENTH CAUSE FOR DISCIPLINE

(Partial Filling of Schedule II Controlled Substances Not in Compliance with the Law)

77. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (o) and (j), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated Title 16, CCR, section 1745, subdivision (d), as follows: Respondent partially filled the following prescriptions for Schedule II controlled substances with the remaining portion of the drugs having been supplied beyond 72 hours without a new prescription issued by the prescriber:

Rx No. on Rx Blank	**Drug/patient initials**	**Date filled**	**Partial dated or filled**	**Order for partial received**
2684618 for #90	morphine ER 60 mg/EJ	#27 on 7/25/14	#63 on 7/30/14	7/31/14 – received after partial fill date
2684672 for #30	Focalin XR 30 mg/AD	#15 on 7/25/14	#15 on 7/28/14; pharmacy could not verify receipt of order to fill	8/25/14 incorrect invoice
2684672 for #30 (should have been 2687989 for #30)	Focalin XR 30 mg/AD	#7 on 7/25/14 or #7 on 8/13/14	#23 on 8/28/14	8/25/14 invoice provided incorrect
Rx No. on Rx Blank	**Drug/patient initials**	**Date filled**	**Partial dated or filled**	**Order for partial received**
6689501 for #120	Ritalin 20 mg/SJ	#105 on 9/2/14	#15 on 9/8/14; per PIC Ferry, no balance date on any document	9/5/14
2684682 for #60	MS ER 60 mg/SJ	#12 on 7/25/14	#48 on 7/30/14	7/28/14

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FIFTEENTH CAUSE FOR DISCIPLINE

(Failure to Report Loss of Controlled Substances)

78. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (j) and (o), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated Title 16, CCR, section 1715.6, as follows: Respondent failed to report to the Board the burglary or theft of controlled substances from the pharmacy on July 13, 2012, as set forth in paragraph 51 above.

SIXTEENTH CAUSE FOR DISCIPLINE

(Failure to Complete Self-Assessment)

79. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated Title 16, CCR, section 1715, by failing to complete a self assessment, as follows: Respondent had a pharmacy technician complete the self-assessment and Respondent signed the form without reading it, as set forth in paragraph (53) above.

SEVENTEENTH CAUSE FOR DISCIPLINE

(Failure to Provide Interpretive Services)

80. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated Title 16, CCR, section 1707.5, subdivision (d), as follows: On or before September 8, 2014, Respondent failed to provide interpretive services to consumers.

BOARD INSPECTION OF MARCH 23, 2016, AND INVESTIGATION

81. On or about March 23, 2016, Board Inspector K. went to Ferrys Pharmacy to conduct an inspection. RPH V. was present along with other pharmacy personnel and provided certain documents to Inspector K. as requested.

Cures Reporting

82. Inspector K. reviewed Ferry Pharmacy's CURES data and found that the pharmacy had not made any reports to CURES between February 28, 2013 and June 21, 2013, November 8, 2013 and November 26, 2013, October 18, 2014 and October 27, 2014, and November 15, 2014

and November 24, 2014. RPH V. told Inspector K. that the pharmacy operated continuously during these time periods actively dispensing prescriptions.

83. On and between May 16, 2016 and May 28, 2016, Inspector K. received various emails containing the pharmacy's dispensing data from September 10, 2014 to March 23, 2016. Inspector K. found, among other things, that between October 20, 2014 and October 25, 2014, and November 17, 2014 and November 22, 2014, the pharmacy dispensed over 170 prescriptions for hydrocodone/APAP 10/325 mg, a total of over 21,000 tablets for the 12 day period, none of which had been reported to CURES.

Expired Drugs

84. During the inspection, Inspector K. found 17 packages of prescription drugs that were expired intermingled with non-expired drugs in the pharmacy's drug stock. At the conclusion of his inspection, Inspector K. provided RPH V. with a copy of his inspection report. Inspector K. instructed Ferry's Pharmacy to remove all expired drugs from the drug stock and provide him with a list of drugs that were to be returned to the pharmacy's reverse distributor.

85. On or about April 4, 2016, Ferry's Pharmacy faxed Inspector K. a list of expired drugs (102 packages) that had been pulled from their inventory on March 24, 2016. Some of the drugs on the list had been expired for a year.

Quality Assurance Program

86. During the inspection, Inspector K. reviewed a binder containing the pharmacy's Quality Assurance ("QA") Program policies and procedures, blank incident reporting forms, and some completed reports of prescription errors. Inspector K. reviewed the documents with RPH V. RPH V. stated that when he discovered a prescription error, he documented the information and left it for PIC Ferry, but did not complete a QA report. Inspector K. found copies of two prescription labels in the binder relating to a possible prescription error. RPH V. stated that a prescription was dispensed on or about February 25, 2016, with the wrong label. The label for Rx #8032827 for Uloric 40 mg was placed in error on another patient's prescription bottle, Rx #8038810 for Synthroid 0.137 mg. RPH V. stated that the patient took some of the wrong medication, but did not suffer any ill effects. A QA incident report was not completed and there

was no documentation of any contact with the prescriber. Inspector K. asked RPH V. about Rx # 8034912; the prescription was issued on January 14, 2016, for 32 tablets of Norco 10/325 mg and was dispensed the next day for 120 tablets. RPH V. stated that a QA report was not completed.

False Expiration Dates on Prescription Labels:

87. Inspector K. had pharmacy staff print him an inventory of the drugs listed in the Parata ("Parata inventory list"). Inspector K. found in reviewing the pharmacy's prescription labels that they had expiration dates which were one year from the date the prescriptions were dispensed by the Parata. Inspector K. decided to audit certain drugs on the Parata inventory list since their expiration dates were less than one year. Inspector K. had pharmacy staff print examples of labels that were recently dispensed from the Parata inventory lists (a total of 16). All of the prescriptions were labeled and dispensed with expiration dates that were longer than the manufacturer or pharmacy assigned expiration date.

Drug Losses:

88. On or about June 29, 2015, the Board received a DEA 106 form from the pharmacy. The report indicated that a non-licensed pharmacy employee was suspected of using drugs illegally. The employee refused a drug test and was terminated. The pharmacy reported a loss of 3,279 tablets of oxycodone 30 mg.

89. On or about June 30, 2015, PIC Ferry was requested to provide the Board with certain information pertaining to the drug loss.

90. On or about July 23, 2015, PIC Ferry informed the Board that the pharmacy had completed an inventory of Schedule II controlled substances on June 22, 2015, revealing a shortage. PIC Ferry conducted an audit using a starting date of September 9, 2014, and an ending date of June 22, 2015, and found a shortage of 3,309 tablets of oxycodone 30 mg.

Drug Audit:

91. During the inspection, Inspector K. obtained copies of the pharmacy's inventories of Schedule II to V controlled substances, one conducted on September 9, 2014, and the other conducted on June 22, 2015. Inspector K. had RPH V. complete a count of the pharmacy's stock on hand of certain controlled substances. Inspector K. then had pharmacy staff print a dispensing

report of all controlled substances filled on March 23, 2016. Inspector K. also obtained the pharmacy's dispensing records for the time period from September 10, 2014 to March 23, 2016.

92. On or about March 28, 2016, Inspector K. sent Ferrys Pharmacy's three wholesalers letters requesting that they provide him with records of all sales of Schedule II to V controlled substances purchased by the pharmacy from September 10, 2014 through March 23, 2016, including all credits. The wholesalers provided the records to Inspector K. as requested.

93. Inspector K. conducted an audit based on the documents provided by Ferrys Pharmacy and their wholesalers. Inspector K. found that the pharmacy had significant shortages of certain controlled substances, and a significant overage of the controlled substances hydrocodone/APAP 5/325 mg and hydrocodone/APAP 10/325 mg, as set forth below.

Deficiencies in Controlled Substance Prescriptions

94. On or about April 25, 2016, Inspector K. received original prescription documents from Ferrys Pharmacy. Inspector K. found that certain controlled substance prescriptions were filled and dispensed by the pharmacy pursuant to faxed prescriptions that were not signed and dated in ink (handwritten) by the prescriber, as set forth below.

95. While reviewing the pharmacy's CURES data, Inspector K. noted some controlled substance prescriptions from out of state prescribers. PIC Ferry sent Inspector K. some of these prescriptions. Inspector K. found two prescriptions that were dispensed on forms which were not in compliance with the law, as more particularly set forth below.

EIGHTEENTH CAUSE FOR DISCIPLINE

(Failure to Report Controlled Substance Prescriptions to CURES)

96. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (j), in that Respondent violated Health and Safety Code section 11165, subdivision (d), as follows: On and between February 28, 2013 and June 21, 2013, November 8, 2013 and November 26, 2013, October 18, 2014 and October 27, 2014, and November 15, 2014 and November 24, 2014, Respondent dispensed prescriptions for Schedule II, III, and IV controlled substances without reporting the information to CURES within seven days of the dispensing dates.

NINETEENTH CAUSE FOR DISCIPLINE

(Failure to Comply with Quality Assurance Program)

97. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent violated Title 16, CCR, section 1711, as follows:

a. Respondent failed to document on the pharmacy's incident reporting forms the medication errors described in paragraph 84 above as required by their QA Program policies and procedures; and failed to engage in a QA Program in a manner to advance error prevention by analyzing, individually and collectively, investigative and other pertinent data collected in response to medication errors to assess the cause and any contributing factors such as system or process failures.

b. Respondent failed to keep or have available at the pharmacy in an immediately retrievable form the date, location, and participants involved in the QA review; pertinent data and other information relating to the medication error(s) reviewed; documentation of any patient contact; the findings and determinations generated by the QA review; and recommended changes to pharmacy policy, procedure, systems, or processes.

TWENTIETH CAUSE FOR DISCIPLINE

(False or Misleading Prescription Labels)

98. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent violated Code sections 4078, subdivision (a)(1), and 4076, subdivision (a)(9), as follows: Respondent dispensed prescriptions with labels which were false or misleading in that the prescription bottles were labeled with expiration dates that were longer than the manufacturers' expiration dates or the expiration dates that were labeled on the cells of the pharmacy's Parata machine, as follows:

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Prescription No.	Date	Drug	Exp. Date on Label	Exp. Date on Parata List
8035839	03/18/2016	carisoprodol 350 mg	03/18/2017	12/01/2016
8040707	03/18/2016	carisoprodol 350 mg	03/18/2017	12/01/2016
8041286	03/18/2016	carisoprodol 350 mg	03/18/2017	12/01/2016
8028008	02/29/2016	metoprolol ER 50 mg	02/28/2017	12/01/2015
8039175	02/29/2016	metoprolol ER 50 mg	02/28/2017	12/01/2015
8014007	03/12/2016	metoprolol ER 50 mg	03/12/2017	12/01/2015
8031950	03/11/2016	levothyroxine 50 mcg	03/11/2017	11/01/2016
8037256	03/11/2016	levothyroxine 50 mcg	03/11/2017	11/01/2016
8023760	03/21/2016	levothyroxine 50 mcg	03/11/2017	11/01/2016
8041350	03/18/2016	prednisone 20 mg	03/17/2017	07/01/2016
8041067	03/16/2016	prednisone 20 mg	03/16/2017	07/01/2016
8041044	03/16/2016	prednisone 20 mg	03/16/2017	07/01/2016
8038371	02/19/2016	prednisone 20 mg	02/18/2017	07/01/2016
8024502	03/22/2016	diazepam 5 mg	03/22/2017	12/01/2016
8033502	03/22/2016	diazepam 5 mg	03/22/2017	12/01/2016
8041616	03/22/2016	diazepam 5 mg	03/22/2017	12/01/2016

TWENTY-FIRST CAUSE FOR DISCIPLINE

(Failure to Maintain Pharmacy, Fixtures, and Equipment so that Drugs Were Safely and Properly Secured)

99. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (o) and (j), in that Respondent violated title 16, CCR, section 1714, subdivisions (b) and (d), as follows:

a. On and between September 9, 2014 and March 23, 2016, Respondent failed to maintain the pharmacy and its facilities, space, fixtures and/or equipment so that drugs were safely and properly secured, resulting in significant shortages of the following controlled substances:

Drug	Shortage
alprazolam 2 mg	-268
buprenorphine 8 mg	-262
methadone 10 mg	-341
Promethazine/codeine liquid	-614
Suboxone film 8/2 mg	-144
Total:	-1,629

b. Respondent failed to ensure that the pharmacy's drug stock was secured with sufficient provisions for effective control against theft or diversion of controlled substances, resulting in a loss or shortage of 3,309 oxycodone 30 mg tablets as reported by Ferry's Pharmacy on or about June 29, 2015.

c. On or about March 23, 2016, Respondent held the following expired drugs for sale intermingled with the pharmacy's stock of non-expired drugs:

Drug	Expiration Date
albuterol 2 mg/5 ml	01/2016
AzaSite	07/31/2015
Drug	**Expiration Date**
Comtan 200 mg	09/2015
Depakote 500 mg	07/26/2015
Depakote ER 250 mg	04/11/2015
hydroxyzine pamoate 25 mg	08/2015
Lipitor 40 mg	10/2015
Lipitor 80 mg	08/2015
Marinol 5 mg	01/2016
Oxycontin 80 mg	01/2016
Phenadoz 25 mg supp.	09/2015

Phenadoz 25 mg supp.	09/2015
Ritalin LA 30 mg	02/2016
Sensipar 30 mg	06/2015
Strattera 25 mg	10/2015
Theo-24 200 mg	08/2015
valcyclovir 500 mg	01/2016

d. Respondent held an additional 102 packages of expired drugs for sale in the pharmacy's drug stock, some of which had been expired for up to one year.

TWENTY-SECOND CAUSE FOR DISCIPLINE

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

100. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent violated Code sections 4081, subdivision (a), and 4105, subdivisions (a) through (c), and Title 16, CCR, section 1718, as follows: On and between September 9, 2014 and March 23, 2016, Respondent failed to maintain an accurate or current inventory of all dangerous drugs in the pharmacy, resulting in significant shortages and overages of controlled substances, as follows:

Drug	**Shortage or Overage**
alprazolam 2 mg	-268
buprenorphine 8 mg	-262
hydrocodone/APAP 10/325 mg	3,986
hydrocodone/APAP 5/325 mg	1,135
methadone 10 mg	-341
Promethazine/codeine liquid	-614
Suboxone film 8/2 mg	-144

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TWENTY-THIRD CAUSE FOR DISCIPLINE

(Violations of Requirements for Controlled Substance Prescriptions)

101. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (j), in that Respondent violated state laws regulating controlled substances, as follows:

a. Respondent filled and dispensed the following controlled substance prescriptions pursuant to faxed prescriptions which did not have the signature and date handwritten in ink by the prescriber, in violation of Health and Safety Code section 11164, subdivision (a)(1):

Date	Number	Drug
09/03/2013	4645430	zolpidem 10 mg
10/07/2013	3649517	Estratest
11/05/2013	4652898	modafinil 200 mg
12/03/2013	4656206	carisoprodol 350 mg
01/17/2014	3661590	Depo-Testosterone
04/04/2014	3671249	estrogens-methyltestosterone
12/11/2014	4702921	zolpidem 10 mg
05/09/2015	8009173	estrogens-methyltestosterone

b. Respondent dispensed controlled substance prescriptions, specifically, prescription number 3642972 issued on August 13, 2013, for 240 tablets of hydrocodone/APAP 10/325 mg (the prescriber was from the state of Oregon), and prescription number 3644395 issued on August 23, 2013, for 90 tablets of hydrocodone/APAP 10/325 mg (the prescriber was from the state of Maryland), that were not in compliance with Health and Section 11162.1 in that the prescription forms were not printed with the following features:

1. A latent, repetitive "void" pattern printed across the entire front of the prescription if the prescription was scanned or photocopied;

2. A watermark printed on the backside of the prescription blank with the words

"California Security Prescription";

3. A description of the security features included on the prescription form;

4. Six quantity check off boxes printed on the form so that the prescriber may indicate the quantity by checking the applicable box;

5. A statement printed on the bottom of the prescription blank that the "Prescription is void if the number of drugs prescribed is not noted;

6. A check box indicating the prescriber's order not to substitute;

7. An identifying number assigned to the approved security printer by the Department of Justice; and/or

8. The lot number printed on the form and each form within that batch numbered sequentially.

TWENTY-FOURTH CAUSE FOR DISCIPLINE

(Failure to Report Controlled Substance Prescriptions to CURES)

102. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (j), in that Respondent, as pharmacist-in-charge of Ferry's Pharmacy, violated Health and Safety Code section 11165, subdivision (d), as follows: On and between February 28, 2013 and June 21, 2013, November 8, 2013 and November 26, 2013, October 18, 2014 and October 27, 2014, and November 15, 2014 and November 24, 2014, Respondent dispensed prescriptions for Schedule II, III, and IV controlled substances without reporting the information to CURES within seven days of the dispensing dates.

TWENTY-FIFTH CAUSE FOR DISCIPLINE

(Failure to Comply with Quality Assurance Program)

103. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent, as pharmacist-in-charge of Ferry's Pharmacy, violated Title 16, CCR, section 1711, as follows:

a. Respondent failed to document on the pharmacy's incident reporting forms the medication errors described in paragraph 84 above as required by their QA Program policies and procedures; and failed to engage in a QA Program in a manner to advance error prevention by

analyzing, individually and collectively, investigative and other pertinent data collected in response to medication errors to assess the cause and any contributing factors such as system or process failures.

b. Respondent failed to keep or have available at the pharmacy in an immediately retrievable form the date, location, and participants involved in the QA review; pertinent data and other information relating to the medication error(s) reviewed; documentation of any patient contact; the findings and determinations generated by the QA review; and recommended changes to pharmacy policy, procedure, systems, or processes.

TWENTY-SIXTH CAUSE FOR DISCIPLINE

(False or Misleading Prescription Labels)

104. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated Code sections 4078, subdivision (a)(1), and 4076, subdivision (a)(9), as follows: Respondent dispensed prescriptions with labels which were false or misleading in that the prescription bottles were labeled with expiration dates that were longer than the manufacturers' expiration dates or the expiration dates that were labeled on the cells of the pharmacy's Parata machine, as follows:

Prescription No.	Date	Drug	Exp. Date on Label	Exp. Date on Parata List
8035839	03/18/2016	carisoprodol 350 mg	03/18/2017	12/01/2016
8040707	03/18/2016	carisoprodol 350 mg	03/18/2017	12/01/2016
8041286	03/18/2016	carisoprodol 350 mg	03/18/2017	12/01/2016
8028008	02/29/2016	metoprolol ER 50 mg	02/28/2017	12/01/2015
8039175	02/29/2016	metoprolol ER 50 mg	02/28/2017	12/01/2015
8014007	03/12/2016	metoprolol ER 50 mg	03/12/2017	12/01/2015
8031950	03/11/2016	levothyroxine 50 mcg	03/11/2017	11/01/2016
8037256	03/11/2016	levothyroxine 50 mcg	03/11/2017	11/01/2016
8023760	03/21/2016	levothyroxine 50 mcg	03/11/2017	11/01/2016

8041350	03/18/2016	prednisone 20 mg	03/17/2017	07/01/2016
8041067	03/16/2016	prednisone 20 mg	03/16/2017	07/01/2016
8041044	03/16/2016	prednisone 20 mg	03/16/2017	07/01/2016
8038371	02/19/2016	prednisone 20 mg	02/18/2017	07/01/2016
8024502	03/22/2016	diazepam 5 mg	03/22/2017	12/01/2016
8033502	03/22/2016	diazepam 5 mg	03/22/2017	12/01/2016
8041616	03/22/2016	diazepam 5 mg	03/22/2017	12/01/2016

TWENTY-SEVENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Pharmacy, Fixtures, and Equipment so that Drugs Were Safely and Properly Secured)

105. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (o) and (j), in that Respondent, as pharmacist-in-charge of Ferry Pharmacy, violated title 16, CCR, section 1714, subdivisions (b) and (d), as follows:

a. On and between September 9, 2014 and March 23, 2016, Respondent failed to maintain the pharmacy and its facilities, space, fixtures and/or equipment so that drugs were safely and properly secured, resulting in significant shortages of the following controlled substances:

Drug	**Shortage**
alprazolam 2 mg	-268
buprenorphine 8 mg	-262
methadone 10 mg	-341
Promethazine/codeine liquid	-614
Suboxone film 8/2 mg	-144
Total:	-1,629

b. Respondent failed to ensure that the pharmacy's drug stock was secured with sufficient provisions for effective control against theft or diversion of controlled substances, resulting in a loss or shortage of 3,309 oxycodone 30 mg tablets as reported by Ferry's Pharmacy on or about June 29, 2015.

c. On or about March 23, 2016, Respondent held the following expired drugs for sale intermingled with the pharmacy's stock of non-expired drugs:

Drug	**Expiration Date**
albuterol 2 mg/5 ml	01/2016
AzaSite	07/31/2015
Comtan 200 mg	09/2015
Depakote 500 mg	07/26/2015
Depakote ER 250 mg	04/11/2015
hydroxyzine pamoate 25 mg	08/2015
Lipitor 40 mg	10/2015
Lipitor 80 mg	08/2015
Marinol 5 mg	01/2016
Oxycontin 80 mg	01/2016
Phenadoz 25 mg supp.	09/2015
Phenadoz 25 mg supp.	09/2015
Drug	**Expiration Date**
Ritalin LA 30 mg	02/2016
Sensipar 30 mg	06/2015
Strattera 25 mg	10/2015
Theo-24 200 mg	08/2015
valcyclovir 500 mg	01/2016

d. Respondent held an additional 102 packages of expired drugs for sale in the pharmacy's drug stock, some of which had been expired for up to one year.

TWENTY-EIGHTH CAUSE FOR DISCIPLINE

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

106. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated Code sections 4081, subdivision (a), and 4105, subdivisions (a) through (c), and Title 16, CCR, section 1718, as follows: On and between September 9, 2014 and March 23, 2016, Respondent failed to maintain an accurate or current inventory of all dangerous drugs in the pharmacy, resulting in significant shortages and overages of controlled substances, as follows:

Drug	Shortage or Overage
alprazolam 2 mg	-268
buprenorphine 8 mg	-262
hydrocodone/APAP 10/325 mg	3,986
hydrocodone/APAP 5/325 mg	1,135
methadone 10 mg	-341
Promethazine/codeine liquid	-614
Suboxone film 8/2 mg	-144

TWENTY-NINTH CAUSE FOR DISCIPLINE

(Violations of Requirements for Controlled Substance Prescriptions)

107. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (j), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated state laws regulating controlled substances, as follows:

a. Respondent filled and dispensed the following controlled substance prescriptions pursuant to faxed prescriptions which did not have the signature and date handwritten in ink by the prescriber, in violation of Health and Safety Code section 11164, subdivision (a)(1):

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Date	Number	Drug
09/03/2013	4645430	zolpidem 10 mg
10/07/2013	3649517	Estratest
11/05/2013	4652898	modafinil 200 mg
12/03/2013	4656206	carisoprodol 350 mg
01/17/2014	3661590	Depo-Testosterone
04/04/2014	3671249	estrogens-methyltestosterone
12/11/2014	4702921	zolpidem 10 mg
05/09/2015	8009173	estrogens-methyltestosterone

b. Respondent dispensed controlled substance prescriptions, specifically, prescription number 3642972 issued on August 13, 2013, for 240 tablets of hydrocodone/APAP 10/325 mg (the prescriber was from the state of Oregon), and prescription number 3644395 issued on August 23, 2013, for 90 tablets of hydrocodone/APAP 10/325 mg (the prescriber was from the state of Maryland), that were not in compliance with Health and Section 11162.1 in that the prescription forms were not printed with the following features:

1. A latent, repetitive "void" pattern printed across the entire front of the prescription if the prescription was scanned or photocopied;

2. A watermark printed on the backside of the prescription blank with the words "California Security Prescription";

3. A description of the security features included on the prescription form;

4. Six quantity check off boxes printed on the form so that the prescriber may indicate the quantity by checking the applicable box;

5. A statement printed on the bottom of the prescription blank that the "Prescription is void if the number of drugs prescribed is not noted;

6. A check box indicating the prescriber's order not to substitute;

7. An identifying number assigned to the approved security printer by the Department of Justice; and/or

8. The lot number printed on the form and each form within that batch numbered sequentially.

OTHER MATTERS

108. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 19913, issued to Ferrys Pharmacy, Inc., doing business as Ferrys Pharmacy, then Ferrys Pharmacy, Inc. shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 19913 is placed on probation or until Pharmacy Permit Number PHY 19913 is reinstated if it is revoked.

109. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 19913, issued to Ferrys Pharmacy, Inc., doing business as Ferrys Pharmacy, then while Respondent Daniel Owen Ferry has been an officer and owner and had knowledge of or knowingly participated in any conduct for which the licensee was disciplined, Respondent Daniel Owen Ferry shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 19913 is placed on probation or until Pharmacy Permit Number PHY 19913 is reinstated if it is revoked.

110. Pursuant to Code section 4307, if discipline is imposed on Pharmacist License Number RPH 24741, issued to Daniel Owen Ferry, then Respondent Ferry 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 24741 is placed on probation or until Pharmacist License Number RPH 24741 is reinstated if it is revoked.

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PRAYER

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

1. Revoking or suspending Pharmacy Permit Number PHY 19913, issued to Ferrys Pharmacy, Inc., doing business as Ferrys Pharmacy;

2. Revoking or suspending Pharmacist License Number RPH 24741, issued to Daniel Owen Ferry;

3. Prohibiting Ferrys Pharmacy, Inc., doing business as Ferrys Pharmacy from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 19913 is placed on probation or until Pharmacy Permit Number PHY 19913 is reinstated if Pharmacy Permit Number PHY 19913 is revoked;

4. Prohibiting Daniel Owen Ferry and Dorothy Ann Ferry from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 19913 is placed on probation or until Pharmacy Permit Number PHY 19913 is reinstated if Pharmacy Permit Number PHY 19913 is revoked;

5. Prohibiting Daniel Owen Ferry and Dorothy Ann Ferry from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacist License Number RPH 24741 is placed on probation or until Pharmacist License Number RPH 24741 is reinstated if Pharmacist License Number RPH 24741 is revoked;

6. Ordering Ferrys Pharmacy, Inc., doing business as Ferrys Pharmacy, and Daniel Owen Ferry, 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

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

DATED: 9/16/17

Virginia Herold

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

SA2016103633