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

In the Matter of the Accusation Against:

THE MEDICINE SHOPPE
PETER K. KWOK, PARTNER
CHERYL L. CHIN, PARTNER
CHERYL KWOK,
aka CHERYL CHIN KWOK,
PHARMACIST-IN-CHARGE
3507 W. Walnut Avenue
Visalia, CA 93277

Pharmacy License No. PHY 40626

and

CHERYL CHIN KWOK 3507 W. Walnut Avenue Visalia, CA 93277

Pharmacist License No. RPH 43606

Respondents.

Case No. 6013

OAH No. 2017100801

DECISION AND ORDER

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

This Decision shall become effective at 5:00 p.m. on May 24, 2018.

It is so ORDERED on April 24, 2018.

BOARD OF PHARMACY DEPARTMENT OF CONSUMER AFFAIRS STATE OF CALIFORNIA

By

Amy Gutierrez, Pharm.D. Board President

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1	XAVIER BECERRA Attorney General of California		
2	DAVID É. BRICE		
3	Supervising Deputy Attorney General PATRICIA WEBBER HEIM		
4	Deputy Attorney General State Bar No. 230889		
5	1300 I Street, Suite 125 P.O. Box 944255		
6	Sacramento, CA 94244-2550 Telephone: (916) 210-7519		
7	Facsimile: (916) 322-8288 Attorneys for Complainant		
8	BEFORE THE		
9	BOARD OF PHARMACY DEPARTMENT OF CONSUMER AFFAIRS		
10	STATE OF CALIFORNIA		
11:	In the Matter of the Accusation Against:	Case No. 6013	
12	THE MEDICINE SHOPPE	OAH No. 2017100801	
13	PETER K. KWOK, PARTNER CHERYL L. CHIN, PARTNER	STIPULATED SETTLEMENT AND	
14.	CHERYL KWOK, aka CHERYL CHIN KWOK,	DISCIPLINARY ORDER	
15	PHARMACIST-IN-CHARGÉ 3507 W. Walnut Avenue Visalia, CA 93277	FOR RESPONDENT THE MEDICINE SHOPPE ONLY	
16	Pharmacy Permit No. PHY 40626		
17,.	and		
18			
19	CHERYL CHIN KWOK 3507 W. Walnut Avenue Visalia, CA 93277		
20	Pharmacist License No. RPH 43606		
21	Respondents,		
22:			
23	the second secon		
24	IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-		
25	entitled proceedings that the following matters are true:		
26	<u>PARTIES</u>		
27	1. Virginia Herold (Complainant) is the Executive Officer of the Board of Pharmacy		
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* 51	STIPULATED SETT	LEMENT FOR THE MEDICINE SHOPPE ONLY (6013)	

STIPULATED SETTLEMENT FOR THE MEDICINE SHOPPE ONLY (6013)

hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against them; the right to present evidence and to testify on its own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

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

CULPABILITY

- 9. Respondent understands and agrees that the charges and allegations in Accusation No. 6013, if proven at a hearing, constitute cause for imposing discipline upon its Pharmacy Permit License No. 40626. Respondent hereby gives up its right to contest those charges.
- 10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent hereby gives up its right to contest that cause for discipline exists based on those charges.
- 11. Respondent agrees that its Pharmacy Permit is subject to discipline and they agree to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

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

discipline, citation, or other administrative action filed by any state or federal agency which involves respondent's pharmacy permit license or which is related to the practice of pharmacy or the manufacturing, obtaining, handling or distributing, billing, or charging for any drug, device or controlled substance.

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

2. Report to the Board

Respondent owner shall report to the board quarterly, on a schedule as directed by the board or its designee. The report shall be made either in person or in writing, as directed. Among other requirements, respondent owner shall state in each report under penalty of perjury whether there has been compliance with all the terms and conditions of probation. Failure to submit timely reports in a form as directed shall be considered a violation of probation. Any period(s) of delinquency in submission of reports as directed may be added to the total period of probation. Moreover, if the final probation report is not made as directed, probation shall be automatically extended until such time as the final report is made and accepted by the board.

3. Interview with the Board

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

4. Cooperate with Board Staff

Respondent owner shall cooperate with the board's inspection program and with the board's monitoring and investigation of respondent's compliance with the terms and conditions of their probation. Failure to cooperate shall be considered a violation of probation.

5. Reimbursement of Board Costs

As a condition precedent to successful completion of probation, respondent owner shall pay to the Board, jointly and severally with Respondent Cheryl Chin Kwok, its costs of investigation

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according to a payment plan approved by the Board. There shall be no deviation from this schedule absent prior written approval by the board or its designee. Failure to pay costs by the deadline(s) as directed shall be considered a violation of probation. The filing of bankruptcy by respondent owner shall not relieve respondent of their

and prosecution in the amount of \$18,000.00. Respondent owner shall make said payments

responsibility to reimburse the board its costs of investigation and prosecution.

6. **Probation Monitoring Costs**

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

7. Status of License

Respondent owner shall, at all times while on probation, maintain current licensure with the board. If respondent owner submits an application to the board, and the application is approved, for a change of location, change of permit or change of ownership, the board shall retain continuing jurisdiction over the license, and the respondent shall remain on probation as determined by the board. Failure to maintain current licensure shall be considered a violation of probation.

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

8. License Surrender While on Probation/Suspension

Following the effective date of this decision, should respondent owner discontinue business, respondent owner may tender the premises license to the board for surrender. The board or its designee shall have the discretion whether to grant the request for surrender or take any other action it deems appropriate and reasonable. Upon formal acceptance of the surrender of

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the license, respondent will no longer be subject to the terms and conditions of probation.

Upon acceptance of the surrender, respondent owner shall relinquish the premises wall and renewal license to the board within ten (10) days of notification by the board that the surrender is accepted. Respondent owner shall further submit a completed Discontinuance of Business form according to board guidelines and shall notify the board of the records inventory transfer.

Respondent owner shall also, by the effective date of this decision, arrange for the continuation of care for ongoing patients of the pharmacy by, at minimum, providing a written notice to ongoing patients that specifies the anticipated closing date of the pharmacy and that identifies one or more area pharmacies capable of taking up the patients' care, and by cooperating as may be necessary in the transfer of records or prescriptions for ongoing patients. Within five days of its provision to the pharmacy's ongoing patients, Respondent owner shall provide a copy of the written notice to the board. For the purposes of this provision, "ongoing patients" means those patients for whom the pharmacy has on file a prescription with one or more refills outstanding, or for whom the pharmacy has filled a prescription within the preceding sixty (60) days.

Respondent owner may not apply for any new licensure from the board for three (3) years from the effective date of the surrender. Respondent owner shall meet all requirements applicable to the license sought as of the date the application for that license is submitted to the board.

Respondent owner further stipulates that he or she shall reimburse the board for its costs of investigation and prosecution prior to the acceptance of the surrender.

9. Notice to Employees

Respondent owner shall, upon or before the effective date of this decision, ensure that all employees involved in permit operations are made aware of all the terms and conditions of probation, either by posting a notice of the terms and conditions, circulating such notice, or both. If the notice required by this provision is posted, it shall be posted in a prominent place and shall remain posted throughout the probation period. Respondent owner shall ensure that any employees hired or used after the effective date of this decision are made aware of the terms and

conditions of probation by posting a notice, circulating a notice, or both. Additionally, respondent owner shall submit written notification to the board, within fifteen (15) days of the effective date of this decision, that this term has been satisfied. Failure to submit such notification to the board shall be considered a violation of probation.

"Employees" as used in this provision includes all full-time, part-time, volunteer, temporary and relief employees and independent contractors employed or hired at any time during probation.

10. Owners and Officers: Knowledge of the Law

Respondent shall provide, within thirty (30) days after the effective date of this decision, signed and dated statements from its owners, including any owner or holder of ten percent (10%) or more of the interest in respondent or respondent's stock, and any officer, stating under penalty of perjury that said individuals have read and are familiar with state and federal laws and regulations governing the practice of pharmacy. The failure to timely provide said statements under penalty of perjury shall be considered a violation of probation.

11. Posted Notice of Probation

Respondent owner shall prominently post a probation notice provided by the board in a place conspicuous and readable to the public. The probation notice shall remain posted during the entire period of probation.

Respondent owner shall not, directly or indirectly, engage in any conduct or make any statement which is intended to mislead or is likely to have the effect of misleading any patient, customer, member of the public, or other person(s) as to the nature of and reason for the probation of the licensed entity.

Failure to post such notice shall be considered a violation of probation.

12. Violation of Probation

If a respondent owner has not complied with any term or condition of probation, the board shall have continuing jurisdiction over respondent license, and probation shall be automatically extended until all terms and conditions have been satisfied or the board has taken other action as

deemed appropriate to treat the failure to comply as a violation of probation, to terminate probation, and to impose the penalty that was stayed.

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

13. Completion of Probation

Upon written notice by the board or its designee indicating successful completion of probation, respondent license will be fully restored.

14. Community Services Program

Within sixty (60) days of the effective date of this decision, respondent owner shall submit to the Board or its designee, for prior approval, a community service program in which respondent shall provide \$10,000 worth of Naloxone to community organizations approved by the Board.

Within thirty (30) days of board approval thereof, respondent owner shall submit documentation to the board demonstrating commencement of the community service program. Respondent owner shall report on progress with the community service program in the quarterly reports.

Failure to timely submit, commence, or comply with the program shall be considered a violation of probation.

15. Consultant Pharmacist Review of Pharmacy Operations

During the period of probation, Respondent shall retain an independent consultant at its own expense who shall be responsible for reviewing pharmacy operations on a twice per month basis for compliance by Respondent with state and federal laws and regulations governing the

practice of pharmacy. The consultant shall be a pharmacist licensed by and not on probation with the Board or its designee, for prior approval, within thirty (30) days of the effective date of this decision. During the period of probation, the Board or its designee retains the discretion to reduce the frequency of the pharmacist consultant's review of Respondent Pharmacy's operations. Failure to timely retain, seek approval of, or ensure timely reporting by the consultant shall be considered a violation of probation.

16. Report of Controlled Substances

Respondent owner shall submit quarterly reports to the board detailing the total acquisition and disposition of such controlled substances as the board may direct. Respondent owner shall specify the manner of disposition (e.g., by prescription, due to burglary, etc.) or acquisition (e.g., from a manufacturer, from another retailer, etc.) of such controlled substances. Respondent owner shall report on a quarterly basis or as directed by the board. The report shall be delivered or mailed to the board no later than ten (10) days following the end of the reporting period. Failure to timely prepare or submit such reports shall be considered a violation of probation.

17. Mandatory Training for All Pharmacist Staff

Within six (6) months of the effective date of this Decision, all pharmacist staff of Respondent Pharmacy shall complete the continuing education course offered jointly by the Board and the U.S. Drug Enforcement Administration, entitled "CURES, Prescription Drug Abuse and Preventing Drug Diversion – What a Pharmacist Needs to Know."

Failure to timely complete the mandatory training shall be considered a violation of probation. The period of probation will be automatically extended until such mandatory training is successfully completed and written proof, in a form acceptable to the Board, is provided to the Board or its designee.

In the event the training described in this term is not offered by the Board within six (6) months of the effective date of this Order, attendance of the first available session shall satisfy the requirements of this term without extending the probation. Attendance of training described in this term between March 10, 2018, and the effective date of this Order shall satisfy the

1	requirements of this term. This term is only applicable to pharmacist(s) currently employed by		
2	Respondent Pharmacy and does not apply to relief personnel who may provide temporary		
3	coverage during the period of probation.		
4	<u>ACCEPTANCE</u>		
5	I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully		
6	discussed it with my attorney, Ivan Petrzelka. I understand the stipulation and the effect it will		
7	have on my Pharmacy Permit. I enter into this Stipulated Settlement and Disciplinary Order		
8	voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the		
9	Board of Pharmacy.		
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12	DATED: 319118		
13	THE MEDICINE SHOPPE; PETER K. KWOK, PARTNER; CHERYL L. CHIN, PARTNER;		
14	CHERYL CHIN KWOK		
15	Respondent		
16	I have read and fully discussed with Respondent The Medicine Shoppe; Peter K. Kwok,		
17	Partner; Cheryl L. Chin, Partner; Cheryl Chin Kwok the terms and conditions and other matters		
18	contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and		
19	content.		
20	DATED: 3-S-P		
21	IVAN PETRZELKA		
22	Attorney for Respondent		
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	STIPULATED SETTLEMENT FOR THE MEDICINE SHOPPE ONLY (6013)		

ENDORSEMENT The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Board of Pharmacy. Respectfully submitted, XAVIER BECERRA Attorney General of California DAVID E. BRICE Supervising Deputy Attorney General PATRICIA WEBBER HEIM Deputy Attorney General Attorneys for Complainant SA2016104515 12989803.doc

STIPULATED SETTLEMENT FOR THE MEDICINE SHOPPE ONLY (6013)

Exhibit A

Accusation No. 6013

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1	XAVIER BECERRA Attorney General of California JANICE K. LACHMAN Supervising Deputy Attorney General PATRICIA WEBBER HEIM Deputy Attorney General State Bar No. 230889				
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3					
4					
5	1300 I Street, Suite 125 P.O. Box 944255				
6	Sacramento, CA 94244-2550 Telephone: (916) 324-5263				
7	Facsimile: (916) 322-8288 Attorneys for Complainant				
8	BEFOR				
9	BOARD OF PHARMACY DEPARTMENT OF CONSUMER AFFAIRS				
10	STATE OF C.	ALIFORNIA			
11	In the Matter of the Accusation Against:	Case No. 6013			
12	THE MEDICINE SHOPPE				
13	PETER K. KWOK, PARTNER CHERYL L. CHIN, PARTNER	ACCUSATION			
14	OWNERS 3507 W. Walnut Avenue				
15	Visalia, CA 93277				
16	Pharmacy Permit No. PHY 40626				
17	and				
18	CHERYL KWOK, aka CHERYL CHIN KWOK, PHARMACIST-IN-CHARGE				
19	3507 W. Walnut Avenue Visalia, CA 93277	•			
20	Pharmacist License No. RPH 43606				
21	Respondents.				
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23	Complainant alleges:				
24	PARTIES				
25	1. Virginia Herold ("Complainant") brings this Accusation solely in her official capacity				
26	as the Executive Officer of the Board of Pharmacy ("Board"), Department of Consumer Affairs.				
27	2On or about January 4, 1995, the Board issued Pharmacy Permit Number PHY 40626				
28	to The Medicine Shoppe ("Respondent The Medic	cine Shoppe"), with Peter K. Kwok and Cheryl			
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4	50-74	
1	75-100	
2	101-150	
3	151 and over	
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5	(8) Prescription blanks shall contain a statement printed on the bottom of	
6	the prescription blank that the "Prescription is void if the number of drugs prescribed is not noted."	
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8	(10) Check boxes shall be printed on the form so that the prescriber may	
9	indicate the number of refills ordered.	
10	,	
11	(13) An identifying number assigned to the approved security printer by the Department of Justice.	
12	the Department of Justice.	
13	(b) Each botch of controlled substance proggainties forms shall have the	
14 15	sequentially beginning with the numeral one	
16	13. Health and Safety Code section 11164 states, in pertinent part:	
17 18	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.	
19	(a) Each prescription for a controlled substance classified in Schedule II,	
20	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	
21	14. Health and Safety Code section 111255 states that "[a]ny drug or device is	
22	adulterated if it has been produced, prepared, packed, or held under conditions whereby it may	
23	have been contaminated with filth, or whereby it may have been rendered injurious to health."	
24	15. Health and Safety Code section 111295 states that "[i]t is unlawful for any person to	
25	manufacture, sell, deliver, hold, or offer for sale any drug or device that is adulterated."	
26	16. Title 21, Code of Federal Regulations ("CFR"), section 1301.75, subdivision (b),	
27_	states that "[c]ontrolled substances listed in Schedules II, III, IV, and V shall be stored in a	
28	securely locked, substantially constructed cabinet. However, pharmacies and institutional	

and Safety Code section 11058, subdivision (c)(1), and a dangerous drug pursuant to Code section 4022. Promethazine with codeine is used to treat cough. "Phenergan with codeine" is a brand of promethazine with codeine.

- 23. Hydrocodone/acetaminophen is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a Schedule II controlled substance pursuant to Title 21, CFR, section 1308.12, subdivision (b)(1)(vi). Hydrocodone/acetaminophen is also a dangerous drug pursuant to Code section 4022. Hydrocodone/acetaminophen is used to treat pain. "Norco" is a brand of hydrocodone/acetaminophen.
- 24. Carisoprodol is a Schedule IV Controlled Substance pursuant to Title 21, CFR, section 1308.14, subdivision (c)(6), and a dangerous drug pursuant to Code section 4022. Carisoprodol is used as a muscle relaxant. "Soma" is a brand of carisoprodol.

CURES Program

- 25. The Controlled Substance Utilization Review and Evaluation System (CURES) program was initiated in 1998 and required mandatory monthly pharmacy reporting of dispensed Schedule II controlled substances. The program was amended in January 2005 to include mandatory weekly reporting of Schedule II to IV medications. The data is collected statewide and can be used by healthcare professionals, such as pharmacists and prescribers, to evaluate and determine whether their patients are utilizing their controlled substances safely and appropriately.
- 26. The component of CURES which is accessible to pharmacists and prescribers is called the Prescription Drug Monitoring Program (PDMP). Registration for access to the PDMP has been available since February 2009. The data may be used to aid in determining if a patient sees multiple prescribers, frequents multiple pharmacies to fill controlled substance prescriptions, and/or obtains early refills of controlled substance prescriptions.

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¹Hydrocodone/acetaminophen was rescheduled to a Schedule II controlled substance effective October 6, 2014.

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FACTUAL ALLEGATIONS

- 27. Board Inspector I. T. analyzed CURES data for Respondent The Medicine Shoppe ("TMS") and found certain "red flags" or irregularities indicating that various doctors were potentially issuing prescriptions for controlled substances for other than a legitimate medical purpose and that TMS was dispensing the drugs indiscriminately; i.e., without exercising its corresponding responsibility with regard to the dispensing or furnishing of the drugs.
- 28. On or about July 1, 2016, Board Inspectors I. T. and S. K. conducted an inspection at TMS and were assisted by Respondent Kwok ("Kwok") and pharmacy technician M. H. The inspectors observed returned or used blister pack cards containing medications for patient F. W., lying in a bin within an open closet. The inspectors asked Kwok about the blister pack cards. Kwok admitted that the pharmacy takes the cards back from two assisted living facilities when a patient has a dose change or the prescriber discontinues any of the medications contained inside the cards. Kwok also admitted that the returned medications which remained the same were redispensed by the pharmacy to the same patient using a new blister pack card.
- 29. Inspector I. T. requested and obtained TMS' books containing controlled substance prescription documents, and she and Inspector S. K. pulled certain prescriptions, from the books, which were identified during I. T.'s review of the pharmacy's CURES data. Later, the inspectors noticed M. H. retrieving a Schedule II controlled substance from an unlocked file cabinet. Kwok stated that she was unaware the cabinet needed to be locked at all times and admitted that it was only locked at the end of the day. At the conclusion of the inspection, Inspector I. T. requested that Kwok provide her with the pharmacy's electronic records of dispensed prescriptions for all patients and all drugs for the time period from February 1, 2012 to July 1, 2016.
- 30. On or about July 12, 2016 and July 19, 2016, Inspector I. T. received copies of TMS' electronic dispensing records. CURES searches were conducted for various patients by the pharmacy and the reports were stapled to the prescription documents, which were collected during the inspection. The CURES reports were attached to prescriptions issued by R. G., MD and S. K., MD. Inspector I. T. found that Kwok utilized the PDMP (Prescription Drug———Monitoring Program) to check the dispensing histories of controlled substances of certain

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patients; however, she failed to appropriately scrutinize the reports for proper spelling of patient names, and failed to investigate further if patients had multiple addresses, if the records indicated the patients were doctor or pharmacy shopping; i.e., obtaining prescriptions for the same controlled substances from different physicians and having them filled at different pharmacies, or when the report produced no records even though Kwok knew, or should have known, she had filled controlled substances for those patients in the past several months and a dispensing history should have come up in her searches.

31. Inspector I. T. reviewed records specifically pertaining to prescriptions written by physician's assistant S. D. R. and doctors S. W., MD, K. T., MD, D. C., MD, R. G., MD, S. D., DO, C. A., MD, and S. K. MD. Inspector I. T. determined based on her examination of the CURES data, the electronic pharmacy records, and the prescription documents that from February 1, 2012 to July 1, 2016, TMS dispensed numerous prescriptions for the controlled substances oxycodone, alprazolam, promethazine with codeine, hydrocodone/acetaminophen, and carisoprodol, issued by the above prescribers, without regard to certain irregularities or factors, as set forth below. Inspector I. T. also found that TMS dispensed controlled substance prescriptions written by Drs. R. G., D on prescription forms that were not in compliance with the law.

FIRST CAUSE FOR DISCIPLINE

(Sell, Deliver, Hold, or Offer for Sale Adulterated Drugs)

32. Respondent The Medicine Shoppe is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (j), in that Respondent sold, delivered, held, and/or offered for sale drugs that were adulterated, in violation of Health and Safety Code sections 111295 and 111255, as follows: Respondent took back used blister pack cards containing medications from assisted living facilities when a patient had a dose change or the prescriber discontinued a medication contained in the cards. Further, Respondent re-dispensed the unchanged medications to the same patient using a new blister pack card, as set forth in paragraph 27 above.

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SECOND CAUSE FOR DISCIPLINE

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

33. Respondent The Medicine Shoppe 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: Respondent kept the file cabinet where Schedule II controlled substances were stored unlocked during pharmacy hours.

THIRD CAUSE FOR DISCIPLINE

(Excessive Furnishing of Controlled Substances)

- 34. Respondent The Medicine Shoppe is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (d), in that Respondent clearly excessively furnished the controlled substances oxycodone, alprazolam, promethazine with codeine, hydrocodone/acetaminophen, and carisoprodol, in violation of Health and Safety Code section 11153, subdivision (a), and dispensed numerous prescriptions containing significant errors, omissions, irregularities, uncertainties, ambiguities and/or alterations, in violation of Title 16, CCR, section 1761, subdivision (a), as follows:
- a. On and between February 1, 2012 and July 1, 2016, Respondent dispensed numerous prescriptions for the above controlled substances without regard to the following irregularities or factors:
- 1. Prescribing trends were incongruent with the primary area of practice listed on the Medical Board of California's website by each prescriber. Physician's assistant S. D. R. and Dr. S. K. practiced internal medicine, Drs. S. W., D. C., and C. A. practiced general medicine, and Dr. R. D. practiced family-medicine; Drs. K. T. and S. D. did not identify a primary area of

practice. Greater than 90% of each of these prescriber's prescriptions were written for highly		
abused controlled substances, such as alprazolam 2 mg, oxycodone 30 mg, promethazine/codeine		
hydrocodone/acetaminophen 10/325 mg and/or carisoprodol 350 mg. Drs. R. G. and C. A.		
exclusively wrote prescriptions for alprazolam 2 mg, oxycodone 30 mg, and		
promethazine/codeine. Dr. S. D. only wrote prescriptions for oxycodone 30 mg and		
promethazine/codeine.		

- 2. 100% of the prescriptions written by the above prescribers were paid for with cash. Further, patients paid cash for high retail cost medications without the financial benefit of insurance.
- 3. Multiple patients' prescriptions for identical controlled substances, written by the above prescribers, were filled by the pharmacy around the same time. Prescriptions were written on the same day, had identical batch numbers, and were either sequential or close in script number. The prescriptions were either consecutively numbered or very close in number.
- 4. All of the patients of the above prescribers receiving prescriptions for oxycodone and alprazolam received the highest tablet strength of both drugs, 30 mg and 2 mg respectively (some patients received two tablets per dose), with no evidence of upward titration from a lower dose.
- 5. The above prescribers' medical offices were located long distances (over 100 miles in many instances) from The Medicine Shoppe.
- 6. Patients traveled far distances (over 100 miles in many instances) to receive controlled substance prescriptions from the above prescribers and to have those prescriptions filled at The Medicine Shoppe.
- 7. Multiple patients of the above prescribers resided at the same address and received either identical or very similar prescriptions for controlled substances.
- 8. Multiple prescriptions were written by Drs. R. G., S. D., S. P., E. S., R. P., and R. A. on prescription forms which contained significant errors and omissions and were not in compliance with Health and Safety Code section 11162.1, as more particularly set forth in paragraph 34 below.

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b. Respondent failed to assume its corresponding responsibility when it failed to appropriately scrutinize patients' drug therapy with readily available tools such as the PDMP and its own pharmacy records, resulting in the dispensing of controlled substances in certain instances to patients who engaged in "doctor shopping" and poly-pharmacy activity and to potentially opioid naïve patients.

FOURTH CAUSE FOR DISCIPLINE

(Dispensing of Controlled Substances Based on Prescription Forms Not in Compliance with the Law)

35. Respondent The Medicine Shoppe is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (j), in that Respondent violated Health and Safety Code section 11164, subdivision (a), when it dispensed prescriptions for controlled substances based on prescription forms that were not in compliance with Health and Safety Code Section 11162.1, as set forth below. A total of 375 prescriptions for controlled substances (approximately 28,590 tablets of oxycodone 30 mg, 6,150 tablets of alprazolam 2 mg and 67,200 ml of promethazine with codeine) were written on prescription forms that were not in compliance with the law and dispensed by Respondent. The pharmacy dispensed 33 controlled substance prescriptions (approximately 2160 tablets of oxycodone 30 mg, 810 tablets of alprazolam 2 mg, and 5760 mL of promethazine with codeine), written by S. K., MD, which were not dated. A total of approximately 30,750 tablets of oxycodone 30 mg, 6,960 tablets of alprazolam 2 mg, and 72,960 mL of promethazine with codeine were dispensed to patients, who presented invalid controlled substance prescriptions to Respondent.

R. G., MD

a. Prescriptions written by Dr. R. G. and dispensed by the pharmacy on February 25, 2015 and February 27, 2015, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but the second check off box incorrectly stated "25-50" instead of "25-49"; and the lot numbers were not printed on the prescription forms.

- b. Prescriptions written by Dr. R. G. and dispensed by the pharmacy on June 23, 2015, June 24, 2015, June 26, 2015, June 29, 2015, July 25, 2015, July 27, 2015, July 28, 2015, July 31, 2015, and August 1, 2015, did not have a latent, repetitive "void" pattern printed across the entire front of the prescription forms; did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "and over 151" instead of "151 and over"; the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice; and lot numbers were not printed on the prescription forms.
- c. Prescriptions written by Dr. R. G. and dispensed by the pharmacy on April 5, 2016, April 11, 2016, April 13, 2016, and April 19, 2016, did not have a latent, repetitive "void" pattern printed across the entire front of the prescription forms; did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; and the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice.
- d. A total of 134 prescriptions, written by Dr. R. G. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

S. D., MD

e. Prescriptions written by Dr. S. D. and dispensed by the pharmacy on November 7, 2012 and November 19, 2012, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "and over 151" instead of "151 and over"; the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice; and lot and batch numbers were not printed on the prescription forms. A total of 66 prescriptions, written by Dr. S. D. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

III

f. Prescriptions written by Dr. S. P. and dispensed by the pharmacy on November 30, 2012 and December 4, 2012, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "151-210" instead of "151 and over"; the prescription forms did not contain a statement printed on the bottom that the "Prescription is void if the number of drugs prescribed is not noted"; and lot and batch numbers were not printed on the prescription forms. A total of 38 prescriptions, written by Dr. S. P. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

E. S., MD

g. Prescriptions written by Dr. E. S. and dispensed by the pharmacy on May 20, 2013 and May 28, 2013, did not have the complete statement printed on the bottom of the forms that the "Prescription is void if the number of drugs *prescribed* is not noted" (the statement was included, but the word "prescribed" was missing). Further, there were no check boxes printed on the prescription forms so that the prescriber may indicate the number of refills ordered (the forms showed "Refill NR 1 2 3 4 5" without any check boxes). A total of 91 prescriptions, written by Dr. E. S. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

R. P., MD

h. Prescriptions written by Dr. R. P. and dispensed by the pharmacy on December 13, 2012 and January 18, 2013, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "151-over" instead of "151 and over"; the forms did not have the complete statement printed on the bottom that the "Prescription is void if the number of drugs *prescribed* is not noted" (the statement was included, but the word "prescribed" was missing); there were no check boxes printed on the prescription forms so that the prescriber may indicate the number of refills ordered (the forms

showed "Refill NR 1 2 3 4 5" without any check boxes); and the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice. A total of 22 prescriptions, written by Dr. R. P. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

R. A., MD

i. Prescriptions written by Dr. R. A. and dispensed by the pharmacy on March 3, 2015, March 4, 2015, and March 9, 2015, did not have a latent, repetitive "void" pattern printed across the entire front of the prescription forms; did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "and 151+" instead of "151 and over"; the forms did not have the correct statement printed on the bottom that the "Prescription is void if the number of drugs prescribed is not *noted*" (the statement was included, but the word "indicated" was used instead of "noted"); there were no check boxes printed on the prescription forms so that the prescriber may indicate the number of refills ordered (the forms showed "Refills 0 1 2 3 4 PRN" without any check boxes); the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice; and lot numbers were not printed on the prescription forms. A total of 8 prescriptions, written by Dr. R. A. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

A. A., MD

j. Prescriptions written by Dr. A. A. and dispensed by the pharmacy on April 21, 2016, April 22, 2016, May 9, 2016, May 11, 2016, May 13, 2016, May 17, 2016, June 8, 2016, June 10, 2016, and June 13, 2016, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; there were two sets of different descriptions of the security features on the backs of the forms (one of them was printed on top of the other); six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "Over 151" instead of "151 and over"; there were no check boxes—printed on the prescription forms so that the prescriber may indicate the number of refills ordered

(the forms showed "Refills 0-1-2-3-4-5" without any check boxes); and lot numbers were not printed on the prescription forms. A total of 16 prescriptions, written by Dr. A. A. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

S. K., MD

k. Respondent Kwok dispensed 33 controlled substance prescriptions (a total of approximately 2,160 tablets of oxycodone 30 mg, 810 tablets of alprazolam 2 mg and 5,760 ml of promethazine with codeine) written by Dr. S. K. that were not dated.

FIFTH CAUSE FOR DISCIPLINE

(Sell, Deliver, Hold, or Offer for Sale Adulterated Drugs)

36. Respondent Kwok is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (j), in that Respondent, as pharmacist-in-charge of The Medicine Shoppe, sold, delivered, held, and/or offered for sale drugs that were adulterated, in violation of Health and Safety Code sections 111295 and 111255, as follows: Respondent took back used blister pack cards containing medications from assisted living facilities when a patient had a dose change or the prescriber discontinued a medication contained in the cards. Further, Respondent re-dispensed the unchanged medications to the same patient using a new blister pack card, as set forth in paragraph 27 above.

SIXTH CAUSE FOR DISCIPLINE

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

37. Respondent Kwok 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 The Medicine Shoppe, 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 (d), 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: Respondent kept the file cabinet where Schedule II controlled substances were stored unlocked during pharmacy hours.

SEVENTH CAUSE FOR DISCIPLINE

(Excessive Furnishing of Controlled Substances)

- 38. Respondent Kwok is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (d), in that Respondent, as pharmacist-in-charge of The Medicine Shoppe, clearly excessively furnished the controlled substances oxycodone, alprazolam, promethazine with codeine, hydrocodone/acetaminophen, and carisoprodol, in violation of Health and Safety Code section 11153, subdivision (a), and dispensed numerous prescriptions containing significant errors, omissions, irregularities, uncertainties, ambiguities and/or alterations, in violation of Title 16, CCR, section 1761, subdivision (a), as follows:
- a. On and between February 1, 2012 and July 1, 2016, Respondent dispensed numerous prescriptions for the above controlled substances without regard to the following irregularities or factors:
- 1. Prescribing trends were incongruent with the primary area of practice listed on the Medical Board of California's website by each prescriber. Physician's assistant S. D. R. and Dr. S. K. practiced internal medicine, Drs. S. W., D. C., and C. A. practiced general medicine, and Dr. R. D. practiced family medicine; Drs. K. T. and S. D. did not identify a primary area of practice. Greater than 90% of each of these prescriber's prescriptions were written for highly abused controlled substances, such as alprazolam 2 mg, oxycodone 30 mg, promethazine/codeine, hydrocodone/acetaminophen 10/325 mg and/or carisoprodol 350 mg. Drs. R. G. and C. A. exclusively wrote prescriptions for alprazolam 2 mg, oxycodone 30 mg, and promethazine/codeine. Dr. S. D. only wrote prescriptions for oxycodone 30 mg and promethazine/codeine.
- 2. 100% of the prescriptions written by the above prescribers were paid for with cash. Further, patients paid cash for high retail cost medications without the financial benefit of insurance.
 - 3. Multiple patients' prescriptions for identical controlled substances, written by

(THE MEDICINE SHOPPE) ACCUSATION

EIGHTH CAUSE FOR DISCIPLINE

(Inappropriate Exercise of Respondent's Education, Training, or Experience as a Pharmacist)

39. Respondent Kwok is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, as defined by Code section 4306.5, subdivision (a), for inappropriately exercising her education, training or experience as a pharmacist, as set forth in paragraph 37 above.

NINTH CAUSE FOR DISCIPLINE

(Failure to Exercise or Implement Best Professional Judgment or Corresponding Responsibility).

40. Respondent Kwok is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, as defined by Code section 4306.5, subdivision (b), for failing to exercise or implement her best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances, as set forth in paragraph 37 above.

TENTH CAUSE FOR DISCIPLINE

(Failure to Consult Appropriate Records)

41. Respondent Kwok is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, as defined by Code section 4306.5, subdivision (c), for failing to consult appropriate records, including, but not limited to, the PDMP and The Medicine Shoppe's pharmacy records, pertaining to the dispensing or furnishing of controlled substances, as set forth in paragraph 37 above.

ELEVENTH CAUSE FOR DISCIPLINE

(Dispensing of Controlled Substances Based on Prescription Forms Not in Compliance with the Law)

42. Respondent Kwok is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (j), in that Respondent, as pharmacist-in-charge of The Medicine Shoppe, violated Health and Safety Code section 11164, subdivision (a), when she dispensed prescriptions for controlled substances based on prescription forms that were not in

compliance with Health and Safety Code Section 11162.1, as set forth below. A total of 375 prescriptions for controlled substances (approximately 28,590 tablets of oxycodone 30 mg, 6,150 tablets of alprazolam 2 mg and 67,200 ml of promethazine with codeine) were written on prescription forms that were not in compliance with the law and dispensed by Respondent. Respondent Kwok dispensed 33 controlled substance prescriptions (approximately 2,160 tablets of oxycodone 30 mg, 810 tablets of alprazolam 2 mg, and 5,760 mL of promethazine with codeine), written by S. K., MD, which were not dated. A total of approximately 30,750 tablets of oxycodone 30 mg, 6,960 tablets of alprazolam 2 mg and 72,960 ml of promethazine with codeine were dispensed to patients, who presented invalid controlled substance prescriptions to Respondent.

R. G., MD

- a. Prescriptions written by Dr. R. G. and dispensed by Respondent Kwok on February 25, 2015 and February 27, 2015, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but the second check off box incorrectly stated "25-50" instead of "25-49"; and the lot numbers were not printed on the prescription forms.
- b. Prescriptions written by Dr. R. G. and dispensed by Respondent Kwok on June 23, 2015, June 24, 2015, June 26, 2015, June 29, 2015, July 25, 2015, July 27, 2015, July 28, 2015, July 31, 2015, and August 1, 2015, did not have a latent, repetitive "void" pattern printed across the entire front of the prescription forms; did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "and over 151" instead of "151 and over"; the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice; and lot numbers were not printed on the prescription forms.
- c. Prescriptions written by Dr. R. G. and dispensed by Respondent Kwok on April 5, 2016, April 11, 2016, April 13, 2016, and April 19, 2016, did not have a latent, repetitive "void" pattern printed across the entire front of the prescription forms; did not have a watermark printed

on the backside of the prescription forms consisting of the words "California Security Prescription"; and the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice.

d. A total of 134 prescriptions, written by Dr. R. G. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

S. D., MD

e. Prescriptions written by Dr. S. D. and dispensed by Respondent Kwok on November 7, 2012 and November 19, 2012, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "and over 151" instead of "151 and over"; the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice; and lot and batch numbers were not printed on the prescription forms. A total of 66 prescriptions, written by Dr. S. D. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

S. P., MD

f. Prescriptions written by Dr. S. P. and dispensed by Respondent Kwok on November 30, 2012 and December 4, 2012, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "151-210" instead of "151 and over"; the prescription forms did not contain a statement printed on the bottom of the forms that the "Prescription is void if the number of drugs prescribed is not noted"; and lot and batch numbers were not printed on the prescription forms. A total of 38 prescriptions, written by Dr. S. P. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

E. S., MD

g. Prescriptions written by Dr. E. S. and dispensed by Respondent Kwok on May 20, 2013 and May 28, 2013, did not have the complete statement printed on the bottom of the forms

 that the "Prescription is void if the number of drugs *prescribed* is not noted" (the statement was included, but the word "prescribed" was missing). Further, there were no check boxes printed on the prescription forms so that the prescriber may indicate the number of refills ordered (the forms showed "Refill NR 1 2 3 4 5" without any check boxes). A total of 91 prescriptions, written by Dr. E. S. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

R. P., MD

h. Prescriptions written by Dr. R. P. and dispensed by Respondent Kwok on December 13, 2012 and January 18, 2013, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "151-over" instead of "151 and over"; the forms did not have the complete statement printed on the bottom that the "Prescription is void if the number of drugs *prescribed* is not noted" (the statement was included, but the word "prescribed" was missing); there were no check boxes printed on the prescription forms so that the prescriber may indicate the number of refills ordered (the forms showed "Refill NR 1 2 3 4 5" without any check boxes); and the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice. A total of 22 prescriptions, written by Dr. R. P. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

R. A., MD

i. Prescriptions written by Dr. R. A. and dispensed by Respondent Kwok on March 3, 2015, March 4, 2015, and March 9, 2015, did not have a latent, repetitive "void" pattern printed across the entire front of the prescription forms; did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "and 151+" instead of "151 and over"; the forms did not have the correct statement printed on the bottom that the "Prescription is void if the number of drugs prescribed is not *noted*" (the statement was included, but the word "indicated" was used instead of "noted"); there were no

check boxes printed on the prescription forms so that the prescriber may indicate the number of refills ordered (the forms showed "Refills 0 1 2 3 4 PRN" without any check boxes); the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice; and lot numbers were not printed on the prescription forms. A total of 8 prescriptions, written by Dr. R. A. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

A. A., MD

j. Prescriptions written by Dr. A. A. and dispensed by Respondent Kwok on April 21, 2016, April 22, 2016, May 9, 2016, May 11, 2016, May 13, 2016, May 17, 2016, June 8, 2016, June 10, 2016, and June 13, 2016, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; there were two sets of different descriptions of the security features on the backs of the forms (one of them was printed on top of the other); six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "Over 151" instead of "151 and over"; there were no check boxes printed on the prescription forms so that the prescriber may indicate the number of refills ordered (the forms showed "Refills 0-1-2-3-4-5" without any check boxes); and lot numbers were not printed on the prescription forms. A total of 16 prescriptions, written by Dr. A. A. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

S. K., MD

k. Respondent Kwok dispensed 33 controlled substance prescriptions (a total of approximately 2,160 tablets of oxycodone 30 mg, 810 tablets of alprazolam 2 mg and 5,760 ml of promethazine with codeine) written by Dr. S. K. that were not dated.

MATTERS IN AGGRAVATION

- 43. To determine the degree of discipline to be assessed against Respondents The Medicine Shoppe and Kwok, if any, Complainant alleges as follows:
- a. On or about October 26, 2016, the Board issued Citation and Fine No. CI 2015-67954 against Respondent The Medicine Shoppe for violations of Code section 4342, subdivision (a)

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(actions by the Board to prevent sales of drugs lacking quality or strength) and Title 16, CCR, section 1716 (variations from a prescription). On or about January 19, 2016, during a Board inspection, it was discovered that Respondent had expired drugs on the pharmacy shelves to be dispensed to customers. Further, the pharmacy dispensed lithium to a patient when the prescription was written for lactulose. The patient took several doses and required hospitalization. The Board ordered Respondent to pay a fine of \$1,000 by November 25, 2016. Respondent has failed to pay the citation.

On or about October 26, 2016, the Board issued Citation and Fine No. CI 2016 72480 b. against Respondent Kwok for violations of Code section 4342, subdivision (a) (actions by the Board to prevent sales of drugs lacking quality or strength) and Title 16, CCR, section 1716 (variations from a prescription). On or about January 19, 2016, during a Board inspection, it was discovered that Respondent, as pharmacist-in-charge of The Medicine Shoppe, had expired drugs on the pharmacy shelves to be dispensed to customers. Further, Respondent, as pharmacist-incharge of The Medicine Shoppe, dispensed lithium to a patient when the prescription was written for lactulose. The patient took several doses and required hospitalization. The Board ordered Respondent to pay fines totaling \$2,000 by November 25, 2016. Respondent has failed to pay the citation.

OTHER MATTERS

- 44. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 40626 issued to The Medicine Shoppe, The Medicine Shoppe shall be prohibited from serving a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 40626 is placed on probation or until Pharmacy Permit Number PHY is reinstated if it is revoked.
- 45. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 40626 issued to The Medicine Shoppe while Peter K. Kwok and/or Cheryl L. Chin (Kwok) have been a partner and owner and had knowledge of or knowingly participated in any conduct for which the licensee was disciplined, Peter K. Kwok and Chery L. Chin (Kwok) shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate,

1	6. Ordering The Medicine Shoppe and Cheryl Kwok, also known as Cheryl Chin Kwok,			
2	to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this			
3	case, pursuant to	case, pursuant to Business and Professions Code section 125.3; and		
4	7. Taki	7. Taking such other and further action as deemed necessary and proper.		
5				
6	DATED: 7	11/17	Ougina Hudd	
7	-		VIRGINIA HEROLD Executive Officer	
8			Board of Pharmacy Department of Consumer Affairs	
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