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8 **BEFORE THE**
BOARD OF PHARMACY
9 **DEPARTMENT OF CONSUMER AFFAIRS**
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. 5355

12 **WESTSIDE PLAZA PHARMACY**
13 **SUWONNEE PONGNORSING,**
OWNER/PHARMACIST-IN-CHARGE
14 **314 I Street**
Modesto, CA 95351

A C C U S A T I O N

15 **Original Permit Number No. PHY 45161**

16 **and**

17 **SUWONNEE PONGNORSING**
18 **307 Pauline Avenue**
Modesto, CA 95358

19 **Original Pharmacist License No. RPH 35104**

20 Respondents.

21
22 Complainant alleges:

23 **PARTIES**

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

26 2. On or about October 2, 2001, the Board issued Original Permit Number PHY 45161
27 to Suwonnee Pongnorsing ("Respondent"), doing business as Westside Plaza Pharmacy
28 ("Westside"). On or about August 31, 2007, Respondent became the pharmacist-in-charge

1 ("PIC") for Westside. The original permit was in full force and effect at all times relevant to the
2 charges brought herein and will expire on October 1, 2015, unless renewed.

3 3. On or about December 12, 1979, the Board issued Original Pharmacist License
4 Number RPH 35104 ("license") to Respondent. On or about March 12, 1992, the license was
5 revoked; however, the revocation was stayed and Respondent was placed on probation for three
6 (3) years on terms and conditions, as set forth in paragraph 46 below. The license was also
7 suspended for thirty (30) days effective March 12, 1992. The license was in full force and effect
8 at all times relevant to the charges brought herein and will expire on November 30, 2015, unless
9 renewed.

10 JURISDICTION

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

13 STATUTORY AND REGULATORY PROVISIONS

14 5. Code section 4300 states, in pertinent part:

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

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

18 (1) Suspending judgment.

19 (2) Placing him or her upon probation.

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

22 (4) Revoking his or her license.

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

24 6. Code section 4300.1 states:

25 The expiration, cancellation, forfeiture, or suspension of a board-issued
26 license by operation of law or by order or decision of the board or a court of law, the
27 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
28 investigation of, or action or disciplinary proceeding against, the licensee or to render
a decision suspending or revoking the license.

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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 or whose license has been procured by fraud or misrepresentation or issued by mistake. Unprofessional conduct shall include, but is not limited to, any of the following:

...

(f) The commission of any act involving moral turpitude, dishonesty, fraud, deceit, or corruption, whether the act is committed in the course of relations as a licensee or otherwise, and whether the act is a felony or misdemeanor or not.

...

(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 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.”

9. Health and Safety Code section 11153, subdivision (a), states, in pertinent part:

A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription

10. Title 21, Code of Federal Regulations, section 1304.03, subdivision (a), states:

Every registrant, including collectors, shall maintain the records and inventories and shall file the reports required by this part, except as exempted by this section. Any registrant that is authorized to conduct other activities without being registered to conduct those activities, pursuant to §§ 1301.22(b), 1307.11, 1307.13, or part 1317 of this chapter, shall maintain the records and inventories and shall file the reports required by this part for persons registered or authorized to conduct such activities. This latter requirement should not be construed as requiring stocks of controlled substances being used in various activities under one registration to be stored separately, nor that separate records are required for each activity. The intent of the Administration is to permit the registrant to keep one set of records which are adapted by the registrant to account for controlled substances used in any activity. Also, the Administration does not wish to require separate stocks of the same substance to be purchased and stored for separate activities. Otherwise, there is no advantage gained by permitting several activities under one registration. Thus, when a researcher manufactures a controlled item, he must keep a record of the quantity manufactured; when he distributes a quantity of the item, he must use and keep invoices or order forms to document the transfer; when he imports a substance, he

1 keeps as part of his records the documentation required of an importer; and when
2 substances are used in chemical analysis, he need not keep a record of this because
3 such a record would not be required of him under a registration to do chemical
4 analysis. All of these records may be maintained in one consolidated record system.
5 Similarly, the researcher may store all of his controlled items in one place, and every
6 two years take inventory of all items on hand, regardless of whether the substances
7 were manufactured by him, imported by him, or purchased domestically by him, of
8 whether the substances will be administered to subjects, distributed to other
9 researchers, or destroyed during chemical analysis.

10 11. Title 21, Code of Federal Regulations, section 1304.11 states, in pertinent part:

12 (a) General requirements. Each inventory shall contain a complete and
13 accurate record of all controlled substances on hand on the date the inventory is
14 taken, and shall be maintained in written, typewritten, or printed form at the
15 registered location. An inventory taken by use of an oral recording device must be
16 promptly transcribed. Controlled substances shall be deemed to be "on hand" if they
17 are in the possession of or under the control of the registrant, including substances
18 returned by a customer, ordered by a customer but not yet invoiced, stored in a
19 warehouse on behalf of the registrant, and substances in the possession of employees
20 of the registrant and intended for distribution as complimentary samples. A separate
21 inventory shall be made for each registered location and each independent activity
22 registered, except as provided in paragraph (e)(4) of this section. In the event
23 controlled substances in the possession or under the control of the registrant are
24 stored at a location for which he/she is not registered, the substances shall be included
25 in the inventory of the registered location to which they are subject to control or to
26 which the person possessing the substance is responsible. The inventory may be taken
27 either as of opening of business or as of the close of business on the inventory date
28 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 . . .

12. Title 21, Code of Federal Regulations, section 1304.21 states, in pertinent part:

(a) Every registrant required to keep records pursuant to § 1304.03 shall
maintain, on a current basis, a complete and accurate record of each substance
manufactured, imported, received, sold, delivered, exported, or otherwise disposed of
by him/her, and each inner liner, sealed inner liner, and unused and returned mail-
back package, except that no registrant shall be required to maintain a perpetual
inventory.

...

(d) In recording dates of receipt, importation, distribution, exportation,
other transfers, or destruction, the date on which the controlled substances are
actually received, imported, distributed, exported, otherwise transferred, or destroyed
shall be used as the date of receipt, importation, distribution, exportation, transfer, or
destruction (e.g., invoices, packing slips, or DEA Form 41)

1 13. Title 21, Code of Federal Regulations, section 1305.13, subdivision (e), states that,
2 “[t]he purchaser must record on Copy 3 of the DEA Form 222 the number of commercial or bulk
3 containers furnished on each item and the dates on which the containers are received by the
4 purchaser.”

5 14. California Code of Regulations, title 16, section 1761, subdivision (b), states that,
6 “[e]ven after conferring with the prescriber, a pharmacist shall not compound or dispense a
7 controlled substance prescription where the pharmacist knows or has objective reason to know
8 that said prescription was not issued for a legitimate medical purpose.”

9 **COST RECOVERY**

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

14 **CONTROLLED SUBSTANCES**

15 16. “Opana,” a brand of oxymorphone, is a Schedule II controlled substance as
16 designated by Health and Safety Code section 11055, subdivision (b)(1)(N).

17 17. “Oxycodone” is a Schedule II controlled substance as designated by Health and
18 Safety Code section 11055, subdivision (b)(1)(M).

19 18. “Norco” is a compound consisting of 10 mg hydrocodone bitartrate, also known as
20 dihydrocodeinone, and 325 mg acetaminophen per tablet, and is a Schedule III controlled
21 substance as designated by Health and Safety Code section 11056, subdivision (e)(4).

22 19. “Vicodin” is a compound consisting of 5 mg hydrocodone bitartrate, also known as
23 dihydrocodeinone, and 500 mg acetaminophen per tablet, and is a Schedule III controlled
24 substance as designated by Health and Safety Code section 11056, subdivision (e)(4).

25 20. “Lyrica,” a brand of pregabalin, is a Schedule V controlled substance as designated
26 by Title 21, Code of Federal Regulations, section 1308.15, subdivision (e)(13).

27 21. “Ambien,” a brand of zolpidem tartrate, is a Schedule IV controlled substance as
28 designated by Health and Safety Code section 11057, subdivision (d)(32).

1 **BACKGROUND**

2 22. In or about October 2012, the United States Drug Enforcement Administration
3 (“DEA”) requested the Board’s assistance in inspecting and investigating various pharmacies,
4 including Westside, with regard to the purchase and furnishing of controlled substances.
5 Westside had allegedly purchased medications containing hydrocodone and oxycodone from
6 several different wholesalers and filled numerous prescriptions for the drugs based upon
7 prescriptions issued by Drs. Terrill Brown and Clair Pettinger.

8 23. Board Inspector J. W. obtained CURES reports on Westside and Drs. Brown and
9 Pettinger for the time period from November 1, 2009 to November 2, 2012. The reports showed
10 that Dr. Brown’s patients had filled their prescriptions primarily at Westside, approximately 8,461
11 prescriptions, with the next highest pharmacy at approximately 862 prescriptions. Dr. Pettinger’s
12 patients had also filled their prescriptions primarily at Westside, approximately 1,954, with the
13 next highest pharmacy at approximately 957 prescriptions.

14 24. Board Inspector J. W. also conducted an internet search of the California Medical
15 Board’s website for Dr. Brown, which revealed that Dr. Brown’s license was publicly
16 reprimanded in August 2007 based upon Dr. Brown’s failure to adequately and accurately
17 document medical services provided to four patients.

18 **AUDIT/INSPECTION OF DECEMBER 11, 2012**

19 25. On or about December 11, 2012, Board Inspectors J. W. and M. P. met with DEA
20 Diversion Investigators (“DI”) B. G. and M. J., Group Supervisor P. K., DEA Special Agent
21 B. C., and IRS Special Agent M. C. at Westside to conduct an accountability audit of the
22 pharmacy. Respondent was not present at Westside at the time, but arrived later after she was
23 contacted by the pharmacist on duty, N. V. B. G. met with Respondent and obtained her consent
24 to perform the audit, including a count of the pharmacy’s controlled substances (Respondent
25 agreed to assist with the count). B. G. asked Respondent where she stored her controlled
26 substance records and inventory. Respondent took the DI’s to her office located in the back of
27 the pharmacy. The controlled substances were stored in numerous drawers throughout the room.

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1 26. Investigator B. G. asked Respondent for the last biennial inventory she had taken of
2 the controlled substances to determine the audit period. Respondent showed B. G. two memo
3 books containing a count of Schedule III to V controlled substances. The most recent inventory
4 had been taken on May 27, 2011. B. G. and Board Inspector M. P. found that the inventory was
5 not in compliance with the Code of Federal Regulations ("CFR") in that there was no indication
6 as to whether the inventory was taken at the opening or close of business, and it failed to include
7 a full description of the controlled substances. Respondent stated that she had approximated the
8 counts for the Schedule III to V controlled substances, but had performed an exact count of the
9 Schedule II controlled substances. Respondent showed B. G. and M. P. a perpetual log listing the
10 Schedule II controlled substances. B. G. reviewed the log and found that Respondent had
11 performed counts of the drugs on random days; i.e., the counts were not conducted on the same
12 day. Respondent stated that she counted the Schedule II controlled substances at the time she
13 actually used them.

14 27. Investigator B. G. stopped the inventory count to review other records for the audit.
15 Respondent showed the DI's several bundles of invoices the pharmacy had received from
16 suppliers relating to the purchase of controlled substances. B. G. reviewed the invoices and found
17 that none of them were stamped with the date they were received in the pharmacy as required by
18 the CFR. Investigator M. J. reviewed the pharmacy's DEA-222 forms and found that they had
19 not been completed as required by law. The DEA concluded that an accountability audit of
20 Westside could not be performed given the pharmacy's lack of record keeping. Nonetheless, this
21 review revealed approximately 252 instances where controlled substance invoices lacked the date
22 of receipt when the controlled substances were actually received. This review also revealed
23 approximately twenty-one instances where controlled substance invoices lacked the number of
24 packages received and/or date of receipt when the controlled substances were actually received.

25 28. As Board Inspector M. P. was inspecting Respondent's office, she discovered
26 prescription vials and bags in a desk drawer dating as far back as February 2012, including
27 partially filled prescriptions of Schedule II controlled substances. M. P. asked Respondent why
28 the drugs were still in the drawers and the balance of the medications had not been dispensed to

1 the patients. Respondent told M. P. that the drugs were for the patients, but did not provide her
2 with any other explanation. M. P. continued looking through the drawer and found more filled
3 prescriptions dating back several months. M. P. took all of the prescriptions and obtained patient
4 profiles for each transaction from the pharmacy clerk. M. P. reviewed the prescriptions and
5 patient profiles and found that the insurance claims related to each were still active. M. P. told
6 Respondent that since the drugs had not been dispensed to the patients and the pharmacy had
7 received payment for them, she needed to reverse the claims and credit the patients' insurance
8 companies for each transaction. J. W. instructed Respondent to provide him with confirmation of
9 the reversals.

10 29. Later, Board Inspectors M. P. and J. W. found bottles of controlled substances from
11 another pharmacy, Paradise Drugs. The bottles had patient labels on them, and a note was affixed
12 to one of the vials, indicating that the medication had been borrowed from Paradise Drugs.
13 Respondent told M. P. that if Westside ran out of a particular drug, they would "borrow" the
14 medication from the other pharmacy. The DI's found additional bottles of controlled substances
15 that were ready to be dispensed to patients with corresponding billings to the patients' insurance.
16 Respondent claimed that she was in the process of returning or crediting the medications to the
17 insurance companies, but had not "gotten to them" yet. J. W. requested the patient prescription
18 histories (patient profiles) for the controlled substances "borrowed" from Paradise Drugs, then
19 instructed Respondent to immediately credit the prescriptions to the insurance companies.

20 30. Investigator B. G. and Group Supervisor P. K. interviewed Respondent regarding the
21 controlled substance orders for hydrocodone and oxycodone that had been issued by Drs. Brown
22 and Pettinger. Respondent claimed that she had "cut off" filling prescriptions issued by Dr.
23 Brown around the second quarter of 2012, but had resumed filling them after Dr. Brown visited
24 Westside.

25 31. Later, Investigator B. G., the other DEA representatives, and IRS Special Agent M.
26 C. interviewed Westside's pharmacy clerk C. S. and pharmacy technician L. P. C. S. stated that
27 the prescriptions issued by Drs. Brown and Pettinger were suspicious. C. S. also stated that some
28 customers would pick up prescriptions for other customers who were not present at Westside at

1 the time, and that those prescriptions were paid mostly in cash. C. S. was shown a photo of Sarith
2 Chim ("Chim"); Chim was subsequently charged in an indictment with conspiring to distribute
3 controlled substances. C. S. stated that Chim had come in to the pharmacy to pick up
4 prescriptions and would speak directly with Respondent. L. P. stated during her interview that
5 they "saw lots" of Drs. Brown and Dr. Pettinger's patients on certain days. L. P. was also shown
6 a photo of Chim. L. P. stated that she had seen him come in to Westside many times.

7 32. After the interviews were completed, Respondent surrendered Westside's DEA
8 registration. The Board Inspectors assisted the DI's in seizing all Schedule II to V controlled
9 substances from Westside's stock inventory and will-call prescriptions. After the DEA left,
10 Board Inspectors J. W. and M. P. retrieved the Drug Usage Report ("DUR") for Dr. Brown for
11 the time period from January 1, 2010 to December 10, 2012. J. W. also contacted Westside's
12 computer processing vendor and obtained a DUR on all prescriptions furnished during the same
13 time period.

14 **ADDITIONAL INVESTIGATION CONDUCTED BY THE BOARD**

15 33. On or about February 26, 2014, Board Inspector J. W. learned during a discussion
16 with IRS Special Agent M. C. that the DEA had removed various prescription documents
17 (scripts) from Westside. M. C. stated that about fifty to seventy of the prescriptions may have
18 been written by Dr. Brown for other than a legitimate medical purpose and had been filled at
19 Westside.

20 34. On or about April 1, 2014, Board Inspector J. W. obtained the prescription documents
21 from the IRS. J. W. found that all but one of the prescriptions had been issued by Dr. Brown. J.
22 W. reviewed the CURES report for Westside. The patient profiles showed that Dr. Brown's
23 "patients" had received prescriptions for oxycodone 30 mg and/or Opana ER 40 mg, and that
24 each patient had received approximately two to three furnishings of the drugs at Westside.

25 35. On July 7, 2014, Board Inspector J. W. received information indicating that thirteen
26 defendants, including Chim, had been indicted by a grand jury for conspiring to manufacture,
27 distribute, and possess with intent to distribute controlled substances, including oxycodone and
28 hydrocodone. On April 11, 2013, in *United States of America v. Sarith Chim, et al.*, United States

1 District Court, Eastern District of California, Case No. 1:13-CR- 00136-AWI-BAM, the grand
2 jury returned a twenty-nine-count indictment, charging thirteen defendants with the above crime
3 as well as other violations of the United States Code. The indictment was based, in part, on a
4 scheme where the defendants would obtain prescriptions for controlled substances (including
5 oxycodone and hydrocodone) and medicinal marijuana from a medical doctor, have the
6 prescriptions filled at a pharmacy, and then illegally sell the controlled substances to others. J.
7 W. conducted an audit of the prescription documents received from the IRS, then extracted
8 prescription furnishing data from the DUR's pertaining to the defendants.

9 36. On or about August 21, 2014, Respondent provided Board Inspector J. W. with
10 prescription histories relating to the prescriptions Westside had failed to furnish to patients or
11 credit back to the insurance companies as determined during the audit/investigation. J. W. found
12 that Westside had reversed the claims on the prescriptions, with the exception of seven
13 prescriptions for five patients.

14 37. On or about August 25, 2014, Board Inspector J. W. sent letters to Valley Wholesale
15 Drug Company, Inc., Top RX, HD Smith Wholesale Drug Company, The Harvard Drug Group
16 LLC, and Masters Pharmaceutical, Inc. requesting records showing Westside's purchase of
17 controlled substances and dangerous drugs for the time period from January 1, 2010 to December
18 10, 2012. J. W. also asked each wholesaler if the pharmacy was ever over the limit, warned, or
19 cut off on their controlled substance purchasing. Later, J. W. spoke with H. C., the owner of
20 Paradise Drugs. H. C. confirmed that his pharmacy had sold medications to Westside. J. W.
21 asked H. C. if he had filled prescriptions for other pharmacies. H. C. initially said no, but then
22 admitted he had filled at least one prescription for Westside. J. W. informed H. C. that several
23 prescription containers (vials) from Paradise Drugs had been found during the DEA audit at
24 Westside. J. W. requested that H. C. provide him with prescription histories on several patients.

25 38. On or about August 26, 2014, Board Inspector J. W. received various documents
26 from H. C., including the patient prescription histories and pick-up logs. The documents showed
27 that several prescriptions were picked up at Paradise Drugs and were signed for by employees of
28 Westside.

1 39. On or about August 28, 2014, Board Inspector J. W. received various documents
2 from Valley Wholesale, including a spreadsheet report of controlled substances purchased by
3 Westside and a written response to J. W.'s inquiry from a company representative. The
4 representative stated that Westside was warned about dispensing to patients of Dr. Brown as the
5 doctor was not from the local area. Later, Valley Wholesale discovered that Westside was
6 dispensing for Dr. Brown's patients again and "cut them off" from control items permanently.
7 The spreadsheet report showed that Valley Wholesale had sold approximately 33,600 oxycodone
8 30 mg tablets and approximately 526,000 Norco tablets to Westside from January 1, 2010 to
9 December 10, 2012.

10 40. On and between September 2 and 10, 2014, Board Inspector J. W. received
11 spreadsheet reports of sales from Top RX, HD Smith Wholesale Drug Company, The Harvard
12 Drug Group LLC, and Masters Pharmaceutical, Inc. The reports showed that between January 1,
13 2010 and December 10, 2012, Westside had purchased approximately 25,200 oxycodone 30 mg
14 tablets and approximately 83,000 Norco tablets from Top RX; approximately 2,700 oxycodone
15 30 mg tablets and approximately 91,000 Norco tablets from HD Smith; approximately 99,000
16 Norco tablets from Harvard Drug Group; and approximately 3,500 Norco tablets from Masters.
17 A Masters' representative informed J. W. that on April 11, 2012, Westside's account was placed
18 on an indefinite no-control status (termination) for the purchasing of controlled substances.
19 Masters had reported two control orders to the DEA that were "suspicious"—an order placed on
20 April 4, 2012 for hydrocodone and Tramadol, and an order placed on April 5, 2012 for
21 oxycodone 30 mg.

22 41. Board Inspector J. W. analyzed the DUR for Westside and found that they had
23 dispensed a number of prescriptions to patients who were located outside of the pharmacy's
24 normal trade area by as many as 453 miles (Mecca, California). Westside had dispensed
25 prescriptions for Norco, Opana, and oxycodone to patients whose addresses were listed in Long
26 Beach, Mecca, Monterey, Murrieta, Norwalk, Oakland, Riverside, Sacramento, San Francisco,
27 San Jose, Santa Rosa, Signal Hill, Wesley, and Winchester. The prescriptions had all been issued
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1 by Dr. Brown, whose office was located (Fresno) approximately eighty-nine miles from
2 Westside.

3 42. Board Inspector J. W. compiled a table based on the above DUR and the prescription
4 documents received from the DEA showing that on and between May 18, 2011 and October 3,
5 2012, Westside filled approximately 268 prescriptions for Opana (approximately 1,920 tablets),
6 oxycodone (approximately 32,100 tablets), and Norco (approximately 6,780 tablets) to over sixty-
7 three different "patients," including the ten defendants identified in paragraph 35 above.¹

8 **FIRST CAUSE FOR DISCIPLINE**

9 **(Acts Involving Moral Turpitude, Dishonesty, Fraud, Deceit, or Corruption)**

10 43. Respondent's original permit and pharmacist license are subject to disciplinary action
11 pursuant to Code section 4301, subdivision (f), for unprofessional conduct, in that Respondent
12 committed acts involving moral turpitude, dishonesty, fraud, deceit, or corruption, as follows:

13 a. In and between February and November 2012, Respondent failed to reverse the
14 claims on the prescriptions identified below or adjust the billings on the claims even though
15 Respondent had not dispensed the medications to the patients (or had dispensed only a portion of
16 the medications) and had received payment for the drugs from the patients' insurance companies²:

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Patient	RX#	Date Filled
B. Kh.	678455	09/25/2012
B. K.	678456	09/25/2012
B. S.	674876	06/28/2012
B. S.	674277	07/31/2012
B. Ke.	677822	11/23/2012
B. Ke.	677823	11/23/2012
J. S.	670876	06/28/2012
J. S.	670877	06/28/2012
J. S.	670876	08/31/2012
J. S.	670877	08/31/2012
K. P.	679212	09/04/2012

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25 ¹ Defendants Sdey Chim, Chanrath Yath, Chanrou Yath, Phally Thach, Raeb Chou, and
26 Chantha Chim were subsequently convicted of violating 18 U.S.C. section 371 (structuring
conspiracy), a felony, and/or 31 U.S.C. sections 5324, subdivisions (a)(1) and (d)(12)
(structuring), a felony. The case as to defendants Chim, Say Eng, Iris Garcia, and Loc Huu Chau
is still pending.

27 ² Even after Inspectors M. P. and J. W. directed Respondent to credit all of the following
28 prescriptions to the insurance company, Respondent failed to credit back seven of them.

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K. K.	676431	10/16/2012
L. B.	675949	07/12/2012 (partial quantity)
L. K.	674941	11/03/2012
L. K.	670458	11/03/2012
L. K.	670457	11/03/2012
L. H.	666853	09/20/2012
L. H.	680300	09/20/2012
L. H.	680299	09/20/2012
M. D.	655831	02/07/2012
R. N.	678213	08/16/2012
R. R.	682821	10/31/2012
S. Se.	683427	11/13/2012
S. Sa.	647810	06/20/2012
S. Sa.	659154	06/20/2012
S. Sa.	659154	07/26/2012
S. Sa.	659158	07/26/2012
T. T.	674579	06/25/2012 (partial quantity)
T. T.	677743	08/09/2012

b. Respondent failed to deliver the following controlled substance prescriptions, each of which were filled by Paradise Drugs, to the patients indicated, and kept the prescriptions within Westside's inventory. Further, Respondent failed to notify Paradise Drugs that the insurance billings/claims on the prescriptions needed to be reversed.

RX#	Patient	Drug	QTY	Date Filled	Pick-Up Record	Insurance Company
C950908	L. K.	hydrocodone/APAP 5 mg/500 mg	60	12/06/2012	Signed for by S. D. of Westside on 12/07/2012	Medicare Part D
C948393	NYR	Lyrica 300 mg	60	11/19/2012	Signed for by C. of Westside on 11/19/2012	Medicare Part D
C949610	U. C.	hydrocodone/APAP 5 mg/500 mg	40	11/28/2012	Signed for by L. of Westside on 11/30/2012	Medi-Cal
C950910	C. K.	hydrocodone/APAP 5 mg/500 mg	40	12/06/2012	Signed for by S. D. of Westside on 12/07/2012	Medi-Cal
C948667	N. T.	zolpidem 10 mg	30	11/21/2012	Signed for by C. of Westside on 11/21/2012	Medicare/ Medi-Cal
C950909	Y. Y.	Zolpidem 10 mg	30	12/06/2012	Signed for by S. D. of Westside on 12/07/2012	Medi-Cal

1 **SECOND CAUSE FOR DISCIPLINE**

2 **(Violations of Federal and State Regulations Governing Pharmacy)**

3 44. Respondent's original permit and pharmacist license are subject to disciplinary action
4 pursuant to Code section 4301, subdivision (o), for unprofessional conduct, in that Respondent
5 violated or attempted to violate, directly or indirectly, assisted in or abetted the violation of, or
6 conspired to violate federal and state regulations governing pharmacy, as follows:

7 a. Respondent failed to record on the invoices, identified in paragraph 27 above, the
8 date the controlled substances were actually received at Westside, in violation of Title 21, Code
9 of Federal Regulations, section 1304.21, subdivision (d).

10 b. Respondent failed to record on the DEA-222 forms, identified in paragraph 27 above,
11 the number of packages of controlled substances that were received at Westside and/or the dates
12 the packages were received on the controlled substances invoices, in violation of Title 21, Code
13 of Federal Regulations, section 1305.13, subdivision (e).

14 c. On or about December 11, 2012, Respondent failed to take a biennial inventory of all
15 stocks of controlled substances on hand at Westside within two years of the previous biennial
16 inventory date, in violation of Title 21, Code of Federal Regulations, section 1304.11, subdivision
17 (c).

18 d. On or about December 11, 2012, Respondent failed to maintain a complete and
19 accurate record of each controlled substance Westside had received, sold, or delivered, in
20 violation of Title 21, Code of Federal Regulations, section 1304.21, subdivision (a), thereby
21 preventing the DEA and Board Inspectors from performing an accountability audit of Westside,
22 in that there were approximately three instances where records were incomplete and inaccurate on
23 the controlled substance received, sold, or delivered.

24 e. On and between May 18, 2011 and October 3, 2012, Respondent dispensed numerous
25 prescriptions for the controlled substances Opana, oxycodone, and Norco, all of which had been
26 issued by Dr. Brown, to over sixty-three different "patients," when Respondent knew, or had
27 objective reason to know, based upon Dr. Brown's medical status, repetitive prescribing pattern
28 of highly abused controlled substances, the location of Dr. Brown's practice in relation to the

1 location of Westside, and the location of Dr. Brown's patients in relation to the location of
2 Westside, that the prescriptions were not issued for a legitimate medical purpose, in violation of
3 California Health and Safety Code section 11153, subdivision (a), and California Code of
4 Regulations, title 16, section 1761, subdivision (b).

5 **MATTERS IN AGGRAVATION**

6 45. To determine the degree of discipline to be assessed against Respondent, if any,
7 Complainant alleges as follows: On or about February 11, 1992, pursuant to the Proposed
8 Decision of the Administrative Law Judge ("ALJ") adopted by the Board as its Decision in the
9 disciplinary proceeding entitled *In the Matter of the Accusation Against Modesto Pharmacy, et*
10 *al.*, Case No. 1504, the Board revoked Respondent's original permit for Modesto Pharmacy and
11 Respondent's pharmacist license, effective March 12, 1992. The revocation of Respondent's
12 pharmacist license was stayed and Respondent was placed on probation for three years on terms
13 and conditions. Respondent's license was also suspended for thirty days effective March 12,
14 1992. The ALJ found that cause for discipline of Respondent's license was established pursuant
15 to Code section 4350.5 for violation of Code sections 4227, subdivision (a), and 4354; Health and
16 Safety Code sections 22650 and 22651; and Title 21, Code of Federal Regulations, sections
17 211.130 and 211.137 by reason of the following:

18 a. On June 19, 1989, Respondent pled guilty to violating Code section 4227, subdivision
19 (a), in *People v. Suwonnee Pongnorsing, et al.*, Stanislaus County Municipal Court, Case No.
20 177962, thereby establishing grounds for discipline based upon Code section 4354. The facts and
21 circumstances underlying the conviction were that on or about June 29, 1988, Respondent
22 furnished the dangerous drug ampicillin upon a prescription that was not from a physician,
23 dentist, podiatrist, or veterinarian.

24 b. On or about June 16 and 29, and July 6 and 20, 1988, Respondent filled prescriptions
25 signed by K. Quinn, R.N., in violation of Code section 4227, subdivision (a).

26 c. On December 8, 1988, 263 vials of drugs seized from Respondent's Westside Plaza
27 Pharmacy were misbranded in that they were not labeled with the name, strength, manufacturer,
28

1 lot number, and expiration of the drugs, in violation of Health and Safety Code sections 22650
2 and 22651, and Title 21, Code of Federal Regulations, sections 211.130 and 211.137.

3 **PRAYER**

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

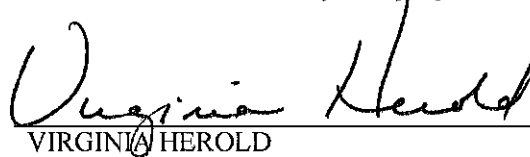
6 1. Revoking or suspending Original Permit Number PHY 45161, issued to Suwonnee
7 Pongnorsing, doing business as Westside Plaza Pharmacy;

8 2. Revoking or suspending Original Pharmacist License Number RPH 35104, issued to
9 Suwonnee Pongnorsing;

10 3. Ordering Suwonnee Pongnorsing, individually, and doing business as Westside Plaza
11 Pharmacy, to pay the Board of Pharmacy the reasonable costs of the investigation and
12 enforcement of this case, pursuant to Business and Professions Code section 125.3; and

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

14
15 DATED: 5/28/15



16 VIRGINIA HEROLD
17 Executive Officer
18 Board of Pharmacy
19 Department of Consumer Affairs
20 State of California
21 Complainant

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