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

In the Matter of the Statement of Issues Against: **MAXIM HEALTH SYSTEMS, LLC; TONI JEAN LISA, AUTHORIZED REPRESENTATIVE** **Nonresident Wholesaler Permit Applicant** Respondent.	Case No. 4862 **STATEMENT OF ISSUES**

Complainant alleges:

PARTIES

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

2. On or about September 28, 2012, the Board of Pharmacy, Department of Consumer Affairs received an application for a Nonresident Wholesaler Permit from Maxim Health Systems, LLC; Toni Jean Lisa, Authorized Representative (Respondent). On or about August 16, 2012, Toni Jean Lisa, aka Toni Jean Lisa Friedman certified under penalty of perjury to the truthfulness of all statements, answers, and representations in the application. The Board denied the application on March 1, 2013.

JURISDICTION

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

4. Section 4161 of the Code states, in pertinent part:

"(a) A person located outside this state that (1) ships, sells, mails, or delivers dangerous drugs or dangerous devices into this state or (2) sells, brokers, or distributes dangerous drugs or devices within this state shall be considered a nonresident wholesaler.

"(b) A nonresident wholesaler shall be licensed by the board prior to shipping, selling, mailing, or delivering dangerous drugs or dangerous devices to a site located in this state or selling, brokering, or distributing dangerous drugs or devices within this state.

"(c) A separate license shall be required for each place of business owned or operated by a nonresident wholesaler from or through which dangerous drugs or dangerous devices are shipped, sold, mailed, or delivered to a site located in this state or sold, brokered, or distributed within this state. A license shall be renewed annually and shall not be transferable.

". . .

"(f) A nonresident wholesaler shall comply with all directions and requests for information from the regulatory or licensing agency of the state in which it is licensed, as well as with all requests for information made by the board.

". . .

"(h) A nonresident wholesaler shall at all times maintain a valid, unexpired license, permit, or registration to conduct the business of the wholesaler in compliance with the laws of the state in which it is a resident. An application for a nonresident wholesaler license in this state shall include a license verification from the licensing authority in the applicant's state of residence.

"(i) The board may not issue or renew a nonresident wholesaler license until the nonresident wholesaler identifies a designated representative-in-charge and notifies the board in writing of the identity and license number of the designated representative-in-charge.

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"(j) The designated representative-in-charge shall be responsible for the nonresident wholesaler's compliance with state and federal laws governing wholesalers. A nonresident wholesaler shall identify and notify the board of a new designated representative-in-charge within 30 days of the date that the prior designated representative-in-charge ceases to be the designated representative-in-charge. . . ."

STATUTORY PROVISIONS

5. Section 475 of the Code states, in pertinent part:

"(a) Notwithstanding any other provisions of this code, the provisions of this division shall govern the denial of licenses on the grounds of:

". . .

"(3) Commission of any act involving dishonesty, fraud or deceit with the intent to substantially benefit himself or another, or substantially injure another.

(4) Commission of any act which, if done by a licentiate of the business or profession in question, would be grounds for suspension or revocation of license. . . ."

6. Section 480 of the Code states:

"(a) A board may deny a license regulated by this code on the grounds that the applicant has one of the following:

". . .

"(2) Done any act involving dishonesty, fraud, or deceit with the intent to substantially benefit himself or herself or another, or substantially injure another.

"(3)(A) Done any act that if done by a licentiate of the business or profession in question, would be grounds for suspension or revocation of license.

(B) The board may deny a license pursuant to this subdivision only if the crime or act is substantially related to the qualifications, functions, or duties of the business or profession for which application is made. . . ."

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7. Section 810 of the Code states, in pertinent part:

"(a) It shall constitute unprofessional conduct and grounds for disciplinary action, including suspension or revocation of a license or certificate, for a health care professional to do any of the following in connection with his or her professional activities:

"(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss under a contract of insurance.

"(2) Knowingly prepare, make, or subscribe any writing, with intent to present or use the same, or to allow it to be presented or used in support of any false or fraudulent claim.

"(b) It shall constitute cause for revocation or suspension of a license or certificate for a health care professional to engage in any conduct prohibited under Section 1871.4 of the Insurance Code or Section 549 or 550 of the Penal Code.

". . .

(c)(4) Nothing in this subdivision shall preclude a board from suspending or revoking a license or certificate pursuant to any other provision of law. . . ."

8. Section 4300 of the Code states, in pertinent part:

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

". . .

(c) The board may refuse a license to any applicant guilty of unprofessional conduct. The board may, in its sole discretion, issue a probationary license to any applicant for a license who is guilty of unprofessional conduct and who has met all other requirements for licensure. . . ."

9. Section 4301 of the Code states:

"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:

"(a) Gross immorality.

". . .

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"(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.

"(g) Knowingly making or signing any certificate or other document that falsely represents the existence or nonexistence of a state of facts.

"...

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

INSURANCE CODE

10. Insurance Code section 1871.4 states, in pertinent part:

"(a) It is unlawful to do any of the following:

"(1) Make or cause to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying any compensation, as defined in Section 3207 of the Labor Code.

"(2) Present or cause to be presented any knowingly false or fraudulent written or oral material statement in support of, or in opposition to, any claim for compensation for the purpose of obtaining or denying any compensation, as defined in Section 3207 of the Labor Code.

"(3) Knowingly assist, abet, conspire with, or solicit any person in an unlawful act under this section.

"...

(d) This section shall not be construed to preclude the applicability of any other provision of criminal law that applies or may apply to any transaction."

PENAL CODE

11. Section 550 of the Penal Code states, in pertinent part:

"(a) It is unlawful to do any of the following, or to aid, abet, solicit, or conspire with any person to do any of the following:

"(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss or injury, including payment of a loss or injury under a contract of insurance.

"(2) Knowingly present multiple claims for the same loss or injury, including presentation of multiple claims to more than one insurer, with an intent to defraud.

"...

"(5) Knowingly prepare, make, or subscribe any writing, with the intent to present or use it, or to allow it to be presented, in support of any false or fraudulent claim.

"(6) Knowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit.

"(7) Knowingly submit a claim for a health care benefit that was not used by, or on behalf of, the claimant.

"(8) Knowingly present multiple claims for payment of the same health care benefit with an intent to defraud.

"(9) Knowingly present for payment any undercharges for health care benefits on behalf of a specific claimant unless any known overcharges for health care benefits for that claimant are presented for reconciliation at that same time.

"(10) For purposes of paragraphs (6) to (9), inclusive, a claim or a claim for payment of a health care benefit also means a claim or claim for payment submitted by or on the behalf of a provider of any workers' compensation health benefits under the Labor Code.

"(b) It is unlawful to do, or to knowingly assist or conspire with any person to do, any of the following:

"(1) Present or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

"(2) Prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(3) Conceal, or knowingly fail to disclose the occurrence of, an event that affects any person's initial or continued right or entitlement to any insurance benefit or payment, or the amount of any benefit or payment to which the person is entitled. . . ."

REGULATORY PROVISION

12. California Code of Regulations, title 16, section 1770, states:

"For the purpose of denial, suspension, or revocation of a personal or facility license pursuant to Division 1.5 (commencing with Section 475) of the Business and Professions Code, a crime or act shall be considered substantially related to the qualifications, functions or duties of a licensee or registrant if to a substantial degree it evidences present or potential unfitness of a licensee or registrant to perform the functions authorized by his license or registration in a manner consistent with the public health, safety, or welfare."

FIRST CAUSE FOR DENIAL OF APPLICATION

(Commission of an Act Involving Dishonesty, Fraud or Deceit With the Intent to Substantially Benefit Itself or Another, or Substantially Injure Another)

13. Respondent Maxim's application is subject to denial under sections 475(a)(3) and 480(a)(2) of the Code in that four of Maxim's former employees pled guilty to[1]: (1) from 2001 through 2009, submitting or causing to be submitted false claims to the state Medicaid program for services not rendered; (2) from 2001 through 2009, submitting or causing to be submitted false claims to the state Medicaid program for services not reimbursable by the state Medicaid program because Maxim lacked adequate documentation to support the services purported to have been performed; and (3) from October 2007 through February 2008, submitting or causing to be submitted false or fraudulent claims to the state Medicaid program for services not reimbursable by the state Medicaid programs because its office in Gainesville, Georgia was not licensed. These actions were a result of a climate that Maxim fostered in its operations which encouraged criminal behavior as more fully described as follows:

[1] Because these former employees admitted to engaging in illegal and unethical conduct during the course and scope of their employment with Respondent, Respondent is vicariously liable for their conduct for the purpose of this action.

a. On or about November 4, 2009, in *United States of America v. Andrew Sabbaghzadeh*, United States District Court, District of New Jersey, Trenton Division, case no. 3-09-cr-00820-AET-1, Andrew Sabbaghzadeh (hereinafter "A.S."), Account Manager for Respondent Maxim's Tempe, Arizona office from November 2007 through November 2008, admitted to the following:

i. Respondent Maxim's Tempe, Arizona office provided staffing of nurses to various facilities in and around Tempe, Arizona, which included an Academic Behavioral Alternative school (ABA), providing special educational services for students with autism, mental retardation, and other health impairments;

ii. In A.S.'s role as Account Manager, he was responsible for, among other things, ensuring that time cards were submitted to Respondent Maxim's corporate office for all shifts worked by nurses so that Maxim could then bill the facilities;

iii. The time cards were supposed to reflect the time actually worked by the nurse and the signature of a supervisor at the facility verifying that the work was completed;

iv. During A.S.'s time as Account Manager, he, along with others working with him, created fraudulent time cards, and submitted them to Respondent Maxim's corporate office;

v. These time cards included forged, cut, and pasted or otherwise fraudulent supervisor signatures when, in fact, a supervisor from the facility had not signed those time cards;

vi. These fraudulent time cards included ones reflecting work done by a nurse, F.J., at ABA schools, when, in fact, F.J. was not at the time an employee of Respondent Maxim and did not actually work the shifts reflected on behalf of Maxim;

vii. Respondent Maxim and others created and submitted these fraudulent time cards in order that the facilities would be billed by Maxim;

viii. As part of this scheme, A.S. submitted, or caused to be submitted, fraudulent time cards resulting in bills from Respondent Maxim to facilities amounting to more than $10,000.00 but less than $30,000.00;

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ix. A.S. engaged in these fraudulent billing practices in response to sales pressure from his superiors, also employees of Respondent Maxim, to generate more revenue for the Tempe, Arizona office;

x. A.S. took these actions knowingly and willfully.

b. On or about December 4, 2009, in *United States of America v. Bryan Lee Shipman,* United States District Court, District of New Jersey, Trenton Division, case no. 3-10-cr-00404-AET-1, Bryan Shipman (hereinafter "B.S."), Respondent Maxim's Regional Account Manager from March 2001 through September 2009, admitted to the following:

i. During B.S.'s time of employment with Respondent Maxim, it was his experience that sales and profits were the number one priority of Maxim;

ii. At at least one point during B.S.'s position as Regional Account Manager, he believed his job was in jeopardy because while all of the other revenues and profitability of offices under his supervision had grown, they did not grow by as a dramatic degree as his supervisors seemed to expect;

iii. The degree of growth demanded by B.S.'s supervisors was based on a belief that dramatic growth was necessary regardless of market conditions;

iv. Between October 2007 and February 2008, B.S. was responsible as the Regional Account Manager for a region of Georgia and Respondent Maxim's offices in Gainesville and Atlanta, which provided staffing of nurses and other caregivers to individuals for home care services in and around the areas where these offices were located;

v. A substantial portion of Respondent Maxim's home care services in Georgia were paid for through public programs, such as Georgia's Medicaid program;

vi. Opening new branch offices within B.S.'s region was a method of increasing the sales of his region;

vii. Before October 2007, B.S. requested that Respondent Maxim open a new branch in Gainesville, Georgia, which was to be an expansion from the office in Atlanta North, which was already in existence at the time;

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viii. The new office was expected both to take over the supervision of care for certain patients who were, up until that point, supervised by Atlanta North, and also to accept referrals and supervise the care of new patients;

ix. J.M. was the Vice President of sales for the region which included Atlanta North and Gainesville offices, and he was B.S.'s supervisor at the time;

x. The Gainesville office began operating in or about October 2007;

xi. Between October 2007 and February 2008, B.S. was aware that the new Gainesville office was operating as a freestanding office, meaning that the Gainesville office was accepting patients and supervising the care of patients without being licensed by the State of Georgia;

xii. During this time, all billings related to the Gainesville office were submitted to Georgia's Medicaid program as if they were attributable to Respondent Maxim's Atlanta North office when, in fact, the Atlanta North office was not involved in the provision of care for those patients;

xiii. Although Respondent Maxim submitted billings for both of the offices as they were all attributable to the Atlanta North office, Maxim, in fact, tracked which billings were attributable to the Gainesville office and which were attributable to the Atlanta North office;

xiv. During this time, B.S. had conversations and/or e-mail exchanges with J.M., J.D., and T.C. in which it was clear they were aware that billings related to the Gainesville office were being submitted to Georgia's Medicaid program as if they were attributable to Respondent Maxim's Atlanta North office;

xv. B.S. believed at that time that if the State regulators learned of the manner in which the Gainesville office was operating, the State of Georgia may have, at a minimum, refused to pay Respondent Maxim based on the claims properly attributable to the Gainesville office and required Maxim to repay monies based on claims already filed through the Atlanta North office which were properly attributable to the Gainesville office;

xvi. During this time, B.S. had conversations and/or e-mail exchanges with J.M., J.D., and T.C. in which it was clear they similarly understood that funds would be recouped by

the State if the State regulators learned of the manner in which the Gainesville office was operating, meaning that it was operating as a freestanding office;

xvii. In order to make it appear that the Gainesville office was not a freestanding office, the billings related to the Gainesville office were submitted to Georgia's Medicaid program as if they were attributable to the Atlanta North office;

xviii. During this time, B.S. had conversations or e-mails with J.M. and J.D. about the fact that Respondent Maxim would be able to avoid recoupment for billings by the Gainesville office by claiming the billings were attributable to Maxim's Atlanta North office when, in fact, they were not;

xix. In order to make it appear that the Gainesville office was not a freestanding office, B.S. and others directed T.S., S.C., and others not to disclose the Gainesville office's existence as a freestanding office to State regulators;

xx. B.S. directed T.S. to be careful about marketing his office so that the office's existence as a freestanding office would not be disclosed to State regulators;

xxi. B.S. and others, including J.D., also directed T.S. and S.C. that original patient records should be kept in Atlanta North, and only copies of patient records be kept in Gainesville so that in the event the Gainesville offices were visited by State regulators, they would be led to believe patient care was being supervised by the Atlanta North office when, in fact, that was not the case;

xxii. B.S. had conversations or e-mail exchanges with J.M., J.D., and T.C. about the need to make sure State regulators did not learn that Respondent Maxim's Gainesville office was operating as a freestanding office;

xxiii. In February 2008, prior to a time when J.D. believed a State regulator would be visiting the Gainesville, Georgia office, J.D. related to B.S. through both an e-mail and telephone conversation that she had a conversation with T.S. and S.C. in which she told him to replace original documents in patient files located in the Gainesville office with copies and to tell the State regulator that the original documents were located in Atlanta North when, in reality, the original documents were located in Gainesville, Georgia. B.S. understood that J.D. gave this

direction in order that the State regulator would not learn that the Gainesville office was functioning as a freestanding office;

xxiv. Between October 2007 and February 2008, more than $400,000.00, but less than $1,000,000.00 in billings, properly attributable to the unlicensed Gainesville, Georgia office, were submitted to the Georgia Medicaid program for reimbursement even if they were attributable to the Atlanta North office.

xxv. B.S. took these actions knowingly and willfully.

c. On or about May 28, 2010, in *United States of America v. Donna Ocansey,* United States District Court, District of New Jersey, Trenton Division, case no. 3-10-cr-00371-AET-1, Donna Ocansey (hereinafter "D.O."), Director of Clinical Services of Respondent Maxim's Cherry Hill, New Jersey office from July through December 2009, admitted to the following:

i. Respondent Maxim's Cherry Hill, New Jersey office provided home healthcare to individuals in and around Cherry Hill, New Jersey;

ii. A substantial portion of Respondent Maxim's home healthcare services were paid for through public programs, such as New Jersey's Medicaid program;

iii. As Director of Clinical Services, D.O. had oversight responsibility for, among other things, ensuring that Medicaid-required supervisory visits of patients were conducted periodically, meaning that a registered nurse periodically visited each patient to check on that patient's condition, and the care the patient was receiving from Respondent's caregivers;

iv. As Director of Clinical Services, D.O. had oversight responsibility for, among other things, ensuring that documentation associated with those supervisory visits was completed;

v. At various times throughout D.O.'s employment with Respondent Maxim as Director of Clinical Services, D.O. completed documentation indicating that she or another registered nurse had conducted a required supervisory visit when D.O. knew that no registered nurse had conducted such a visit;

vi. At various times during that same time period, D.O. completed documentation indicating that supervisory visits had been completed on certain dates within required time periods when she knew they were not completed within those time periods;

vii. Throughout D.O.'s employment with Respondent Maxim, D.O. fabricated documentation to make it appear that supervisory visits were properly conducted within required time periods when, in fact, they were not. D.O. did so knowing that the information she was putting on the documentation was not accurate;

viii. D.O. did these things in response to pressure from her superiors, also employees of Respondent Maxim, to make sure that all supervisory visits were completed, despite not being given adequate resources to conduct all necessary visits;

ix. D.O. took these actions knowingly and willfully;

x. From July through December 2009, in Camden County, D.O. knowingly and willfully falsified, concealed, and covered-up by scheme or device a material fact, and made materially false fictitious and fraudulent statements, made and used materially false writings and documents knowing them to contain materially false fraudulent statements in connection with the delivery of and payment for healthcare benefits.

d. On June 17, 2010, in *United States of America v. Gregory Munzel,* United States District Court, District of New Jersey, Trenton Division, case no. 3-09-cr-00895-AET-1, Gregory Munzel (hereinafter "G.M."), Account Manager for Respondent Maxim's Charleston, South Carolina office from 2001 through 2005, admitted to the following:

i. Respondent Maxim's South Carolina office provided home healthcare to individuals in and around Charleston, South Carolina;

ii. A substantial portion of Respondent Maxim's home healthcare services were paid for through public programs, such as South Carolina's Medicaid program and Community Long-Term Program;

iii. In the role of Account Manager, G.M. had oversight responsibility for, among other things, the documentation associated with the provision of healthcare services to home care patients, which included documentation to ensure that all care givers utilized by Respondent Maxim were properly credentialed, that is that they had documentation reflecting, for example, that they were properly licensed or had completed any necessary training;

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iv. Throughout G.M.'s employment with Respondent Maxim, G.M. fabricated documentation to make it appear that care givers were properly credentialed when, in fact, they were not. This was a practice G.M. learned from a superior, who was also an employee of Maxim;

v. G.M. created copies of altered CPR cards to be included in care giver personnel files to make it appear as if those care givers were current on their training requirements to be eligible to provide services to home care patients;

vi. G.M. did these things in response to sales pressure from his superiors, also employees of Respondent Maxim, to generate more revenue;

vii. It was G.M.'s experience that the forging of credentials for care givers to meet sales expectations from superiors was a common occurrence with Respondent Maxim;

viii. In the role of Account Manager, G.M. was aware that individuals working under his supervision were similarly forging credentials for care givers;

ix. In G.M.'s role as Account Manager, he was also responsible for ensuring that time cards and other forms were submitted to Respondent Maxim's corporate office for all shifts worked by caretakers so that Maxim could then bill for these home healthcare services provided. These time cards and other forms were supposed to reflect the time actually worked by the care givers;

x. During G.M.'s time as Account Manager of the Charleston, South Carolina office, he became aware that a care giver, M.M., prepared time cards purporting to reflect home care services rendered that had overlapping hours, that is reflecting that M.M. was providing care to different patients at different locations at the same time;

xi. G.M. understood it was not possible for M.M. to be servicing two different patients at separate locations at the same time;

xii. G.M., along with others working with him, nevertheless submitted to Respondent Maxim's corporate offices the total M.M. hours billed for home care services so that Maxim could, in turn, bill Medicaid. These bills were submitted, despite G.M.'s awareness that they were based on false information;

xiii. Under the CLTC Program, care givers were required to place a telephone call to a system utilized by the program at the beginning and end of the provision of home care to confirm that they were actually beginning and ending the provision of care at the times which Respondent would then send a bill;

xiv. For instances where a care giver failed to utilize the CLTC Program's telephone system, the program allowed a bill to be submitted if Respondent Maxim submitted a form reflecting the identity of the care giver who provided the care. Under these circumstances, the program assigned a strike to such a care giver who repeatedly failed to utilize the telephone system and they were then prevented from billing for services under the program;

xv. To avoid any of Respondent Maxim's care givers being barred from billing for services according to the CLTC Program strike system, G.M. submitted false claims to the program which reflected the name of a care giver whom G.M. knew did not provide the home health care services to the patient. These forms were submitted as the basis for bills to South Carolina's CLTC Program, and this was done intentionally to bypass the CLTC Program's strike system;

xvi. G.M. engaged in these practices and allowed those working under him to engage in these practices in response to sales pressure from his superiors, also employees of Respondent Maxim, to generate more revenue for the Charleston, South Carolina office;

xvii. G.M. was aware that sales employees, known as recruiters, working under his supervision in the Charleston office, also engaged in these practices to generate false paperwork in connection with the billing of home care services;

xviii. False documents submitted to Respondent Maxim's corporate offices by G.M. and others under his supervision resulted in bills from Maxim to South Carolina Medicaid amount to more than $10,000.00 but less than $30,000.00;

xix. G.M. took these actions knowingly and willfully.

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SECOND CAUSE FOR DENIAL OF APPLICATION

(Unprofessional Conduct—Commission of an Act Substantially Related to the Qualifications, Functions, or Duties of a Wholesaler)

14. Respondent Maxim's application is subject to denial under sections 480(a)(3), 810(a), and 4301(o) of the Code in that from 2001 through 2009, Maxim, by and through its employees, engaged in unprofessional conduct, as more fully set forth in paragraph 13 and all of its subparts.

THIRD CAUSE FOR DENIAL OF APPLICATION

(Unprofessional Conduct—Engaging in Conduct Prohibited Under Section 1871.4 of the Insurance Code and Section 550 of the Penal Code)

15. Respondent Maxim's application is subject to denial under sections 480(a)(3) and 810(b) of the Code in that from 2001 through 2009, Maxim, by and through its employees, engaged in conduct prohibited under Section 1871.4 of the Insurance Code and Section 550 of the Penal Code, as more fully set forth in paragraph 13 and all of its subparts.

FOURTH CAUSE FOR DENIAL OF APPLICATION

(Unprofessional Conduct—Gross Immorality)

16. Respondent Maxim's application is subject to denial under sections 480(a)(3) and 4301(a) of the Code in that from 2001 through 2009, Maxim, by and through its employees, engaged in grossly immoral conduct, as more fully set forth in paragraph 13 and all of its subparts.

FIFTH CAUSE FOR DENIAL OF APPLICATION

(Unprofessional Conduct—Commission of an Act Involving Moral Turpitude, Dishonesty, Fraud, Deceit, or Corruption)

17. Respondent Maxim's application is subject to denial under sections 480(a)(3) and 4301(f) of the Code in that from 2001 through 2009, Maxim, by and through its employees, committed acts involving moral turpitude, dishonesty, fraud, deceit, and corruption, as more fully set forth in paragraph 13 and all of its subparts.

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SIXTH CAUSE FOR DENIAL OF APPLICATION

(Unprofessional Conduct—Knowingly Making or Signing Any Certificate or Other Document That Falsely Represents the Existence or Nonexistence of a State of Facts)

18. Respondent Maxim's application is subject to denial under sections 480(a)(3) and 4301(g) of the Code in that from 2001 through 2009, Maxim, by and through its employees, knowingly made or signed documents that falsely represented the existence or nonexistence of a state of facts, as more fully set forth in paragraph 13 and all of its subparts.

SEVENTH CAUSE FOR DENIAL OF APPLICATION

(Unprofessional Conduct—Violating or Attempting to Violate, Directly or Indirectly, any Provision or Term of the Business and Professions Code Applicable to Pharmacy or the Applicable Federal and State Laws and Regulations Governing Pharmacy)

19. Respondent Maxim's application is subject to denial under sections 480(a)(3) and 4301(o) of the Code in that from 2001 through 2009, Maxim, by and through its employees, violated or attempted to violate, directly or indirectly, provisions and terms of the Business and Professions Code applicable to pharmacy as well as applicable federal and state laws and regulations governing pharmacy, as more fully set forth in paragraph 13 and all of its subparts.

PRAYER

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

1. Denying the application of Maxim Health Systems, LLC; Toni Jean Lisa, Authorized Representative for a Nonresident Wholesaler Permit; and

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

DATED: 7/23/14

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

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