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

In the Matter of the Accusation Against: **PMC PHARMACY** **901 Campus Drive, # 108** **Daly City, CA 94015** **Pharmacy License No. PHY 48762** **ANGELA PO-CHU YEUNG** **2830 34th Avenue** **San Francisco, CA 94116** **Pharmacist License No. RPH 31278** **PMC PHARMACY** **843 Malcolm Road** **Burlingame, CA 94010** **Pharmacy License No. PHY 50377** **GEORGE A. POOLE** **1245 Encina Drive** **Millbrae, CA 94030** **Pharmacist License No. RPH 23279** **KIMBERLY MAE DE LUNA** **111 Caspar Place** **Novato, CA 94947** **Pharmacist License No. RPH 61593** **BARBARA JIANG** **901 Campus Drive, #108** **Daly City, CA 94015** **Pharmacist Technician License No. TCH 52663** **RONALD WING KO** **1534 Plaza Lane, #141** **Burlingame, CA 94010** **Pharmacist License No. RPH 44077** Respondents.	Case Nos. 4496 and 4528 OAH No. 2014030853 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER** **<u>ONLY AS TO RESPONDENTS</u>** **PMC Daly City** **PMC Burlingame** **Barbara Jiang**

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 October 21, 2016.

It is so ORDERED on September 21, 2016.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By _____
Amy Gutierrez, Pharm.D.
Board President

KAMALA D. HARRIS
Attorney General of California
LINDA K. SCHNEIDER
Senior Assistant Attorney General
JOSHUA A. ROOM
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455 Golden Gate Avenue, Suite 11000
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Attorneys for Complainant

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In the Matter of the Accusation Against: **PMC PHARMACY** **901 Campus Drive, # 108** **Daly City, CA 94015** **Pharmacy License No. PHY 48762** **ANGELA PO-CHU YEUNG** **2830 34th Avenue** **San Francisco, CA 94116** **Pharmacist License No. RPH 31278** **PMC PHARMACY** **843 Malcolm Road** **Burlingame, CA 94010** **Pharmacy License No. PHY 50377** **GEORGE A. POOLE** **1245 Encina Drive** **Millbrae, CA 94030** **Pharmacist License No. RPH 23729** **KIMBERLY MAE DE LUNA** **111 Caspar Place** **Novato, CA 94947** **Pharmacist License No. RPH 61593** **BARBARA JIANG** **901 Campus Drive, # 108** **Daly City, CA 94015** **Pharmacy Technician License No. TCH 52663** **RONALD WING KO** **1534 Plaza Lane, #141** **Burlingame, CA 94010** **Pharmacist License No. RPH 44077** Respondents.	Case Nos. 4496 and 4528 OAH No. 2014030853 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER** **<u>ONLY AS TO RESPONDENTS</u>** **PMC Daly City** **PMC Burlingame** **Barbara Jiang**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and responsibility of the Board of Pharmacy, Department of Consumer Affairs, the parties hereby agree to the following Stipulated Settlement and Disciplinary Order to be submitted to the Board for approval and adoption as the final disposition of the First Amended Accusation, solely with respect to Respondents PMC Daly City, PMC Burlingame, and Barbara Jiang. This stipulation is not applicable to Respondents Angela Po-Chu Yeung, Kimberly Mae De Luna, George A. Poole, or Ronald Wing Ko, who are separately represented herein.

PARTIES

1. Virginia Herold ("Complainant"), Executive Officer, Board of Pharmacy, brought this action solely in her official capacity and is represented herein by Kamala D. Harris, Attorney General of the State of California, by Joshua A. Room, Supervising Deputy Attorney General.

2. The three signatory Respondents are: (1) Nursing Care Pharmacies Inc. dba PMC Pharmacy, formerly at 901 Campus Drive, #108, Daly City, CA 94015, Barbara Jiang, Chief Executive Officer and owner, Pharmacy License No. PHY 48762 (Respondent PMC Daly City); (2) Nursing Care Pharmacies Inc. dba PMC Pharmacy, at 843 Malcolm Road, Burlingame, CA 94010, Barbara Jiang, Chief Executive Officer and owner, Pharmacy License No. PHY 50377 (Respondent PMC Burlingame); and (3) Barbara Jiang, Pharmacy Technician License No. TCH 52663 (Respondent Jiang). All three are represented herein by Sidney Luscutoff, of Luscutoff, Lendormy & Associates, 400 Montgomery Street, 6th Floor, San Francisco, CA 94104.

3. On or about May 22, 2008, the Board of Pharmacy issued Pharmacy License No. PHY 48762 to Respondent PMC Daly City. The License was in full force and effect at all times relevant until Respondent PMC Daly City discontinued business on or about July 29, 2013. The Pharmacy License was cancelled on or about July 1, 2014.

4. On or about September 15, 2010, the Board of Pharmacy issued Pharmacy License No. PHY 50377 to Respondent PMC Burlingame. The License was in full force and effect at all times relevant and will expire on September 1, 2016, unless renewed.

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5. On or about November 17, 2003, the Board of Pharmacy issued Pharmacy Technician License No. TCH 52663 to Respondent Jiang. The License was in full force and effect at all times relevant. It expired September 30, 2015, and was cancelled January 3, 2016.

JURISDICTION

6. On or about October 21, 2013, Accusation No. 4496 and 4528 was filed before the Board of Pharmacy (Board), Department of Consumer Affairs, against all Respondents except Respondent Ko, who was not initially named. The Accusation and all other statutorily required documents were properly served on all Respondents except Respondent Ko on November 5, 2013. Respondents PMC Daly City, PMC Burlingame, Poole, and Jiang timely filed Notices of Defense contesting the Accusation. On or about October 26, 2015, First Amended Accusation No. 4496 and 4528 was filed before the Board against all Respondents including Respondent Ko. The First Amended Accusation and all other statutorily required documents were properly served on all Respondents. Respondent Ko timely filed a Notice of Defense contesting the First Amended Accusation. A copy of First Amended Accusation No. 4496 and 4528 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

7. Respondents have carefully read, fully discussed with counsel, and understand the charges and allegations in First Amended Accusation No. 4496 and 4528. Respondents have also carefully read, fully discussed with counsel, and understand the effects of this Stipulated Settlement and Disciplinary Order on their respective licenses and license histories.

8. Respondents are fully aware of their legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to be represented by counsel at their own expense; the right to confront and cross-examine the witnesses against them; the right to present evidence and to testify on their 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.

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9. Respondents voluntarily, knowingly, and intelligently waive and give up each and every right set forth above.

CULPABILITY

10. Respondents understand and agree that the charges and allegations in First Amended Accusation No. 4496 and 4528, if proven at a hearing, constitute cause for imposing discipline upon their respective licenses. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondents agree that, at a hearing, Complainant could establish a factual basis for charges in the First Amended Accusation and a basis for discipline. Respondents hereby give up their right(s) to contest those charges. Respondents agree that their respective licenses are subject to discipline and agree to be bound by the disciplinary orders and probationary terms set forth in the Disciplinary Order below.

RESERVATION

11. Admissions made by Respondents herein are only for the purposes of this proceeding, or any other proceedings in which the Board of Pharmacy or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

12. This stipulation shall be subject to approval by the Board of Pharmacy. Respondents understand and agree that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondents or their counsel. By signing the stipulation, Respondents understand and agree that they may not withdraw their 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, this 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, and the Board shall not be disqualified from further action against any respondent by having considered this matter.

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13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

14. This Stipulated Settlement and Disciplinary Order is intended by the parties to be an integrated writing representing the complete, final, and exclusive embodiment of their agreement. It supersedes any and all prior or contemporaneous agreements, understandings, discussions, negotiations, and commitments (written or oral). This Stipulated Settlement and Disciplinary Order may not be altered, amended, modified, supplemented, or otherwise changed except by a writing executed by an authorized representative of each of the parties.

15. In consideration of the foregoing, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

AS TO RESPONDENTS PMC DALY CITY AND JIANG

IT IS HEREBY ORDERED that Pharmacy License No. PHY 48762, issued to Respondent PMC Daly City, and Pharmacy Technician License No. TCH 52663, issued to Respondent Jiang, are each surrendered and accepted by the Board of Pharmacy.

1. The surrender of the licenses and the acceptance of the surrendered licenses by the Board constitutes the imposition of discipline against respondents. This stipulation constitutes a record of the discipline and becomes a part of each respondent's license history with the Board.

2. Each of these two respondents shall lose all rights and privileges to practice under their respective licenses in California as of the effective date of the Board's Decision and Order.

3. Each of these two respondents shall cause to be delivered to the Board their respective pocket licenses and, if any were issued, wall certificate(s), on or before the effective date of the Decision and Order.

4. These two respondents may not apply, reapply, or petition for any license from the Board for three (3) years from the effective date of the Decision and Order.

5. If either of these two respondents ever applies for licensure or petitions for reinstatement in the State of California, the Board shall treat it as a new application for licensure. Each such respondent must comply with all the laws, regulations and procedures for licensure in effect at the time the application or petition is filed, and all of the charges and allegations contained in First Amended Accusation No. 4496 and 4528 applicable to that respondent shall be deemed to be true, correct and admitted by each such respondent when the Board determines whether to grant or deny the application or petition.

6. Prior to issuance of a new or reinstated license to either of these two respondents, each shall pay to the Board costs of investigation and enforcement of $10,000.00. This obligation shall run to each respondent, so that each must make full payment of $10,000.00 prior to issuance to that respondent, and neither may claim credit for any payment made by the other. In addition, Respondent Jiang may not be issued a new or reinstated license by the Board until all financial obligations owed by Respondent PMC Burlingame (see below) have been satisfied. Thus, the Board must have received full payment of Respondent Jiang's $10,000.00 cost obligation, plus the $25,000.00 civil penalty and $42,000.00 in costs payable by Respondent PMC Burlingame, and must have satisfactory documentation that PMC Burlingame has provided $10,000.00 worth of community service, before a new or reinstated license may issue to Respondent Jiang.

7. Should either of these two respondents ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in First Amended Accusation No. 4496 and 4528 applicable to that respondent shall be deemed to be true, correct, and admitted by that respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure to that respondent.

AS TO RESPONDENT PMC BURLINGAME

IT IS HEREBY ORDERED that Pharmacy License No. PHY 50377, issued to Respondent PMC Burlingame, is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. **Civil Penalty**

Respondent shall pay a civil penalty to the Board of $25,000.00, with the full amount of the civil penalty due and payable within one hundred (100) days of the effective date of this decision.

Respondent understands and agrees that this civil penalty is an administrative fine pursuant to 11 U.S.C. § 523(a)(7), and as such is not dischargeable in bankruptcy.

There shall be no deviation from this payment schedule absent prior written approval by the Board or its designee. Failure to timely pay the civil penalty in full shall be considered a violation of probation.

2. **Engagement of Pharmacy Consultant**

During the period of probation, respondent shall retain a Board-approved independent consultant at its own expense who shall be responsible for reviewing pharmacy operations on a monthly basis for compliance with state and federal laws and regulations governing the practice of pharmacy and for compliance with the obligations of a pharmacist-in-charge. The consultant shall be a pharmacist licensed by and not on probation with the Board and whose name shall be submitted to the Board or its designee, for prior approval, within thirty (30) days of the effective date of this decision. Respondent is not precluded from submitting for approval the name(s) of any consultant(s) already engaged or employed by the pharmacy, and may seek approval of a preferred consultant prior to the effective date of this decision. After twelve (12) such monthly reviews, respondent may submit a written request to the Board or its designee for permission to reduce the frequency of consultant reviews from monthly to quarterly. Whether or not to grant such request is solely within the discretion of the Board or its designee. The consultant may be required to submit a report to the Board or its designee after any monthly or quarterly review, in a format specified by the Board or its designee.

Failure to timely retain, seek approval of, or ensure timely reporting by, a consultant, shall be considered a violation of probation.

3. **Community Service**

Within sixty (60) days of the effective date of this decision, respondent shall submit to the Board or its designee, for prior approval, a community service program in which respondent shall

provide free health-care related items or services to a community or charitable facility or agency. The community service program may include, but need not be limited to: provision of sharps disposal containers; free or reduced-cost immunizations; PMC Burlingame professional staff conducting on-site education and counseling activities at nursing homes, residential care facilities, hospitals or community centers; and/or other similar health-care related items or services, with a total value of $10,000.00, including the value of materials and labor provided. The community service program shall begin no later than March 2017 and shall be completed no later than the end of calendar year 2018.

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

Failure to timely submit, secure approval, commence, or comply with the community service program shall be considered a violation of probation

4. **Obey All Laws**

Respondent shall obey all state and federal laws and regulations.

Respondent shall report any of the following occurrences to the board, in writing, within seventy-two (72) hours of such occurrence:

- ☐ an arrest or issuance of a criminal complaint for violation of any provision of the Pharmacy Law, state and federal food and drug laws, or state and federal controlled substances laws
- ☐ a plea of guilty or nolo contendere in any state or federal criminal proceeding to any criminal complaint, information or indictment
- ☐ a conviction of any crime
- ☐ discipline, citation, or other administrative action filed by any state or federal agency which involves respondent's pharmacy 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.

5. **Report to the Board**

Respondent shall report to the Board quarterly, on a schedule as directed by the board or its designee.[1] The report shall be made either in person or in writing, as directed. Among other requirements, respondent 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 period of probation. Also, 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.

6. **Interview with the Board**

Upon receipt of reasonable prior notice, respondent 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.

7. **Cooperate with Board Staff**

Respondent 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 its probation. Failure to cooperate shall be considered a violation of probation.

8. **Status of License**

Respondent shall, at all times while on probation, maintain current licensure with the Board. Failure to maintain current licensure shall be considered a violation of probation .If respondent 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 new license, and respondent shall remain on probation as determined by the board.

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[1] Any reporting, cooperation, or appearance requirement(s) herein are required to be performed or completed by an owner, officer or other individual acting on behalf of respondent that is authorized to act on behalf of respondent and/or bind the entity.

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

9. **Prohibition on Accepting Returned Drugs or Devices**

Respondent shall not accept any returned dangerous drugs or devices, or permit such return, from any source, for the duration of probation. Any acceptance or permitting of any return of a dangerous drug or device shall be considered a violation of 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 owner(s) and officer(s), 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. **Notice to Employees**

Respondent shall, upon or before the effective date of this decision, ensure that all employees involved in pharmacy 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.

12. **Posted Notice of Probation**

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

13. **Reimbursement of Board Costs**

As a condition precedent to successful completion of probation, respondent shall pay to the board costs of investigation and prosecution in the amount of $42,000.00. Respondent shall be permitted to make payments on a plan approved by the Board or its designee that calls for the first payment to be made within one hundred twenty (120) days of the effective date of this decision and calls for payment to be made in full within four (4) years of the effective date. There shall be no deviation from the approved schedule absent prior written approval by the Board or its designee. Failure to pay by deadline(s) as directed shall be considered a violation of probation.

14. **Probation Monitoring Costs**

Respondent 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.

15. **License Surrender While on Probation**

Following the effective date of this decision, should respondent discontinue business, respondent may tender its pharmacy license to the board for surrender. The board or its designee shall have discretion whether to grant the request for surrender or take any other appropriate or reasonable action. If the surrender is accepted, it shall constitute a disciplinary surrender and shall become a part of respondent's license history with the Board. Upon acceptance of the surrender, respondent will no longer be subject to terms and conditions of probation.

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By the effective date of such accepted surrender, respondent shall arrange for destruction of, transfer to, sale of, or storage in a facility licensed and approved by the Board or its designee of, all dangerous drugs and dangerous devices. Respondent shall further arrange for transfer of all records of acquisition and disposition of dangerous drugs to a facility licensed and approved by the Board or its designee. Respondent shall provide timely written proof of such disposition to the Board, shall submit a completed Discontinuance of Business form, and shall return its wall and renewal license to the Board, all within five (5) days of such disposition.

Respondent shall also, by the effective date of the surrender, arrange for continuity 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 (5) days of its provision to the pharmacy's ongoing patients, Respondent 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.

16. **Violation of Probation**

If respondent violates probation in any respect, the Board, after giving respondent notice and an opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If respondent has not complied with any term or condition of probation, the Board shall have continuing jurisdiction over respondent, and probation shall be automatically extended, until all terms and conditions are satisfied or the Board has taken action as deemed appropriate to treat the failure to comply as a violation of probation, to terminate probation, and/or to impose the penalty that was stayed. If a petition to revoke probation or 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.

In the event a petition to revoke probation or accusation is filed against respondent, all of the charges and allegations in First Amended Accusation No. 4496 and 4528 shall be deemed to

be true, correct, and admitted by respondent for the purposes of a decision on the petition to revoke probation or accusation.

17. **Completion of Probation**

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

ACCEPTANCE

I am authorized to act on behalf of Respondent PMC Daly City. I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Sidney Luscutoff. I understand the stipulation and the effect it will have on my Pharmacy License. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: 6/1/16

Barbara Jiang, Chief Executive Officer, for
PMC DALY CITY
Respondent

I am authorized to act on behalf of Respondent PMC Burlingame. I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Sidney Luscutoff. I understand the stipulation and the effect it will have on my Pharmacy License. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: 6/1/16

Barbara Jiang, Chief Executive Officer, for
PMC BURLINGAME
Respondent

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Sidney Luscutoff. I understand the stipulation and the effect it will have on my Pharmacy Technician License. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: 6/1/16

BARBARA JIANG
Respondent

I have read and fully discussed with Respondents PMC Daly City, PMC Burlingame, and Barbara Jiang, the terms and conditions and other matters contained in this Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 6-3-2016

SIDNEY LUSCUTOFF
LUSCUTOFF, LENDORMY & ASSOCIATES
Attorneys for Respondents

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Board of Pharmacy.

Dated: 8/15/16

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
LINDA K. SCHNEIDER
Senior Assistant Attorney General

JOSHUA A. ROOM
Supervising Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 4496 and 4528

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Attorneys for Complainant

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Complainant alleges:

PARTIES

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

2. On or about May 22, 2008, the Board of Pharmacy issued Pharmacy License No. PHY 48762 to Nursing Care Pharmacies Inc. dba PMC Pharmacy, at 901 Campus Drive, #108, Daly City, CA 94015, Barbara Jiang, Chief Executive Officer and owner (Respondent PMC Daly City). The Pharmacy License was in full force and effect until it discontinued business on or about July 29, 2013. The Pharmacy License was cancelled on or about July 1, 2014.

3. On or about August 3, 1977, the Board of Pharmacy issued Pharmacist License No. RPH 31278 to Angela Po-Chu Yeung (Respondent Yeung). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2017, unless renewed. Between on or about May 22, 2008 and on or about September 1, 2010, Respondent Yeung served and/or was listed in records maintained with or by the Board as Pharmacist in Charge (PIC) for Respondent PMC Daly City.

4. On or about September 15, 2010, the Board of Pharmacy issued Pharmacy License No. PHY 50377 to Nursing Care Pharmacies Inc. dba PMC Pharmacy, at 843 Malcolm Road, Burlingame, CA 94010, Barbara Jiang, Chief Executive Officer and owner (Respondent PMC Burlingame). The Pharmacy License was in full force and effect at all times relevant to the charges brought herein and will expire on September 1, 2016, unless renewed.

5. On or about August 10, 1964, the Board of Pharmacy issued Pharmacist License No. RPH 23729 to George A. Poole (Respondent Poole). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2016, unless renewed. Between on or about November 1, 2010 and on or about January 1, 2012, Respondent Poole served and/or was listed in records maintained with or by the Board as Pharmacist in Charge (PIC) for Respondent PMC Burlingame.

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6. On or about October 2, 2008, the Board of Pharmacy issued Pharmacist License No. RPH 61593 to Kimberly Mae De Luna (Respondent De Luna). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2016, unless renewed. Between on or about January 2, 2012 and on or about October 31, 2014, Respondent De Luna served and/or was listed in records maintained with or by the Board as Pharmacist in Charge (PIC) for Respondent PMC Burlingame.

7. On or about November 17, 2003, the Board of Pharmacy issued Pharmacy Technician License No. TCH 52663 to Barbara Jiang (Respondent Jiang). The Pharmacy Technician License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2015, unless renewed. At all times relevant to the charges brought herein, Respondent Jiang served as manager, administrator, owner, member, officer, director, associate, and/or partner of Respondent PMC Daly City and/or Respondent PMC Burlingame.

8. On or about March 5, 1991, the Board of Pharmacy issued Pharmacist License No. RPH 44077 to Ronald Wing Ko (Respondent Ko). The License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2016, unless renewed.

JURISDICTION

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

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

11. Section 4300.1 of the Code provides that the expiration, cancellation, forfeiture, or suspension of a Board-issued license, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee, shall not deprive the Board of jurisdiction to commence or proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license.

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

13. Section 4302 of the Code provides that the Board may deny, suspend, or revoke any license of a corporation where conditions exist in relation to any person holding 10 percent or more of the corporate stock of the corporation, or where conditions exist in relation to any officer or director of the corporation, that constitute grounds for disciplinary action against a licensee.

14. Section 4307 of the Code provides, in pertinent part, that any person who has been denied a license or whose license has been revoked or is under suspension, or who has failed to renew his or her license while it was under suspension, or who has been a manager, administrator, owner, member, officer, director, associate, or partner of any partnership, corporation, firm, or association whose application for a license has been denied or revoked, is under suspension or has been placed on probation, and while acting as the manager, administrator, owner, member, officer, director, associate, or partner had knowledge of or knowingly participated in any conduct for which the license was denied, revoked, suspended, or placed on probation, shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee: (1) where the license is placed on probation, for up to five years, and (2) where the license is denied or revoked, until the license is issued or reinstated.

15. Section 4342, subdivision (a), of the Code, provides that the Board may institute any action or actions as may be provided by law and that, in its discretion, are necessary, to prevent the sale of pharmaceutical preparations and drugs that do not conform to the standard and tests as to quality and strength, provided in the latest edition of the United States Pharmacopoeia or the National Formulary, or that violate any provision of the Sherman Food, Drug and Cosmetic Law (Part 5 (commencing with Section 109875) of Division 104 of the Health and Safety Code).

COST RECOVERY

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

STATUTORY AND REGULATORY PROVISIONS

17. Section 4301 of the Code provides, in pertinent part, that the Board shall take action against any holder of a license who is guilty of "unprofessional conduct," defined to include, but not be 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.

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

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

18. Section 4013 of the Code requires, in pertinent part, that any facility licensed by the Board join the Board's e-mail notification list within 60 days of obtaining a license or at the time of license renewal, and further that it update its e-mail address with the Board's e-mail notification list within 30 days of a change in the facility's e-mail address.

19. Section 4040 of the Code requires, in pertinent part, that a "prescription" include: the name and address of the patient; name and quantity of the drug or device prescribed and directions for use; date of issuance of the prescription; name, address and telephone number of the prescriber, his or her license classification, and his or federal registry number (if a controlled substance); notice of the condition or purpose for which the drug is being prescribed, if requested by the patient; and if in writing, the signature of the prescriber. This section further allows that a prescription for a non-Schedule II dangerous drug that contains at least the name and signature of the prescriber, the name and address of the patient in a manner consistent with paragraph (2) of subdivision (a) of Section 11164 of the Health and Safety Code, the name and quantity of the drug prescribed, directions for use, and the date of issue, may be treated as a prescription as long as any additional information required by subdivision (a) is readily retrievable in the pharmacy.

20. Section 4059 of the Code provides, in pertinent part, that a person may not furnish any dangerous drug, except upon the valid prescription of an authorized prescriber.

21. Health and Safety Code section(s) 11162.1 and/or 11164 require that, except pursuant to certain defined exceptions, every controlled substance prescription shall be written on a security prescription form meeting the requirements of Health and Safety Code section 11162.1.

22. Health and Safety Code section 11159.2 allows a controlled substance prescription for use by a patient with a terminal illness to be written on a prescription form that does not meet the security prescription form requirements of Health and Safety Code section 11162.1 where the prescription (1) contains at least the information contained in Health and Safety Code section 11164, subdivision (a) (signed and dated by prescriber in ink, prescriber address and telephone number, patient name, refill information, name, quantity, strength, and directions for use) and (2) the prescriber has certified the patient is terminally ill by writing "11159.2 exemption."

23. Health and Safety Code section 11167.5 allows an order for a Schedule II controlled substance for a patient of a licensed skilled nursing facility, a licensed intermediate care facility, a licensed home health agency, or a licensed hospice to be dispensed upon an oral or electronically transmitted prescription so long as certain conditions are met:

- If transmitted orally, the pharmacist shall, prior to filling the prescription, reduce the prescription to writing in ink in the handwriting of the pharmacist, on a form.
- If the prescription is transmitted electronically, the pharmacist shall, prior to filling the prescription, produce, sign, and date a hard copy prescription.
- The prescription shall contain the date the prescription was orally or electronically transmitted, the name of the patient, the name and address of the licensed facility, the name and quantity of the controlled substance, the directions for use, and the prescriber's name, address, category of licensure, license number, and federal registration number. The original shall be endorsed with the pharmacy's name and address and state license number, and the signature of the person who received the controlled substances at the facility. The facility shall forward to the dispensing pharmacist documentation substantiating each oral or electronic transmission.

24. Section 4040.5 of the Code, in pertinent part, defines "reverse distributor" to mean and include "every person who acts as an agent for pharmacies, drug wholesalers, manufacturers, and other entities by receiving, inventorying, and managing the disposition of outdated or nonsalable dangerous drugs."

25. Section 4043 of the Code, in pertinent part, defines "wholesaler" to mean and include "a person who acts as a wholesale merchant, broker, jobber, customs broker, reverse distributor, agent, or a nonresident wholesaler, who sells for resale, or negotiates for distribution, or takes possession of, any drug or device included in Section 4022."

26. Section 4160 of the Code provides, in pertinent part, that a wholesaler license shall be required for a person or entity to act as a wholesaler, that every wholesaler shall be supervised or managed by a Designated Representative in Charge, and that the Designated Representative in Charge shall be responsible for the wholesaler's compliance with state and federal laws.

27. 21 U.S.C. § 822 and/or 21 C.F.R. § 1301.11 require persons that manufacture or distribute controlled substances to register with the Drug Enforcement Agency (DEA), and allow registrants to distribute controlled substances to "ultimate users." There is no like authority for an ultimate user or other non-registrant to provide (return) controlled substances to a registrant.

28. Section 4052.7 of the Code provides, in pertinent part, that a pharmacy may, at a patient's request, repackage a drug previously dispensed to the patient or to the patient's agent pursuant to a prescription, but that it shall have in place policies and procedures for doing so and shall label the repackaged prescription container with (1) all the information required by section 4076, and (2) the name and address of the pharmacy repackaging the drug and the name and address of the pharmacy that initially dispensed the drug to the patient.

29. Section 4076 of the Code requires, in pertinent part, that a pharmacist not dispense any prescription except in a container correctly labeled with elements including: (1) the trade name of the drug or generic name and manufacturer; (2) directions for use; (3) patient name; (4) prescriber name; (5) date of issue; (6) pharmacy name and address, prescription number or other means of identifying the prescription; (7) strength; (8) quantity; (9) expiration date; (10) condition or purpose (if on prescription); (11) physical description, including color, shape, and any code.

30. Section 4077, subdivision (a), of the Code, reinforces that except as provided in subdivisions (b) and (c) of section 4076, no person shall dispense a dangerous drug except in a container correctly labeled with the information required by section 4076.

31. Section 4081 of the Code provides, in pertinent part, that all records of manufacture, sale, acquisition, or disposition of dangerous drugs or dangerous devices shall be kept open to inspection and retained for at least three years, that a current inventory shall be kept by every pharmacy that maintains a stock of dangerous drugs or dangerous devices, and that the owner(s), officer(s), partner(s), and pharmacist in charge or designated representative in charge shall be jointly responsible for maintaining the records and keeping the inventory.

32. Section 4105 of the Code requires, in pertinent part, that unless a waiver is granted by the board, all records and other documentation of the acquisition and disposition of dangerous drugs and devices by any entity licensed by the board be retained on the licensed premises, in a readily retrievable form, for three years from the date of making.

33. Section 4332 of the Code makes it unlawful for any person: to fail, neglect, or refuse to maintain the records required by Section 4081; or, when called upon by an authorized officer or a member of the board, to fail, neglect, or refuse to produce or provide the records within a reasonable time; or to willfully produce or furnish records that are false.

34. Section 4333 of the Code, in pertinent part, requires that all prescriptions filled by a pharmacy and all other records required by section 4081 shall be maintained on the premises and available for inspection by authorized officers of the law for a period of at least three years, and further requires that in cases where the pharmacy discontinues business, these records shall be maintained in a Board-licensed facility for at least three years.

35. California Code of Regulations, title 16, section 1718, provides that "current inventory" as used in sections 4081 and 4332 "shall be considered to include complete accountability for all dangerous drugs handled by every licensee," and that the controlled substances inventories required by 21 C.F.R. § 1304 shall be available for inspection upon request for at least 3 years after the date of the inventory.

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36. 21 C.F.R. § 1304.11(c) provides that after an initial inventory is taken, the registrant shall take a new inventory of all stocks of controlled substances on hand at least every two years, on any date which is within two years of the previous biennial inventory date.

37. Section 4101 of the Code provides, in pertinent part, that a pharmacist may take charge of and act as the pharmacist-in-charge of a pharmacy upon application by the pharmacy and approval by the Board, and requires that the pharmacist-in-charge notify the Board within 30 days if he or she ceases to act as pharmacist-in-charge of a pharmacy.

38. Section 4113 of the Code requires, in pertinent part, that each pharmacy designate a pharmacist-in-charge and notify the Board within 30 days, that such designation shall be subject to approval by the Board, and that the pharmacist-in-charge shall be responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy.

39. Section 4305 of the Code provides: failure by any pharmacist to notify the board in writing that he or she has ceased to act as the pharmacist-in-charge of a pharmacy, or by any pharmacy to notify the board in writing that a pharmacist-in-charge is no longer acting in that capacity, within 30 days, shall constitute grounds for disciplinary action; operation of a pharmacy for more than 30 days without supervision or management by a pharmacist-in-charge shall constitute grounds for disciplinary action; and any person who has obtained a license to conduct a pharmacy, who willfully fails to timely notify the board that the pharmacist-in-charge of the pharmacy has ceased to act in that capacity, and who continues to permit the compounding or dispensing of prescriptions, or the furnishing of drugs or poisons, in his or her pharmacy, except by a pharmacist subject to the supervision and management of a responsible pharmacist-in-charge, shall be subject to summary suspension or revocation of his or her pharmacy license.

40. Section 4169, subdivision (a), of the Code provides, in pertinent part, that a person or entity shall not purchase, trade, sell, or transfer dangerous drugs: that the person knew or reasonably should have known were adulterated, as set forth in Article 2 (commencing with Section 111250) of Chapter 6 of Part 5 of Division 104 of the Health and Safety Code; that the person knew or reasonably should have known were misbranded, as defined in Section 111335 of the Health and Safety Code; or after the beyond use date on the label.

41. Health and Safety Code section 111250 provides that a drug or device is adulterated if it consists, in whole or in part, of any filthy, putrid, or decomposed substance.

42. Health and Safety Code section 111255 provides that a drug or device is adulterated if it has been produced, prepared, packed, or held under conditions whereby it may have been contaminated with filth, or whereby it may have been rendered injurious to health.

43. Health and Safety Code section 111295 provides that it is unlawful for any person to manufacture, sell, deliver, hold, or offer for sale any drug or device that is adulterated.

44. Health and Safety Code section 111305 provides that it is unlawful for any person to receive in commerce, or to deliver or proffer for delivery, any drug or device that is adulterated.

45. Health and Safety Code section 111330 provides that a drug or device is misbranded if its labeling is false or misleading in any particular.

46. Health and Safety Code section 111335 provides that a drug or device is misbranded if its labeling or packaging does not conform to the requirements of Chapter 4.

47. Health and Safety Code section 111340 provides that a drug or device is misbranded unless its label contains (a) the name and address of the manufacturer, packer, or distributor, and (b) an accurate statement of the quantity of the contents (weight, measure, or numerical count).

48. Health and Safety Code section 111390 provides that a drug or device is misbranded if its container is so made, formed, or filled as to be misleading.

49. Health and Safety Code section 111395, subdivision (c), provides that a drug is misbranded if "[t]he contents of the original package have been, wholly or partly, removed and replaced with other material in the package."

50. Health and Safety Code section 111440 provides that it is unlawful for any person to manufacture, sell, deliver, hold, or offer for sale any drug or device that is misbranded.

51. 21 U.S.C. § 351 provides, in pertinent part, that a drug or device shall be deemed to be adulterated, *inter alia*: if it has been prepared, packed, or held under insanitary conditions whereby it may have been contaminated with filth, or whereby it may have been rendered injurious to health; it is a drug and any substance has been (1) mixed or packed therewith so as to reduce its quality or strength or (2) substituted wholly or in part therefor.

52. 21 U.S.C. § 352 provides, in pertinent part, that a drug or device shall be deemed to be misbranded: if its labeling is false or misleading in any particular; if in package form unless it bears a label containing the name and place of business of the manufacturer, packer, or distributor, and an accurate statement of the quantity of the contents in terms of weight, measure, or numerical count; if it is a drug and its container is so made, formed, or filled as to be misleading; if it is an imitation of another drug; if it is offered for sale under the name of another drug; or if it is dangerous to health when used in the dosage or manner, or with the frequency or duration prescribed, recommended, or suggested in the labeling thereof.

53. California Code of Regulations, title 16, section 1707.1, and subdivision (a)(1)(B)(3) thereof provide, in pertinent part, that a pharmacy shall maintain medication profiles on all of its patients who have prescriptions filled therein except when the pharmacist has reasonable belief that the patient will not continue to obtain prescription medications from that pharmacy, and the patient medication record shall make immediately retrievable during the pharmacy's normal operating hours information including the date on which a drug was dispensed or refilled.

54. California Code of Regulations, title 16, section 1717, subdivision (b) requires, in pertinent part, that for each prescription on file, certain information shall be readily retrievable in the pharmacy, including the date dispensed and the name or initials of the dispensing pharmacist.

55. California Code of Regulations, title 16, section 1707.2 requires, in pertinent part, that a dispensing pharmacist shall provide consultation to the patient or the patient's agent in all care settings upon request or whenever the pharmacist in his or her professional judgment deems it warranted, and in any care setting in which the patient or patient's agent is present whenever the prescription drug has not previously been dispensed to a patient or has not been previously dispensed to a patient in the same dosage form, strength or with the same written directions. This section further requires that when the patient or patient's agent is not present (including but not limited to a drug shipped by mail) a pharmacy shall ensure that the patient receives written notice of his or her right to request consultation, and receives a telephone number from which the patient may obtain oral consultation from a pharmacist who has ready access to the patient's record.

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56. California Code of Regulations, title 16, section 1714, subdivision (c), requires in pertinent part that each pharmacy be equipped with a sink with hot and cold running water.

57. California Code of Regulations, title 16, section 1715, subdivision (a), requires that the pharmacist-in-charge of each pharmacy shall complete a self-assessment of the pharmacy's compliance with federal and state pharmacy law before July 1 of every odd-numbered year, and subdivision (d) requires that each self-assessment shall be kept for three years after completion.

58. California Code of Regulations, title 16, section 1735.2, subdivision (j) requires that prior to allowing any drug product to be compounded in a pharmacy, the pharmacist-in-charge shall complete a self-assessment for compounding pharmacies developed by the board. The first section must be completed by the pharmacist-in-charge before any compounding is performed. The second section must be completed by the pharmacist-in-charge before any sterile compounding is performed. The applicable sections of the self-assessment shall subsequently be completed before July 1 of each odd-numbered year, within 30 days of the start of a new pharmacist-in-charge, and within 30 days of the issuance of a new pharmacy license.

59. California Code of Regulations, title 16, section 1716 provides, in pertinent part, that pharmacists shall not deviate from the requirements of a prescription except upon prior consent of the prescriber or to select a generic substitute in accordance with section 4073 of the Code.

60. California Code of Regulations, title 16, section 1761, provides that no pharmacist shall compound or dispense any prescription containing a significant error, omission, irregularity, uncertainty, ambiguity or alteration. Upon receipt of any such prescription, the pharmacist shall contact the prescriber to obtain the information needed to validate the prescription.

61. Health and Safety Code section 11165 provides, in pertinent part, for establishment and maintenance of a Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of prescribing and dispensing of Schedule II, III, and IV controlled substances, and requires, in pertinent part, that for each prescription for a Schedule II, III, or IV controlled substance, the dispensing pharmacy or clinic transmit a report with certain information on the patient, prescriber, controlled substance, and prescription, to the California Department of Justice, on a weekly basis in a format prescribed by the California Department of Justice.

62. California Code of Regulations, title 16, section 1735.3, requires, in pertinent part, that for each compounded drug product, the pharmacy records shall include: the master formula record; the date the drug product was compounded; the identity of the pharmacy personnel who compounded the drug product; the identity of the pharmacist reviewing the final drug product; the quantity of each component used in compounding the drug product; the manufacturer, expiration date and lot number of each component (except for certain exceptions not applicable here); the pharmacy assigned reference or lot number for the compounded drug product; the expiration date of the final compounded drug product; and the quantity or amount of drug product compounded. It further requires pharmacies to maintain records of proper acquisition, storage, and destruction of chemicals, bulk drug substances, drug products, and components used in compounding. It further requires pharmacies to maintain and retain all records required by this article in the pharmacy in a readily retrievable form for at least three years from the date a record was created.

63. California Code of Regulations, title 16, section 1735.5, subdivision (a) requires that any pharmacy engaged in compounding shall maintain a written policy and procedure manual for compounding that establishes procurement procedures, methodologies for the formulation and compounding of drugs, facilities and equipment cleaning, maintenance, operation, and other standard operating procedures related to compounding.

64. California Code of Regulations, title 16, section 1735.7, subdivision (a) provides that any pharmacy engaged in compounding shall maintain written documentation sufficient to demonstrate that pharmacy personnel have the skills and training required to properly and accurately perform their assigned responsibilities relating to compounding.

65. California Code of Regulations, title 16, section 1764, provides, in pertinent part, that no pharmacy shall exhibit, discuss, or reveal the contents of any prescription, or any medical information furnished by the prescriber with any person other than the patient or his or her authorized representative, the prescriber, or other licensed practitioner then caring for the patient or a person duly authorized by law to receive such information.

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66. Civil Code section 56.10 provides, in pertinent part, that no provider of health care, health care service plan, or contractor shall disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan without first obtaining an authorization, except under certain conditions not applicable here.

67. 45 C.F.R. § 164.502 (HIPAA regulation), in pertinent part, prohibits any covered entity or business associate from using or disclosing protected health information, except under certain conditions not applicable here.

BOARD INVESTIGATIONS AND CAUSES FOR DISCIPLINE

68. Respondents have separately or together been the subject of at least three inspections or investigations: a routine inspection in 2011 that led to issuance of citations (see Discipline Considerations, below), an investigation in 2011 and 2012 that led to the filing of the original Accusation, and another investigation in 2014 and 2015 that led to the filing of this First Amended Accusation. The allegations pertaining to each inspection and investigation, and the causes for discipline arising out of each, will be presented serially.

THE 2011 INSPECTION

69. On or about February 18, 2011, a routine inspection was performed at Respondent PMC Burlingame. Respondents Poole (then Pharmacist in Charge (PIC)) and Jiang assisted with the inspection. During the inspection and follow-up contacts, the Board Inspector(s) discovered various potential violations of pharmacy law, including possession of key(s) to the pharmacy by non-pharmacist(s), exceeding the pharmacist to pharmacy technician ratio, and employment of an unlicensed pharmacy technician. Citations were issued to Respondents PMC Burlingame and Poole as a result (see Discipline Considerations section, below). During the inspection and follow-up, the Board Inspector(s) also noted the pharmacy's failure to transmit controlled substance dispensing data to CURES, and made clear to Respondent Jiang, owner/manager, that it was Respondent PMC Burlingame's obligation to do so timely.

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THE 2011-2012 INVESTIGATION

70. On or about August 11, 2011, the Board received a complaint from a family member of patient R.K.[1] alleging that Respondent PMC Daly City had engaged in mistaken or fraudulent billing of both patient R.K. (as to co-pays) and his insurance provider(s), with regard to drugs dispensed to patient R.K. by Respondent PMC Daly City in/via a nearby assisted living facility.

71. Board of Pharmacy Inspector(s) conducted an investigation of the complaint, during which a review was conducted of medications dispensed and billed to patient R.K, as well as a sample of twenty (20) other patients also resident in the same assisted living facility, and/or their insurance provider(s), by Respondent PMC Daly City and/or Respondent PMC Burlingame, for differing time periods between in or about June 2009 and in or about March 2012.

72. During some part of this time period, Respondent Yeung served as the pharmacist-in-charge for Respondent PMC Daly City, and Respondents Poole and then De Luna served as the pharmacist-in-charge for Respondent PMC Burlingame.

73. That review revealed a pattern and practice of billing and dispensing by respondent pharmacies, under the supervision of their respective pharmacists in charge and shared CEO and primary owner (Respondent Jiang), that included:

a. On several occasions, Respondent PMC Daly City processed a prescription written for patient R.K. calling for a particular quantity of the prescribed drug (60, 30, or 15 doses, depending on the drug), but actually dispensed to patient R.K. some quantity less than the prescribed amount (the amount less varying from a shortage of 3 doses to a shortage of 42 doses).

b. Likewise, on at least two occasions, Respondent PMC Burlingame processed a prescription written for patient R.K. calling for a particular quantity of the prescribed drug (30 or 15 doses), but actually dispensed to patient R.K. some quantity less than the prescribed amount (one shortage was 3 doses and the other was 7 doses);

c. On each of these occasions, Respondent(s) PMC Daly City and/or PMC Burlingame billed patient R.K. and/or his insurer(s) for the full amount(s) of the prescribed doses.

[1] Full names will be revealed to Respondents, if requested, during discovery.

d. On several other occasions, Respondent(s) PMC Daly City and/or PMC Burlingame billed patient(s) R.K., D.K., P.S., J.H., M.M., E.R., and/or G.G., and/or their respective insurer(s), for prescriptions that were never actually furnished to the patient(s).

e. As a result of the foregoing discrepanc(ies) between drugs actually dispensed and those for which pharmacy records showed dispensing transactions, the inventory records (i.e., the records of acquisition and disposition) maintained by Respondent(s) PMC Daly City and/or PMC Burlingame were not maintained in a complete and accurate form.

f. On several other occasions, Respondent(s) PMC Daly City and/or PMC Burlingame dispensed prescriptions to patient(s) R.K., D.K., P.S., J.H., M.M., E.R., and/or G.G. with labels dating dispensing on or about the first of the month, but in fact the prescriptions were processed and billed on various dates later in the month, so that the prescription dates maintained in the pharmacy database(s) did not match the dates on which the prescriptions were dispensed.

g. As a result of the foregoing, the patient history/medication profile information maintained by Respondents PMC Daly City and/or PMC Burlingame for patient(s) R.K., D.K., P.S., J.H., M.M., E.R., and/or G.G., was not accurate and/or complete.

CAUSES FOR DISCIPLINE FROM THE 2011-2012 INVESTIGATION

AS TO ALL RESPONDENTS EXCEPT RESPONDENT KO

FIRST CAUSE FOR DISCIPLINE

(Incomplete Inventory and/or Records of Acquisition and/or Disposition)

74. Respondents PMC Daly City, Yeung, PMC Burlingame, Poole, De Luna, and Jiang are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) and/or 4302 of the Code, by reference to section(s) 4081, 4105, and/or 4332 of the Code, and/or California Code of Regulations, title 16, section 1718, for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 72 above, Respondents failed to maintain an accurate, complete, and readily retrievable inventory and/or records of acquisition and disposition of all dangerous drugs.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

75. Respondents PMC Daly City, Yeung, PMC Burlingame, Poole, De Luna, and Jiang are subject to discipline under section(s) 4301 and/or 4302 of the Code in that Respondents, as described above and below in paragraphs 72-73 and 75-78, engaged in unprofessional conduct.

AS TO PMC RESPONDENTS AND RESPONDENT JIANG

THIRD CAUSE FOR DISCIPLINE

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

76. Respondents PMC Daly City, PMC Burlingame, and Jiang, are subject to discipline under section 4301(f) and/or 4302 of the Code, for acts involving moral turpitude, dishonesty, fraud, deceit, or corruption, in that, as described in paragraph 72 above, Respondents billed in full for prescriptions only partially dispensed, and/or for prescriptions never delivered.

AS TO ALL RESPONDENTS EXCEPT RESPONDENTS JIANG AND KO

FOURTH CAUSE FOR DISCIPLINE

(Inaccurate Date(s) in Dispensing Record(s))

77. Respondents PMC Daly City, Yeung, PMC Burlingame, Poole, and De Luna are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, by reference to California Code of Regulations, title 16, section 1707.1, for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 72 above, Respondents dispensed or were responsible for dispensing medications on dates other than the dates labeled and maintained in patient medication histories/profiles, resulting in discrepancies therein.

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FIFTH CAUSE FOR DISCIPLINE

(Deviation(s) From Prescription(s))

78. Respondents PMC Daly City, Yeung, PMC Burlingame, Poole, and De Luna are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, by reference to California Code of Regulations, title 16, section 1716, for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 72 above, Respondents dispensed or were responsible for the dispensing of medications in quantities other than were prescribed.

SIXTH CAUSE FOR DISCIPLINE

(Inaccurate Date(s) in Dispensing Record(s))

79. Respondents PMC Daly City, Yeung, PMC Burlingame, Poole, and De Luna are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, by reference to California Code of Regulations, title 16, section 1717, subdivision (b), for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 72 above, Respondents dispensed or were responsible for the dispensing of medications on dates other than the dates labeled and maintained in the pharmacy database(s), resulting in inaccuracies therein.

THE 2014-2015 INVESTIGATION

80. Respondent PMC Daly City ceased operation in or about July 2013. In response to another complaint, Board Inspector(s) returned to Respondent PMC Burlingame in 2014-2015, for a series of inspections and follow-up communications and investigation. Board Inspector(s) were assisted during inspection(s) by Respondents Ko, Jiang, and De Luna. Respondent De Luna was the Pharmacist in Charge (PIC) during much of the investigation, until October 31, 2014. This investigation discovered several additional potential violations of pharmacy law, including:

a. During an inspection on or about April 4, 2014, Board Inspector(s) discovered, in an office within the pharmacy, a closet containing: five (5) boxes of oral morphine solution, a Schedule II controlled substance, each with a prescription label on the box; a bag with two other boxes containing dangerous drugs, some in bottles with pharmacy labels, some from PMC and some from other pharmacies; and another box containing other Schedule II controlled substances in bottles with patient labels affixed to the bottles. Board Inspector(s) also discovered, in a conference room within the pharmacy, a refrigerator containing three (3) boxes of oral morphine solution, also labeled with patient information. One box contained one full bottle and one partial bottle, and the partial bottle had what appeared to be lipstick on the lip of the bottle. Respondent Jiang said that the morphine in the closet and the refrigerator had been returned from patients, and was supposed to go to a reverse distributor for destruction. Respondent Jiang said it was their practice to take back medication from patients for destruction, but not to take back controlled substances. She believed it was permissible to take back controlled substances until 2013. She also said they received some medications to repackage into bubble packs. During the inspection, Board Inspector(s) observed a courier delivery from a board and care home containing controlled substances as well as dangerous drugs returned to the pharmacy. That delivery also contained numerous medications delivered to Respondent PMC Burlingame "for repackaging." Respondent De Luna said they did not have a log or record of medications received in this way. Many of the medications received were already in blister cards / bubble packs from another pharmacy. Some of these blister cards / bubble packs had been "used" (previously dispensed) as demonstrated by a broken foil seal. Others were intact. When asked, pharmacy staff were not able to explain why medications already in blister cards / bubble packs were delivered "for repackaging." Nor were they able to explain why controlled substances and dangerous drugs were being returned to the pharmacy, or what the pharmacy was doing with returned medications upon their receipt. Nor did any explanation for the returns accompany the medications as they were delivered by the courier. Board Inspector(s) noted that several of the returned bubble packs had the original printed label quantities crossed out and a different quantity handwritten, a few were filled with a different quantity than was indicated on the label, and some were only partially filled.

b. Elsewhere in the pharmacy, Board Inspector(s) noted that a significant area of the pharmacy was dedicated to "repackaging" of prescriptions for patients, with approximately eight (8) or nine (9) rows of shelves and several bins on each shelf containing numerous bottles with patient names. When asked, Respondent Jiang was not able to produce a repackaging log or other record that would document receipt of all of the bottles received for "repackaging." The records of Respondent PMC Burlingame did not include, for instance: the name or contact information for the original dispensing pharmacy; the date the drugs were received or the quantity received; any signatures documenting delivery/receipt of the drugs; or other records of acquisition.

c. Board Inspector(s) also observed eleven (11) labels on prescriptions filled and made ready for delivery to facilities by the pharmacy that had one manufacturer's name typed on the label and another manufacturer's name written over it in ink. For at least eight (8) of these bubble packed medications, the physical description of the tablet required on the label would change for different manufacturers, and one or the other would be inaccurate. These dispensed prescriptions also had discrepancies between the quantity listed on the label and the amount in the container. The discrepancies ranged from overages of one (1) to three (3) doses to shortages from eight (8) up to one hundred and seventy seven (177) doses (label quantity of 270, quantity dispensed 93).

d. Also on or about April 4, 2014, Board Inspector(s) discovered, in a hallway within the pharmacy, blister cards or bubble packs that had been prepared in the pharmacy for delivery to a facility (Vintage Sonoma) serviced by Respondent PMC Burlingame. Several of these had labels from dates in October 2013, but had not yet been delivered, and were not to be delivered until May 2014. The Inspector(s) noted sixteen (16) instances where the quantity labeled on the blister card or bubble pack exceeded the quantity contained within. The smallest discrepancy was a shortage of nineteen (19) doses, on twelve (12) of the packages, where the label quantity was thirty (30) and the dispensed quantity was eleven (11). The largest discrepancy was seventy six (76), between a label quantity of one hundred twenty (120) and an actual of forty four (44).

e. These prescriptions, which had been prepared for dispensing to the patients, did not appear on the respective patient medication profiles. The prescriptions were in the pharmacy computer as having been filled but placed "on hold," with confusing notations as to quantity.

d. Also on or about April 4, 2014, Board Inspector(s) discovered, in a dumpster outside the pharmacy, numerous containers and labels with patient health information visible. The dumpster contained packs, containers, and/or labels with patient health information from Respondents PMC Daly City and PMC Burlingame, as well as others from Walgreens, CVS, and Kaiser pharmacies. Respondent Jiang said she was not aware this kind of disposal was improper, but instructed staff to remove patient health information from the dumpster.

e. Also on or about April 4, 2014, Board Inspector(s) discovered thirteen (13) stock bottles of branded (brand name) medications where the quantity of tablets or capsules contained in the stock bottle exceeded the expected quantity on the label (hereinafter "overfill"). The overfill discrepancies ranged from a low of twenty (20) excess tablets or capsules to a high of one hundred forty six (146) tablets or capsules. No pharmacy staff could explain these overfills. The Board Inspector(s) believed these were the result of returned drugs being placed into the bottles.

f. Also on or about April 4, 2014, Respondent De Luna was asked for her completed self-assessment form, and produced a self-assessment dated January 6, 2012. She said this was the only completed self-assessment available, and she did not have one from the most recent odd-numbered year (2013). When asked, Respondent De Luna also admitted she had not completed a compounding self-assessment, and did not know it was required. Respondent De Luna admitted that Respondent PMC Burlingame was engaged in compounding. When asked, Respondent De Luna said that she did most of the compounding, but that the pharmacy had no documentation of her training, of any compounding policies and procedures, or records of compounded drugs. She could provide no examples or documentation regarding compounded preparations. There were no compounding worksheets or compounding logs, or other records related to compounding process.

g. In a further discussion with the Board Inspector(s), Respondent De Luna described a typical "repackaging" transaction, involving patient P.U. In this instance, the pharmacy billed for ninety (90) doses, which Respondent De Luna said should not have happened for a "repackaging" transaction (where the drug had already been dispensed and billed by another pharmacy). But only thirty (30) tablets were initially dispensed. Respondent De Luna said all ninety (90) would eventually be dispensed, but the pharmacy kept no records of partial and subsequent fills.

h. During the inspection on or about April 4, 2014, Board Inspector(s) also asked for any documentation showing that Respondent PMC Burlingame was successfully transmitting its dispensed controlled substance prescriptions to the CURES database. The CURES database did not show any data received from Respondent PMC Burlingame. Respondent Jiang was not able to produce any such documentation, but said she was "sure" it was being transmitted.

i. On or about April 7, 2014, Board Inspector(s) returned for a follow-up inspection of Respondent PMC Burlingame. At the outset of the inspection, Respondent Jiang provided additional documentation relating to the prior inspection, including a written statement by which Respondent Jiang took "full responsibility" for the patient health information discovered in the dumpster outside the pharmacy and the boxes of "expired medications" found in the office, and said Respondent De Luna had no knowledge of or responsibility for either. Board Inspector(s) sought to confirm the removal of the patient health information from the dumpster, but found that many of the bubble packs, vials, and/or labels containing patient health information were still in the dumpster. Respondent Jiang instructed her staff to remove and destroy same. This time the Board Inspector(s) took photos to document the removal of the patient health information.

j. Also on or about April 7, 2014, Board Inspector(s) conducted a further inquiry into the blister cards / bubble packs prepared for delivery but not yet delivered to Vintage Sonoma. There were thirty-one (31) prescriptions total dispensed on dates in and between September 2013 and March 2014 but not yet delivered. All those containing medication contained a quantity less than the labeled quantity, with the discrepancies ranging from nineteen (19) doses to two hundred thirty seven (237) doses (between labeled quantity of 270 and dispensed quantity of 33.) When asked, Respondent De Luna confirmed that these dispensed prescriptions were ready for delivery, and would be delivered as soon as the facility indicated it was ready to receive them. However, none of these dispensed medications appeared on the patient medication profiles for the patients in question. Nor was Respondent De Luna able to find any other record in the pharmacy of these dispensed medications. She could not explain why these medications were not on the profiles for these patients, nor could she explain why there were no other records of these prescriptions.

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k. Board Inspector(s) also inspected other blister cards / bubble packs dispensed and made ready for delivery to other facilities serviced by Respondent PMC Burlingame. Many of these had a date of May 1, 2014 written in ink over "white out." They were staged according to designated recipient facility. Each prescription had a quantity typed on it as produced by the pharmacy computer. On each label was a different quantity written in ink. The quantities inside each package corresponded to the quantity written in ink, but the quantity on the patient profile as having been dispensed corresponded to the quantity printed by the computer. The numbers in ink were anywhere from one (1) to five (5) doses larger than those printed by the computer. As a result, the patient medication profiles would be inaccurate by those differentials. On several of these prescriptions, Board Inspector(s) also observed (again) that the pharmacy billed insurance under one manufacturer but dispensed another (the label would have one manufacturer's name crossed out and another manufacturer's name written in by hand). Board Inspector(s) also found another batch of dispensed blister cards / bubble packs with manufacturer names substituted by hand, and with a quantity on the patient medication profile and therefore billed to insurance that was significantly more than that contained in the packaging. In this case, the discrepancies varied from one (1) dose up to one hundred eighteen (118) doses (180 billed, 62 dispensed).

l. Also on or about April 7, 2014, Board Inspector(s) reviewed numerous "prescription" documents (at least sixty five (65)) pursuant to which Respondent PMC Burlingame had filled prescriptions, and identified numerous ways in which those documents deviated from prescription requirements in California law. Respondent De Luna acknowledged that these documents were deficient as "prescriptions." Deficiencies included: prescriptions signed by a nurse rather than a prescriber; medication "lists" treated as prescriptions; instructions from a prescriber to a nurse treated as a prescription; prescription copies filled with no hard copies received; "prescription" documents with twenty one (21) and thirty six (36) drugs listed, multiple prescription numbers and uncertain quantities; answers to facility requests for prescriptions from prescribers treated as prescriptions; "prescriptions" with no patient names; and so on. In a sampling of "prescription" documents, Board Inspector(s) identified "prescriptions" for at least nineteen (19) patients that were non-compliant. All had been dispensed by Respondent De Luna or Respondent Ko.

m. Board Inspector(s) also identified eleven (11) "prescription" documents for controlled substances in the pharmacy that were non-compliant with requirements for controlled substances. In several instances, the pharmacy had relied on a purported "hospice" exception under Health and Safety Code section 11167.5 and/or a "terminal illness" exception under Health and Safety Code section 11159.2, but had not met the requirements for compliance with either section. For most of these, there were no original prescription documents and/or the prescriptions had not been adequately reduced to writing by the pharmacy and/or entered into pharmacy records.

n. During the inspection, Respondent Jiang provided Board Inspector(s) with documents purporting to show transmissions to CURES by Respondent PMC Burlingame. The documents in question did not establish CURES transmissions by Respondent PMC Burlingame. Subsequent review of CURES records between January 1, 2012 and April 8, 2014 established that during that period, despite having already been reminded to do so during the February 18, 2011 inspection, Respondent PMC Burlingame had not transmitted any dispensing information to CURES.

o. During the inspection, Board Inspector(s) asked to inspect the sink with hot and cold running water that was dedicated to the pharmacy. They were told there was no such sink. They asked Respondents Ko and De Luna what sink they used for preparing compounded medications and other pharmacy tasks. They replied that they used the bathroom or the break room sink(s).

p. On or about April 10, 2014, Board Inspector(s) returned for another inspection of Respondent PMC Burlingame. They reviewed the stock on the shelves for additional "overfills" in stock bottles. Board Inspector(s) observed at least one hundred sixty (160) bottles on shelves which contained quantities greater than the labeled quantities ("overfills"). The overfills ranged from a low of six (6) extra doses up to a high of two hundred thirty five and a half (235.5) extra doses (labeled for one hundred (100), actual quantity three hundred thirty five and a half (335.5)). Board Inspector(s) also noted other questionable items among the pharmacy's stock, including:

- Three (3) opened nitroglycerin bottles, with tablets missing – entire bottles of nitroglycerin are supposed to be dispensed as "unit of use" containers;
- Four (4) amber vials on the shelves with no labels to identify the contents; and
- One (1) bottle of potassium chloride 20meq with an unidentifiable tablet inside.

q. During the inspection on or about April 10, 2014, Respondent Jiang stated that the pharmacy had registered for the Board's e-mail notification list as of April 10, 2014; Respondent De Luna admitted that Respondent PMC Burlingame had not previously done so. By way of her responses on a completed pharmacy self-assessment form delivered to the Board Inspector(s), Respondent De Luna made further admissions including: that the drug stock of the pharmacy was not clean, orderly, properly stored, properly labeled, kept in-date, etc.; that she as Pharmacist in Charge (PIC) had not had adequate authority to assure the pharmacy's compliance; that she had not completed a biennial pharmacy self-assessment in 2013; that the pharmacy had dispensed on incomplete prescriptions; and that CURES data had not been transmitted on a weekly basis. Her responses also indicated the pharmacy was not providing or offering patient consultation.

r. Also during the inspection on or about April 10, 2014, Respondent Jiang stated that in an effort to deal with "limited shelf space," it had been the pharmacy's policy to combine opened bottles with the same drug/NDC [National Drug Code Directory] number and same lot number. She affirmed that the pharmacy would thereafter discontinue this practice. Board Inspector(s) observed that there had actually been shelves available in the pharmacy with empty space.

s. In further investigation of the "overfill" bottles discovered during the inspection on or about April 4, 2014, Board Inspector(s) conducted a review in or about April and May 2014 of prescriptions for twenty three (23) patients pursuant to which the contents of these stock bottles were or may have been dispensed to patients. That review revealed another large number of "prescription" documents that did not comply with prescription requirements. In one sample of one hundred and six (106) "prescription" documents reviewed, at least ninety (90) did not comply with requirements of Business and Professions Code section 4040. Thus, at least one hundred (100) prescriptions or refills were dispensed to patients that were not appropriately authorized.

t. In or about May and June 2014, Board Inspector(s) had follow-up contacts with the staff/ownership/management of the pharmacy. They continued to explain to Respondents Jiang and De Luna that the "repack logs" the pharmacy was now beginning to keep were insufficient as records of acquisition or disposition of the drugs received for repackaging. The log(s) continued to omit, *inter alia*, the quantities received, the date received, and the prior dispensing pharmacy.

u. On or about June 27, 2014, Board Inspector(s) returned for another inspection of Respondent PMC Burlingame. On this occasion, they observed bags on the floor of the pharmacy containing blister cards / bubble packs prepared for delivery to the facilities serviced. In one such bag, Board Inspector(s) discovered both a vial and a bubble pack labeled for patient S.G., with the vial containing five (5) tablets of oxybutynin, and the bubble pack containing thirty (30) tablets of the same drug. Respondent Ko's initials were on the label(s) as the dispensing pharmacist, and he admitted to reviewing and dispensing both containers. He explained that the vial with five (5) tablets was for the rest of June, while the bubble pack was for July. When Board Inspector(s) examined the patient medication profile for patient S.G., however, only the thirty (30) tablets in the bubble pack were listed as dispensed. There was no record of the five (5) tablets in the vial.

v. Prior to, during, and subsequent to the further inspection undertaken on or about June 27, 2014, Board Inspector(s) conducted a further review of the repackaging procedures and/or documentation at Respondent PMC Burlingame. That review revealed several deficiencies in these procedures and documentation. For example, with regard to patient E.A:

- Board Inspector(s) observed three (3) cassettes each filled with fifteen (15) tablets of diazepam 5mg for delivery to patient E.A. The date on the label was May 1, 2014. The prescription number was written in, and Board Inspector(s) were informed by a clerk that the handwritten number was the prescription number from a (previously-dispensed) Kaiser prescription bottle. The manufacturer was whited out on the label and "IVAX" was written over the previous manufacturer name. Board Inspector(s) were informed the cassettes were scheduled for delivery on June 27, 2014. The patient medication profile for patient E.A. showed thirty (30) tablets of diazepam dispensed, rather than forty five (45). When asked for documentation of the repackaging, the clerk printed screen prints showing dispensing transactions on April 30, 2014 and May 1, 2014, each showing three (3) tablets dispensed.
- Respondent PMC Burlingame had not assigned its own prescription number to these "repackaging" dispensing transactions. The cassettes in question had only the prior Kaiser dispensing prescription number.

- Board Inspector(s) received confusing and/or conflicting information from staff and employees of the pharmacy regarding whether or how it was possible to tell whether a dispensing transaction reflected in the profile had resulted in a pharmacy billing. Among other things, they were told: that a "P" appearing before a prescription in the patient medication profile meant it was a "profile only" prescription, and was not a transaction for which the pharmacy would bill; and that the transaction screen would be "grey" when the pharmacy had billed, and remain white when it had not.
- The repackaging log showed that diazepam was repackaged for patient E.A. on May 26, June 5, and June 23, 2014 for forty five (45) tablets each time. There were no corresponding entries on the patient medication profiles to reflect these transactions.
- The patient medication profile showed that patient E.A. received ninety (90) tablets of diazepam on April 30, 2014 and thirty (30) tablets of diazepam on May 1, 2014. Yet the prescription information showed that the prescription was written on May 1, 2012. This prescription could not have been dispensed after November 1, 2012. As indicated above, neither of the transaction screen prints matched the profile.
- The transaction screen prints showed that patient E.A. was billed for three (3) tablets of diazepam on April 30, 2014 ($33.29 cash) and May 1, 2014 ($19.14 cash). The screen was "grey," indicating that patient E.A. was charged for repackaging.
- The label for the cassettes was dated May 1, 2014, but Board Inspector(s) were told that they were scheduled for delivery on June 27, 2014. No pharmacist signature or initials was on the label for the cassettes.

w. Further review discovered similar discrepancies between the repackaging log, patient medication profile, medication cassettes and labels, and transaction screen prints for patient M.R. Respondent De Luna explained these discrepancies as resulting, at least in part, from the practice model of the pharmacy whereby the pharmacy would send medications on a different day than it billed for those medications, would engage in partial fills, and would allegedly complete those partial fills on a subsequent date or dates. Respondent De Luna was not able to produce records demonstrating that partial fills were ever completed, or on what date, in what quantity, etc.

x. Board Inspector(s) discovered structural deficiencies in the records maintained by the pharmacy, including that they did not maintain records of deliveries to patients at facilities that would show partial fill deliveries, completing deliveries, or deliveries of repackaged medications. They also continued to keep incomplete records of medications received for repackaging.

y. Based on further review and audits conducted during the succeeding months, Board Inspector(s) also discovered, consistent with the 2011-2012 investigation, a pattern of over-filling of patient prescriptions and over-billing of patients and/or insurers, including the following:

- For patient W.K.K., RX 867004, for metformin, both the label and patient profile showed that a ninety (90) day supply (two hundred seventy (270) tablets) was billed to insurance on or about June 28, 2013. However, the refill request treated as the prescription document stated "quantity is a 30 day supply."
- For patient L.C., RX 876728, for mirtazapine, the prescription was written September 18, 2013 for thirty (30) mirtazapine 15mg with five (5) refills. The prescription was filled and billed ten (10) times between September 18, 2013 and June 13, 2014, resulting in four (4) excess fills and bills.
- For patient C.M., RXs 877299 and 877300, these prescriptions were written on September 20, 2013 to "decrease valsartan to 80mg" and "decrease atenolol to 50mg," respectively. No prescriber signed either document. No quantities were given. No refills were authorized. Respondents filled and billed RX 877299 for thirty (30) tablets of valsartan ten (10) times between September 18, 2013 and June 10, 2014, and filled and billed RX 877300 for thirty (30) tablets of atenolol ten (10) times between September 21, 2013 and June 10, 2014.
- For patient M.S., RX 874345 was an electronic prescription written on August 27, 2013 for thirty (30) tablets of risperidone 1mg with no refills. This prescription was filled and billed eleven (11) times between August 27, 2013 and June 1, 2014. And RX 905316 was an oral prescription for Zoloft 50mg. The prescription was filled and billed twice, on May 2, 2014 and June 1, 2014.

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- For patient S.C., RX 869454 was filled upon a refill request for Aricept 5mg signed and dated July 9, 2013 by a prescriber. Eleven (11) refills were added. The patient profile shows that this medication was filled and billed fourteen (14) times between May 20, 2013 and June 1, 2014.
- For patient M.C., RX 872018 for one hundred eighty (180) tablets of metoprolol 100mg was filled and billed four (4) times between September 11, 2013 and June 1, 2014, but the pharmacy was not able to produce an original prescription document. Similarly, RX 874421 for ninety (90) tablets of Namenda 10mg was filled and billed four (4) times between September 11, 2013 and June 1, 2014, but the pharmacy was not able to produce an original prescription document.
- By review of patient medication profiles for the period between January 1, 2013 and April 7, 2014, Board Inspector(s) identified numerous similar instances where prescriptions were filled and billed (to patients and/or insurance) more times than was authorized by the prescription document(s) in question. For numerous patients, Board Inspector(s) also discovered a pattern of billing whereby the pharmacy was billing thirteen (13) times during the year for a year's supply of medications. This was typically accomplished by a "break" in the billing pattern: several months of first-of-month billing followed by billing on other days of the month (with at least one overlap), followed by a return to first-day billing, resulting in thirteen (13) bills.

z. Finally, the further review and audits conducted during the succeeding months by Board Inspector(s) also revealed substantial discrepancies in the inventory records maintained by the pharmacy. These discrepancies included:

- Substantial numbers of dangerous drugs and controlled substances in the inventory of Respondent PMC Burlingame that could not be accounted for in any of the orders placed with or received from the pharmacy's wholesalers, and the presence of which could not otherwise be accounted for in pharmacy records. There were thirty (30) drugs/NDC numbers, including at least six (6) controlled substances, for which a legitimate acquisition source was not documented in pharmacy records.

- There were also twelve (12) drugs/NDCs that had been ordered but never dispensed.
- Substantial overages of drugs in the numbers dispensed plus physical inventory of the pharmacy above what should have been present based on the records of drug acquisition and disposition, including: 12,039 extra doses of amlodipine 10mg; 8609.5 extra doses of citalopram 10mg, 27,565.5 extra doses of furosemide 10mg; 9,384.5 extra doses of hydralazine 10mg; 6,206.5 extra doses of isosobide din 20mg; 19,404 extra doses of lisinopril 20mg; 11,907 extra doses of mirtazapine 15mg; 3,278.5 extra doses of mirtazapine 30mg; 1,573 extra doses of morphine sulfate ER 15mg; 240 extra doses of oxycodone 30mg; 16,170 extra doses of pantoprazole 40mg; 26,371 extra doses of simvastatin 20mg; 4,741 extra doses of Abilify 5mg (over $100,000 current market value); 3,715 extra doses of Abilify 10mg (over $75,000 current market value); 3,689 extra doses of Abilify 15mg (over $75,000 current market value); 1,386 extra doses of Abilify 20mg (over $35,000 current market value); and nine (9) other dangerous drugs/controlled substances.

81. On or about October 31, 2014, Respondent De Luna disassociated as Pharmacist in Charge (PIC) of Respondent PMC Burlingame. The pharmacy gave no notice to the Board until on or about December 4, 2014. On or about that date, Respondent PMC Burlingame proposed Respondent Poole as PIC. The Board disapproved this designation. On or about December 26, 2014, the pharmacy designated pharmacist Terry Fred Cater (RPH 28226) as the Interim PIC for the pharmacy, pursuant to Business and Professions Code section 4113, subdivision (e).

82. On or about November 6, 2014, Mr. Cater, then acting as a consultant, confirmed that the pharmacy had changed the labeling on its "repackaging" containers to conform to section(s) 4052.7 and/or 4076 of the Code, including by recording the name and address of the originally-dispensing pharmacy. He also confirmed that Respondent PMC Burlingame was now keeping records of signature logs for all deliveries, so as to have more complete disposition records.

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CAUSES FOR DISCIPLINE FROM THE 2014-2015 INVESTIGATION

AS TO RESPONDENTS PMC BURLINGAME, POOLE, DE LUNA, AND JIANG

SEVENTH CAUSE FOR DISCIPLINE

(Failure to Timely Register for Board E-Mail Notification List)

83. Respondents PMC Burlingame, Poole, De Luna, and Jiang are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) and/or 4302 of the Code, by reference to section 4013 of the Code, for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 80 above, Respondents failed to register an e-mail address for the Board's e-mail notification list within sixty (60) days of licensure of the pharmacy on September 15, 2010, or to register or update an e-mail address with the Board thereafter prior to April 10, 2014.

AS TO RESPONDENTS PMC BURLINGAME, DE LUNA, AND JIANG

EIGHTH CAUSE FOR DISCIPLINE

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

84. Respondents PMC Burlingame, De Luna, and Jiang, are subject to discipline under section(s) 4301(f) and/or 4113(c) and/or 4302 of the Code, for acts involving moral turpitude, dishonesty, fraud, deceit, or corruption, including, as described above in paragraph 80:

- Accepting returns of dangerous drugs and controlled substances, particularly after professing that controlled substances would not be accepted for return;
- Engaging in widespread "repackaging" of drugs already packaged for unit dose;
- Labeling drugs dispensed with quantities significantly greater than dispensed;
- Disclosing or exposing patient health information;
- "Overfilling" medication stock bottles with drugs from uncertain sources;
- Thus, possessing, selling, and/or dispensing adulterated or misbranded drugs;
- Billing patients for repackaging transactions;
- Billing in full for prescriptions only partially dispensed;

- Failing to record dispensed medications on patient medication profiles;
- Recording false information regarding dispensed medications on patient profiles;
- Dispensing drugs based on incomplete, inadequate, or insufficient prescriptions;
- Falsely representing compliance with CURES transmission requirements;
- Failing to adequately track "repackaging" drugs received or delivered;
- Engaging in misleading and confusing packaging and dispensing protocols;
- Creating or dispensing false refills, and/or over-filling prescriptions;
- Over-billing patients or insurers for more than a year's supply of medication;
- Dispensing more medications than could be accounted for by acquisitions; and/or
- Maintaining overstocks of drugs that could not be traced to any source.

NINTH CAUSE FOR DISCIPLINE

(Incomplete Inventory and/or Records of Acquisition and/or Disposition)

85. Respondents PMC Burlingame, De Luna, and Jiang are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) and/or 4302 of the Code, by reference to section(s) 4081, 4105, and/or 4332 of the Code, and/or California Code of Regulations, title 16, section 1718, for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 80 above, Respondents failed to maintain an accurate, complete, and readily retrievable inventory and/or records of acquisition and disposition of all dangerous drugs.

TENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

86. Respondents PMC Burlingame, De Luna, and Jiang are subject to discipline under section(s) 4301 and/or 4302 of the Code in that Respondents, as described above and below in paragraphs 80-85 and 87-103, engaged in unprofessional conduct.

AS TO RESPONDENTS PMC BURLINGAME, DE LUNA, AND KO

ELEVENTH CAUSE FOR DISCIPLINE

(Inaccurate Date(s) in Dispensing Record(s))

87. Respondents PMC Burlingame, De Luna, and Ko are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, by reference to California Code of Regulations, title 16, section 1707.1, for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 80 above, Respondents dispensed or were responsible for dispensing medications on dates other than the dates labeled and maintained in patient medication histories/profiles, resulting in discrepancies therein.

TWELFTH CAUSE FOR DISCIPLINE

(Deviation(s) From Prescription(s))

88. Respondents PMC Burlingame, De Luna, and Ko are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, by reference to California Code of Regulations, title 16, section 1716, for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 80 above, Respondents dispensed or were responsible for the dispensing of medications in quantities other than were prescribed.

THIRTEENTH CAUSE FOR DISCIPLINE

(Inaccurate Date(s) in Dispensing Record(s))

89. Respondents PMC Burlingame, De Luna, and Ko are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, by reference to California Code of Regulations, title 16, section 1717, subdivision (b), for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or

assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 80 above, Respondents dispensed or were responsible for the dispensing of medications on dates other than dates labeled and/or recorded in pharmacy records.

FOURTEENTH CAUSE FOR DISCIPLINE

(Inadequate Compounding Record(s))

90. Respondents PMC Burlingame, De Luna, and Ko are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, by reference to California Code of Regulations, title 16, section 1735.3, for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 80 above, Respondents maintained inadequate compounding records.

FIFTEENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Compounding Staff Training Record(s))

91. Respondents PMC Burlingame, De Luna, and Ko are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, by reference to California Code of Regulations, title 16, section 1735.7, for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 80 above, Respondents maintained no compounding staff training records.

AS TO RESPONDENTS PMC BURLINGAME AND DE LUNA

SIXTEENTH CAUSE FOR DISCIPLINE

(Dispensing Pursuant to Inadequate and/or Improper Prescription Documents)

92. Respondents PMC Burlingame and De Luna are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, by reference to section(s) 4040 and/or 4059 of the Code, and/or Health and Safety Code section(s) 11159.2, 11162.1, 11164, and/or 11167.5, for

violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 80 above, Respondents dispensed or were responsible for dispensing dangerous drugs and/or controlled substances pursuant to "prescription" documents not meeting the requirements therefor.

SEVENTEENTH CAUSE FOR DISCIPLINE

(Improper Acceptance of Dangerous Drug/Controlled Substance Returns)

93. Respondents PMC Burlingame and De Luna are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, by reference to section(s) 4043 and/or 4160 of the Code, and/or 21 U.S.C. § 822 and/or 21 C.F.R. § 1301.11, for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 80 above, Respondents accepted returns/take-backs of dangerous drugs and/or controlled substances without being licensed as a reverse distributor and/or without other appropriate authorization to do so.

EIGHTEENTH CAUSE FOR DISCIPLINE

(Non-Compliant Drug Repackaging)

94. Respondents PMC Burlingame and De Luna are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, by reference to section 4052.7 of the Code, for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 80 above, Respondents engaged in repackaging of dangerous drugs and/or controlled substances without meeting the statutory requirements for repackaging, including that they failed to include on the repackaged drug(s) the name and address of the originally-dispensing pharmacy.

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NINETEENTH CAUSE FOR DISCIPLINE

(Dispensing Dangerous Drug in Inadequately Labeled Container)

95. Respondents PMC Burlingame and De Luna are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, by reference to section(s) 4076 and/or 4077 of the Code, for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 80 above, Respondents dispensed medications in containers lacking the requisite information, including: containers that were not labeled with an accurate quantity; containers with dates that were not the accurate dates of dispensing and/or did not correspond to the patient medication profiles; and/or containers that were labeled with duplicate and/or interlineated manufacturer names.

TWENTIETH CAUSE FOR DISCIPLINE

(Violation(s) of Pharmacist in Charge Requirement(s))

96. Respondents PMC Burlingame and De Luna are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, by reference to section(s) 4101, 4113, and/or 4305 of the Code, for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 80 above, Respondents: failed to notify the Board within thirty (30) when Respondent De Luna ceased acting as Pharmacist in Charge (PIC) on or about October 31, 2014; and/or operated without a PIC between on or about October 31, 2014 and on or about December 26, 2014.

TWENTY-FIRST CAUSE FOR DISCIPLINE

(Selling, Delivering, Holding, or Offering For Sale Adulterated or Misbranded Drugs)

97. Respondents PMC Burlingame and De Luna are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, and/or Health and Safety Code section(s) 111250, 111255, 111295, 111305, 111330, 111335, 111340, 111390, 111395, and/or 111440, and/or 21

U.S.C. § 351 and/or 21 U.S.C. § 352, for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 80 above, Respondents sold, delivered, held, or offered for sale drugs that were adulterated and/or misbranded, including those "overfilled" bottles that were, *inter alia*, "prepared, packed, or held under conditions whereby" they "may have been contaminated with filth, or whereby" they "may have been rendered injurious to health," where their packaging was "false or misleading in any particular," did not contain "an accurate statement of the quantity of the contents (weight, measure, or numerical count)," and/or "[t]he contents of the original package have been, wholly or partly, removed and replaced with other material in the package."

TWENTY-SECOND CAUSE FOR DISCIPLINE

(Failure(s) to Offer Patient Consultation(s))

98. Respondents PMC Burlingame and De Luna are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, by reference to California Code of Regulations, title 16, section 1707.2 for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 80 above, Respondents failed to provide or offer consultation(s) to patient(s) of the pharmacy.

TWENTY-THIRD CAUSE FOR DISCIPLINE

(Failure to Have Dedicated Pharmacy Sink)

99. Respondents PMC Burlingame and De Luna are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, by reference to California Code of Regulations, title 16, section 1714, subdivision (c), for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 80 above, the pharmacy lacked a dedicated sink with hot and cold water.

TWENTY-FOURTH CAUSE FOR DISCIPLINE

(Failure to Complete Pharmacy Self-Assessment Form(s))

100. Respondents PMC Burlingame and De Luna are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, by reference to California Code of Regulations, title 16, section 1715, subdivision (a) and/or California Code of Regulations, title 16, section 1735.2, subdivision (j), for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 80 above, the pharmacy/Pharmacist in Charge (PIC) failed to complete the biennial pharmacy self-assessment form required to be completed on or prior to July 1, 2013, and/or the pharmacy/PIC failed to complete the pharmacy self-assessment form for compounding pharmacies that was required to be completed before any drug was compounded in the pharmacy.

TWENTY-FIFTH CAUSE FOR DISCIPLINE

(Failure to Report Controlled Substance Dispensing to CURES)

101. Respondents PMC Burlingame and De Luna are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, and/or Health and Safety Code section 11165, for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 80 above, between on or about January 1, 2012 and on or about April 8, 2014, the pharmacy did not appropriately or accurately transmit controlled substance dispensing data to CURES.

TWENTY-SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Compounding Policy and Procedure Manual)

102. Respondents PMC Burlingame and De Luna are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, by reference to California Code of Regulations, title 16, section 1735.5, for violating statutes regulating controlled substances or dangerous drugs,

and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 80 above, Respondents failed to maintain a written policy and procedure manual for compounding.

TWENTY-SEVENTH CAUSE FOR DISCIPLINE

(Unconsented Disclosure and/or Exposure of Patient Health Information)

103. Respondents PMC Burlingame and De Luna are subject to discipline under section(s) 4301(j) and/or (o) and/or 4113(c) of the Code, by reference to California Code of Regulations, title 16, section 1764, Civil Code section 56.10, and/or 45 C.F.R. § 164.502, for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 80 above, Respondents disclosed and/or exposed, caused to be disclosed and/or exposed, and/or failed to safeguard from disclosure and/or exposure, patient health information that was placed into the pharmacy dumpster.

OTHER MATTERS

104. Pursuant to section 4307 of the Code, if discipline is imposed on Pharmacy License No. PHY 48762, issued to Nursing Care Pharmacies Inc. dba PMC Pharmacy, at 901 Campus Drive, #108, Daly City, CA 94015, Barbara Jiang, Chief Executive Officer and owner (Respondent PMC Daly City), or on Pharmacy License No. PHY 50377, issued to Nursing Care Pharmacies Inc. dba PMC Pharmacy, at 843 Malcolm Road, Burlingame, CA 94010, Barbara Jiang, Chief Executive Officer and owner (Respondent PMC Burlingame) and if Barbara Jiang (Respondent Jiang), while acting as manager, administrator, owner, member, officer, director, associate, or partner, had knowledge of or knowingly participated in any conduct for which either license was disciplined, Respondent Jiang shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if either license is placed on probation or, if either license is revoked, until it is reinstated.

DISCIPLINE CONSIDERATIONS

105. To assist in determining the proper level of discipline, if any, to be imposed on Respondent PMC Daly City, Respondent PMC Burlingame, and/or Respondent Poole, Complainant further alleges the following license history for each of these Respondents:

a. On or about May 22, 2008, in a prior disciplinary action titled *In the Matter of the Statement of Issues Against Nursing Care Pharmacies, Inc. dba PMC Pharmacy*, Case No. 3025 before the Board of Pharmacy, Respondent PMC Daly City's Pharmacy License was subject to disciplinary action imposed by the Board as follows:

i. On or about January 16, 2008, Statement of Issues No. 3025 was filed before the Board, with regard to Respondent PMC Daly City's application for a Community Pharmacy Permit submitted on or about July 20, 2007, alleging that the application was subject to denial pursuant to Business and Professions Code section(s) 480(a)(2), 480(a)(3), 4110, 4300(c), 4301(f) and/or 4301(o), and/or California Code of Regulations, title 16, section 1709, because Respondent PMC Daly City had participated in or benefited from a transfer of ownership of the pharmacy that had taken place on or about January 1, 2006, which had not been reported to the Board, and by so doing had operated a pharmacy without a valid permit, had failed to notify the Board of an ownership change, and had engaged in dishonest, fraudulent, or deceitful acts.

ii. In or about February 2008, Respondent PMC Daly City agreed to a Stipulated Settlement and Disciplinary Order admitting to all of the charges and allegations alleged in the Statement of Issues, and agreeing to accept the stipulated Disciplinary Order, which specified that upon satisfaction of all statutory and regulatory requirements, a pharmacy license would be issued to Respondent PMC Daly City and immediately revoked, with the revocation stayed in favor of a period of probation of five (5) years, on specified terms and conditions.

iii. By Decision and Order of the Board effective May 21, 2008, the stipulation was made the decision of the Board, issuing Pharmacy License No. 48762 to Respondent PMC Daly City, which was immediately revoked, with revocation stayed in favor of a period of probation of five (5) years on specified terms and conditions. That Decision and Order is now final and is incorporated by reference as if fully set forth herein.

b. On or about June 22, 2011, Citation No. CI 2010 46206, with a fine of $2,000.00, was issued to Respondent PMC Daly City alleging violations of (i) California Code of Regulations, title 16, section 1714, subdivisions (d) and (e), because on one or more dates in August 2010 only Respondent Jiang and her relative were in possession of keys to the pharmacy, and neither the pharmacist in charge nor the staff pharmacist on duty were ever allowed possession of the key to the pharmacy and (ii) Business and Professions Code section 4115, subdivision (f)(1), because on one or more dates in August 2010, there was only one pharmacist scheduled or on duty while the number of pharmacy technicians scheduled or on duty exceeded one. That citation is now final and is incorporated by reference as if fully set forth herein.

c. On or about June 16, 2011, Citation No. CI 2010 47415, with a fine of $2,000.00, was issued to Respondent PMC Burlingame alleging violations of (i) California Code of Regulations, title 16, section 1714, subdivision (e), because on one or more dates in February 2011, the key to the pharmacy was in the possession of a non-pharmacist manager who used the key to open the pharmacy, and the key was not maintained in a tamper-evident container reserved for delivery to a pharmacist or used to provide emergency access, (ii) Business and Professions Code section 4115, subdivision (f)(1), because on one or more dates in February 2011, there was only one pharmacist scheduled or on duty while the number of pharmacy technicians scheduled or on duty exceeded one, and (iii) Business and Professions Code section 4115, subdivision (e), because on one or more dates in or between December 2010 and February 2011, an individual acted as a pharmacy technician without a valid pharmacy technician license issued by the Board. That citation is now final and is incorporated by reference as if fully set forth herein.

d. On or about June 16, 2011, Citation No. CI 2010 48547, with a fine of $1,250.00, was issued to Respondent Poole, in his capacity as Pharmacist in Charge (PIC) for Respondent PMC Burlingame, alleging violations of (i) California Code of Regulations, title 16, section 1714, subdivision (e), because on one or more dates in February 2011, the key to the pharmacy was in the possession of a non-pharmacist manager who used the key to open the pharmacy, and the key was not maintained in a tamper-evident container reserved for delivery to a pharmacist or used to provide emergency access, (ii) Business and Professions Code section 4115, subdivision (f)(1),

because on one or more dates in February 2011, there was only one pharmacist scheduled or on duty while the number of pharmacy technicians scheduled or on duty exceeded one, and (iii) Business and Professions Code section 4115, subdivision (e), because on one or more dates in or between December 2010 and February 2011, an individual acted as a pharmacy technician without a valid pharmacy technician license issued by the Board. That citation is now final and is incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Pharmacy License No. PHY 48762, issued to Nursing Care Pharmacies Inc. dba PMC Pharmacy, at 901 Campus Drive, #108, Daly City, CA 94015, Barbara Jiang, Chief Executive Officer and owner (Respondent PMC Daly City);

2. Revoking or suspending Pharmacist License No. RPH 31278, issued to Angela Po-Chu Yeung (Respondent Yeung);

3. Revoking or suspending Pharmacy License No. PHY 50377, issued to Nursing Care Pharmacies Inc. dba PMC Pharmacy, at 843 Malcolm Road, Burlingame, CA 94010, Barbara Jiang, Chief Executive Officer and owner (Respondent PMC Burlingame);

4. Revoking or suspending Pharmacist License No. RPH 23729, issued to George A. Poole (Respondent Poole);

5. Revoking or suspending Pharmacist License No. RPH 61593, issued to Kimberly Mae De Luna (Respondent De Luna);

6. Revoking or suspending Pharmacy Technician License No. TCH 52663, issued to Barbara Jiang (Respondent Jiang);

7. Revoking or suspending Pharmacist License No. RPH 44077, issued to Ronald Wing Ko (Respondent Ko);

8. Prohibiting Barbara Jiang (Respondent Jiang) from serving as manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy License No. PHY 48762 or Pharmacy License No. PHY 50377 are placed on probation or, if either license is revoked, until the revoked license is reinstated;

9. Ordering Respondents, jointly and severally, to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

10. Taking such other and further action as is deemed necessary and proper.

DATED: 10/26/15

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

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

In the Matter of the Accusation Against: **PMC PHARMACY** **901 Campus Drive, # 108** **Daly City, CA 94015** **Pharmacy License No. PHY 48762** **ANGELA PO-CHU YEUNG** **2830 34th Avenue** **San Francisco, CA 94116** **Pharmacist License No. RPH 31278** **PMC PHARMACY** **843 Malcolm Road** **Burlingame, CA 94010** **Pharmacy License No. PHY 50377** **GEORGE A. POOLE** **1245 Encina Drive** **Millbrae, CA 94030** **Pharmacist License No. RPH 23729** **KIMBERLY MAE DE LUNA** **246 Dennise Drive** **Daly City, CA 94015** **Pharmacist License No. RPH 61593** **and** **BARBARA JIANG** **901 Campus Drive, # 108** **Daly City, CA 94015** **Pharmacy Technician License No. TCH 52663** Respondents.	Case Nos. 4496 and 4528 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about May 22, 2008, the Board of Pharmacy issued Pharmacy License No. PHY 48762 to Nursing Care Pharmacies Inc. dba PMC Pharmacy, at 901 Campus Drive, #108, Daly City, CA 94015, Barbara Jiang, Chief Executive Officer and owner (Respondent PMC Daly City). The Pharmacy License was in full force and effect at all times relevant to the charges brought herein and will expire on May 1, 2014, unless renewed.

3. On or about August 3, 1977, the Board of Pharmacy issued Pharmacist License No. RPH 31278 to Angela Po-Chu Yeung (Respondent Yeung). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2014, unless renewed. Between on or about May 22, 2008 and on or about September 1, 2010, Respondent Yeung served and/or was listed in records maintained with or by the Board as Pharmacist in Charge (PIC) for Respondent PMC Daly City.

4. On or about September 15, 2010, the Board of Pharmacy issued Pharmacy License No. PHY 50377 to Nursing Care Pharmacies Inc. dba PMC Pharmacy, at 843 Malcolm Road, Burlingame, CA 94010, Barbara Jiang, Chief Executive Officer and owner (Respondent PMC Burlingame). The Pharmacy License was in full force and effect at all times relevant to the charges brought herein and will expire on September 1, 2014, unless renewed.

5. On or about August 10, 1964, the Board of Pharmacy issued Pharmacist License No. RPH 23729 to George A. Poole (Respondent Poole). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2014, unless renewed. Between on or about November 1, 2010 and on or about January 1, 2012, Respondent Poole served and/or was listed in records maintained with or by the Board as Pharmacist in Charge (PIC) for Respondent PMC Burlingame.

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6. On or about October 2, 2008, the Board of Pharmacy issued Pharmacist License No. RPH 61593 to Kimberly Mae De Luna (Respondent De Luna). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2014, unless renewed. Since on or about January 2, 2012, Respondent De Luna has served and/or has been listed in records maintained with or by the Board as Pharmacist in Charge (PIC) for Respondent PMC Burlingame.

7. On or about November 17, 2003, the Board of Pharmacy issued Pharmacy Technician License No. TCH 52663 to Barbara Jiang (Respondent Jiang). The Pharmacy Technician License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2013, unless renewed. At all times relevant to the charges brought herein, Respondent Jiang has served as officer and part-owner of Respondent PMC Daly City and Respondent PMC Burlingame.

JURISDICTION

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

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

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

11. Section 4300.1 of the Code provides that the expiration, cancellation, forfeiture, or suspension of a Board-issued license, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee, shall not deprive the Board of jurisdiction to commence or proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license.

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STATUTORY AND REGULATORY PROVISIONS

12. Section 4301 of the Code provides, in pertinent part, that the Board shall take action against any holder of a license who is guilty of "unprofessional conduct," defined to include, but not be 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.

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

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

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

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

14. Section 4081 of the Code provides, in pertinent part, that all records of manufacture, sale, acquisition, or disposition of dangerous drugs or dangerous devices shall be kept open to inspection and retained for at least three years, that a current inventory shall be kept by every pharmacy that maintains a stock of dangerous drugs or dangerous devices, and that the owner(s), officer(s), partner(s), and pharmacist in charge or designated representative in charge shall be jointly responsible for maintaining the records and keeping the inventory.

15. Section 4105 of the Code requires, in pertinent part, that unless a waiver is granted by the board, all records and other documentation of the acquisition and disposition of dangerous drugs and devices by any entity licensed by the board be retained on the licensed premises, in a readily retrievable form, for three years from the date of making.

16. Section 4332 of the Code makes it unlawful for any person: to fail, neglect, or refuse to maintain the records required by Section 4081; or, when called upon by an authorized officer

or a member of the board, to fail, neglect, or refuse to produce or provide the records within a reasonable time; or to willfully produce or furnish records that are false.

17. California Code of Regulations, title 16, section 1707.1, and subdivision (a)(1)(B)(3) thereof provide, in pertinent part, that a pharmacy shall maintain medication profiles on all of its patients who have prescriptions filled therein except when the pharmacist has reasonable belief that the patient will not continue to obtain prescription medications from that pharmacy, and the patient medication record shall make immediately retrievable during the pharmacy's normal operating hours information including the date on which a drug was dispensed or refilled.

18. California Code of Regulations, title 16, section 1716 provides, in pertinent part, that pharmacists shall not deviate from the requirements of a prescription except upon the prior consent of the prescriber or to select the drug product in accordance with Section 4073 of the Code [pertaining to substitution of generic for brand name].

19. California Code of Regulations, title 16, section 1717, subdivision (b) requires, in pertinent part, that for each prescription on file, certain information shall be maintained and be readily retrievable in the pharmacy, including the date dispensed, and the name or initials of the dispensing pharmacist. All prescriptions filled or refilled by an intern pharmacist must also be initialed by the supervising pharmacist before they are dispensed.

20. California Code of Regulations, title 16, section 1718, states:

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

"The controlled substances inventories required by Title 21, CFR, Section 1304 shall be available for inspection upon request for at least 3 years after the date of the inventory."

COST RECOVERY

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

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FACTUAL BACKGROUND

22. On or about August 11, 2011, the Board received a complaint from a family member of patient R.K.[1] alleging that Respondent PMC Daly City had engaged in mistaken or fraudulent billing of both patient R.K. (as to co-pays) and his insurance provider(s), with regard to drugs dispensed to patient R.K. by Respondent PMC Daly City in/via a nearby assisted living facility.

23. Board of Pharmacy Inspector(s) conducted an investigation of the complaint, during which a review was conducted of medications dispensed and billed to patient R.K, as well as a sample of twenty (20) other patients also resident in the same assisted living facility, and/or their insurance provider(s), by Respondent PMC Daly City and/or Respondent PMC Burlingame, for differing time periods between in or about June 2009 and in or about March 2012.

24. That review revealed a pattern and practice of billing and dispensing by respondent pharmacies, under the supervision of their respective pharmacists in charge and shared CEO and primary owner (Respondent Jiang), that included:

a. On several occasions, Respondent PMC Daly City processed a prescription written for patient R.K. calling for a particular quantity of the prescribed drug (60, 30, or 15 doses, depending on the drug), but actually dispensed to patient R.K. some quantity less than the prescribed amount (the amount less varying from a shortage of 3 doses to a shortage of 42 doses).

b. Likewise, on at least two occasions, Respondent PMC Burlingame processed a prescription written for patient R.K. calling for a particular quantity of the prescribed drug (30 or 15 doses), but actually dispensed to patient R.K. some quantity less than the prescribed amount (one shortage was 3 doses and the other was 7 doses);

c. On each of these occasions, Respondents PMC Daly City and/or PMC Burlingame billed patient R.K. and/or his insurer(s) for the full amount(s) of the prescribed doses.

d. On several other occasions, Respondents PMC Daly City and/or PMC Burlingame billed patient(s) R.K., D.K., P.S., J.H., M.M., E.R., and/or G.G., and/or their respective insurer(s), for prescriptions that were never actually dispensed to the patient(s).

[1] The full name will be revealed to Respondents, if requested, during discovery.

e. As a result of the foregoing discrepancy between drugs actually dispensed and those for which pharmacy records showed dispensing transactions, the inventory records (i.e., the records of acquisition and disposition) maintained by Respondents PMC Daly City and/or PMC Burlingame were not maintained in a complete and accurate form.

f. On several other occasions, Respondents PMC Daly City and/or PMC Burlingame dispensed prescriptions to patient(s) R.K., D.K., P.S., J.H., M.M., E.R., and/or G.G. with labels dated on or about the first of the month dispensed, but in fact the prescriptions were processed and billed on various dates later in the month, so that the prescription dates maintained in the pharmacy database(s) did not match the dates on which the prescriptions were dispensed.

g. As a result of the foregoing discrepancy between dates labeled as dispensed, and dates actually dispensed, the patient history/medication profile information maintained by Respondents PMC Daly City and/or PMC Burlingame for patient(s) R.K., D.K., P.S., J.H., M.M., E.R., and/or G.G. was not accurate and/or complete.

CAUSES FOR DISCIPLINE

AS TO ALL RESPONDENTS

FIRST CAUSE FOR DISCIPLINE

(Incomplete Inventory and/or Records of Acquisition and/or Disposition)

25. Respondents are each and severally subject to discipline under section 4301(j) and/or (o) and/or section 4113(c) of the Code, by reference to section(s) 4081, 4105, and/or 4332 of the Code, and/or California Code of Regulations, title 16, section 1718, for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 24 above, Respondents failed to maintain an accurate, complete, and readily retrievable inventory and/or records of acquisition and disposition of all dangerous drugs in the pharmacy inventory.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

26. Respondents are each and severally subject to discipline under section 4301 of the Code in that Respondents, as described above and below, engaged in unprofessional conduct.

AS TO PMC RESPONDENTS AND RESPONDENT JIANG

THIRD CAUSE FOR DISCIPLINE

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

27. Respondents PMC Daly City, PMC Burlingame, and Jiang, are each and severally subject to discipline under section 4301(f) of the Code, for acts involving moral turpitude, dishonesty,fraud, deceit, or corruption, in that, as described in paragraph 24 above, Respondents billed in full for prescriptions only partially dispensed, and/or for prescriptions never delivered.

AS TO ALL RESPONDENTS EXCEPT RESPONDENT JIANG

FOURTH CAUSE FOR DISCIPLINE

(Inaccurate Date(s) in Dispensing Record(s))

28. Respondents PMC Daly City, Yeung, PMC Burlingame, Poole, and De Luna are each and severally subject to discipline under section 4301(j) and/or (o) and/or section 4113(c) of the Code, by reference to California Code of Regulations, title 16, section 1707.1, for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 24 above, Respondents dispensed or were responsible for dispensing medications on dates other than the dates labeled and maintained in patient medication histories/profiles, resulting in discrepancies therein.

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FIFTH CAUSE FOR DISCIPLINE

(Deviation(s) From Prescription(s))

29. Respondents PMC Daly City, Yeung, PMC Burlingame, Poole, and De Luna are each and severally subject to discipline under section 4301(j) and/or (o) and/or section 4113(c) of the Code, by reference to California Code of Regulations, title 16, section 1716, for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 24 above, Respondents dispensed or were responsible for the dispensing of medications in quantities other than were prescribed.

SIXTH CAUSE FOR DISCIPLINE

(Inaccurate Date(s) in Dispensing Record(s))

30. Respondents PMC Daly City, Yeung, PMC Burlingame, Poole, and De Luna are each and severally subject to discipline under section 4301(j) and/or (o) and/or section 4113(c) of the Code, by reference to California Code of Regulations, title 16, section 1717, subdivision (b), for violating statutes regulating controlled substances or dangerous drugs, and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy, in that, as described in paragraph 24 above, Respondents dispensed or were responsible for the dispensing of medications on dates other than the dates labeled and maintained in the pharmacy database(s), resulting in inaccuracies therein.

DISCIPLINE CONSIDERATIONS

31. To assist in determining the proper level of discipline, if any, to be imposed on Respondent PMC Daly City, Respondent PMC Burlingame, and/or Respondent Poole, Complainant further alleges the following license history for each of these Respondents:

a. On or about May 22, 2008, in a prior disciplinary action titled *In the Matter of the Statement of Issues Against Nursing Care Pharmacies, Inc. dba PMC Pharmacy*, Case No. 3025

before the Board of Pharmacy, Respondent PMC Daly City's Pharmacy License was subject to disciplinary action imposed by the Board as follows:

i. On or about January 16, 2008, Statement of Issues No. 3025 was filed before the Board, with regard to Respondent PMC Daly City's application for a Community Pharmacy Permit submitted on or about July 20, 2007, alleging that the application was subject to denial pursuant to Business and Professions Code section(s) 480(a)(2), 480(a)(3), 4110, 4300(c), 4301(f) and/or 4301(o), and/or California Code of Regulations, title 16, section 1709, because Respondent PMC Daly City had participated in or benefited from a transfer of ownership of the pharmacy that had taken place on or about January 1, 2006, which had not been reported to the Board, and by so doing had operated a pharmacy without a valid permit, had failed to notify the Board of an ownership change, and had engaged in dishonest, fraudulent, or deceitful acts.

ii. In or about February 2008, Respondent PMC Daly City agreed to a Stipulated Settlement and Disciplinary Order admitting to all of the charges and allegations alleged in the Statement of Issues, and agreeing to accept the stipulated Disciplinary Order, which specified that upon satisfaction of all statutory and regulatory requirements, a pharmacy license would be issued to Respondent PMC Daly City and immediately revoked, with the revocation stayed in favor of a period of probation of five (5) years, on specified terms and conditions.

iii. By Decision and Order of the Board effective May 21, 2008, the stipulation was made the decision of the Board, issuing Pharmacy License No. 48762 to Respondent PMC Daly City, which was immediately revoked, with revocation stayed in favor of a period of probation of five (5) years on specified terms and conditions. That Decision and Order is now final and is incorporated by reference as if fully set forth herein.

b. On or about June 22, 2011, Citation No. CI 2010 46206, with a fine of $2,000.00, was issued to Respondent PMC Daly City alleging violations of (i) California Code of Regulations, title 16, section 1714, subdivisions (d) and (e), because on one or more dates in August 2010 only Respondent Jiang and her relative were in possession of keys to the pharmacy, and neither the pharmacist in charge nor the staff pharmacist on duty were ever allowed possession of the key to the pharmacy and (ii) Business and Professions Code section 4115, subdivision (f)(1), because on

one or more dates in August 2010, there was only one pharmacist scheduled or on duty while the number of pharmacy technicians scheduled or on duty exceeded one. That citation is now final and is incorporated by reference as if fully set forth herein.

c. On or about June 16, 2011, Citation No. CI 2010 47415, with a fine of $2,000.00, was issued to Respondent PMC Burlingame alleging violations of (i) California Code of Regulations, title 16, section 1714, subdivision (e), because on one or more dates in February 2011, the key to the pharmacy was in the possession of a non-pharmacist manager who used the key to open the pharmacy, and the key was not maintained in a tamper-evident container reserved for delivery to a pharmacist or use to provide emergency access, (ii) Business and Professions Code section 4115, subdivision (f)(1), because on one or more dates in February 2011, there was only one pharmacist scheduled or on duty while the number of pharmacy technicians scheduled or on duty exceeded one, and (iii) Business and Professions Code section 4115, subdivision (e), because on one or more dates in or between December 2010 and February 2011, an individual acted as a pharmacy technician without a valid pharmacy technician license issued by the Board. That citation is now final and is incorporated by reference as if fully set forth herein.

d. On or about June 16, 2011, Citation No. CI 2010 48547, with a fine of $1,250.00, was issued to Respondent Poole, in hs capacity as Pharmacist in Charge (PIC) for Respondent PMC Burlingame, alleging violations of i) California Code of Regulations, title 16, section 1714, subdivision (e), because on one or more dates in February 2011, the key to the pharmacy was in the possession of a non-pharmacist manager who used the key to open the pharmacy, and the key was not maintained in a tamper-evident container reserved for delivery to a pharmacist or use to provide emergency access, (ii) Business and Professions Code section 4115, subdivision (f)(1), because on one or more dates in February 2011, there was only one pharmacist scheduled or on duty while the number of pharmacy technicians scheduled or on duty exceeded one, and (iii) Business and Professions Code section 4115, subdivision (e), because on one or more dates in or between December 2010 and February 2011, an individual acted as a pharmacy technician without a valid pharmacy technician license issued by the Board. That citation is now final and is incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Pharmacy License No. PHY 48762, issued to Nursing Care Pharmacies Inc. dba PMC Pharmacy, at 901 Campus Drive, #108, Daly City, CA 94015, Barbara Jiang, Chief Executive Officer and owner (Respondent PMC Daly City);

2. Revoking or suspending Pharmacist License No. RPH 31278, issued to Angela Po-Chu Yeung (Respondent Yeung);

3. Revoking or suspending Pharmacy License No. PHY 50377, issued to Nursing Care Pharmacies Inc. dba PMC Pharmacy, at 843 Malcolm Road, Burlingame, CA 94010, Barbara Jiang, Chief Executive Officer and owner (Respondent PMC Burlingame);

4. Revoking or suspending Pharmacist License No. RPH 23729, issued to George A. Poole (Respondent Poole).

5. Revoking or suspending Pharmacist License No. RPH 61593, issued to Kimberly Mae De Luna (Respondent De Luna);

6. Revoking or suspending Pharmacy Technician License No. TCH 52663, issued to Barbara Jiang (Respondent Jiang);

7. Ordering Respondents, jointly and severally, to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

8. Taking such other and further action as is deemed necessary and proper.

DATED: 10/21/13

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

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