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

In the Matter of the Accusation Against: **SIXTH AVENUE PHARMACY** **2121 Fifth Avenue** **San Diego, CA 92101** **Pharmacy Permit No. PHY 46288,** **and** **ALMA JEAN LOECHLER CHAPPELL** **6641 Bluefield Court** **San Diego, CA 92120** **Pharmacist License No. RPH 27119** Respondents.	Case No. 5194 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about April 5, 2018, Complainant Virginia Herold, in her official capacity as the Executive Officer of the Board of Pharmacy, Department of Consumer Affairs, filed Accusation No. 5194 against Sixth Avenue Pharmacy (Respondent Pharmacy) and Alma Jean Loechler Chappell (Respondent Chappell) before the Board of Pharmacy. (Accusation attached as Exhibit A.)

2. On or about June 6, 2003, the Board of Pharmacy (Board) issued Pharmacy Permit No. PHY 46288 to Respondent Pharmacy. The Pharmacy Permit expired on February 18, 2014, and has not been renewed.

3. On or about June 9, 1971, the Board of Pharmacy issued Pharmacist License Number RPH 27119 to Respondent Chappell. The Pharmacist License expired on October 31, 2015, and has not been renewed.

3. On or about April 10, 2018, Respondents were served by Certified and First Class Mail copies of the Accusation No. 5194, Statement to Respondent, Notice of Defense, Request for Discovery, Discovery Statutes (Government Code sections 11507.5, 11507.6, and 11507.7), and Notice of Hearing. Respondent Pharmacy was served at its address of record which, pursuant to Business and Professions Code section 4100, is required to be reported and maintained with the Board. Respondent Pharmacy's address of record was and is: 2121 Fifth Avenue, San Diego, CA 92101. Both the Certified and First Class copies of the pleadings were returned by the US Mail, marked "unable to forward."

4. The same pleadings were served upon Respondent Chappell by Certified and First Class Mail to her address of record which was and is 6641 Bluefield Court, San Diego, CA 92120. None of the mailings to this address were returned by the US Mail.[1]

5. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c) and/or Business & Professions Code section 124.

6. Government Code section 11506(c) states, in pertinent part:

> (c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense . . . and the notice shall be deemed a specific denial of all parts of the accusation . . . not expressly admitted. Failure to file a notice of defense . . . shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

[1] Respondent's daughter sent a letter signed by her mother via email to the Office of the Attorney General stating that her mother was in hospice and would not be filing a notice of defense contesting the accusation.

7. The Board takes official notice of its records and the fact that Respondents failed to file a Notice of Defense within 15 days after service upon them of the Accusation, and therefore waived their right to a hearing on the merits of Accusation No. 5194.

8. California Government Code section 11520(a) states, in pertinent part:

> (a) If the respondent either fails to file a notice of defense . . . or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent . . . .

9. Pursuant to its authority under Government Code section 11520, the Board finds Respondents are in default. The Board will take action without further hearing and, based on the relevant evidence contained in the Default Decision Evidence Packet in this matter, as well as taking official notice of all the investigatory reports, exhibits and statements contained therein on file at the Board's offices regarding the allegations contained in Accusation No. 5194, finds that the charges and allegations in Accusation No. 5194, are separately and severally, found to be true and correct by clear and convincing evidence.

10. The Board finds that the actual costs for Investigation and Enforcement are $48,170.50 as of May 1, 2018.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Sixth Avenue Pharmacy and Respondent Chappell have subjected Pharmacy Permit No. PHY 46288 and Pharmacist License No. RPH 27119 to discipline.

2. The agency has jurisdiction to adjudicate this case by default.

3. The Board of Pharmacy is authorized to revoke Respondents' Pharmacist License and Pharmacy Permit based upon the following violations alleged in the Accusation which are supported by the evidence contained in the Default Decision Evidence Packet in this case:

a. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsections (j) and (o), and California Code of Regulations section 1715.6 for failing to report the theft of controlled substances to the Board within 30 days, including amounts and strengths, from the date that the Pharmacy was robbed.

b. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsections (j) and (o), 4169, subsection (a)(2), and 4342 as well as Health and Safety Code sections 111255 and 111295 in that Respondents re-dispensed medication that had been stolen when the pharmacy was robbed, held by the thief for some time, held by the police for some time, and then returned to the pharmacy in a potentially adulterated form, rather than sending them for destruction.

c. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsection (j) and (o), 4169, subsection (a)(4), and section 4342, subsections (a) and (b), as well as Health and Safety Code sections 111330 and 111440 in that Respondents deliberately dispensed expired medication.

d. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsections (j) and (o) and 4169, subsection (a)(3), in that DEA Diversion Investigators located prescription medication bottles of oxycodone containing more tablets in the bottle than the label stated.

e. Respondents are subject to disciplinary action for unprofessional conduct under Code sections 4301, subsections (j) and (o), and title 16, California Code of Regulations, section 1714(b) and 1714(d), for failing to maintain effective control over drugs and secure drugs against theft/loss as well.

f. Respondents are subject to disciplinary action for unprofessional conduct under Code sections 4301, subsections (j) and (o), and Business and Professions Codes 4081(a) and 4105(a) which requires a current inventory be kept by the pharmacy.

g. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsection (j) and (o), and California Code of Regulations, title 16, section 1714, subsection (c) in that multiple inspections revealed the pharmacy to be dirty, dusty, and musty smelling.

h. Respondent Chappell has subjected her license to discipline under section 4301, subdivisions (f) and (g) of the Code for unprofessional conduct in that Respondent created

fraudulent prescriptions to obtain narcotics from the pharmacy using fraud, deceit, and dishonesty.

i. Respondent Chappell has subjected her license to discipline under section 4301, subdivisions (q) of the Code for unprofessional conduct in that Respondent attempted to subvert the board's investigation by creating false prescriptions and a fake audit, altering prescription records, lying to Board Inspectors, attempting to hide prescriptions, not producing requested records, and telling patient DW to not cooperate with authorities.

j. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsections (j) and (o), in that Respondents failed to submit California Utilization Review and Evaluation System (CURES) reports on their controlled substance data on a weekly basis as required by Health and Safety Code 11165(d).

k. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsections (j) and (o), in that Respondents failed to complete self assessment reports pursuant to California Code of Regulations 1715 (a), which requires a self-assessment be completed by July 1 of every odd numbered year.

l. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsections (j) and (o), 4059, subdivision (a), and section 4060 for unprofessional conduct in that they possessed and furnished dangerous drugs and controlled substances to patients without a valid prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor.

m. Respondents subjected their licenses to discipline under section 4301 which states in pertinent part the Board shall take action against any holder of a license who is guilty of unprofessional conduct including: (f) The commission of any act involving moral turpitude, dishonesty, fraud, deceit or corruption; and (g) knowing making or signing a document that falsely represents the existence or nonexistence of a state of facts.

n. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsections (j) and (o), Code section 4073, California Code of Regulation Section

1716, and in that Respondents substituted generic drugs and/or varied the medication that was dispensed from that listed on the prescription.

o. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsections (j) and (o), and California Code of Regulations 1761(a) and (b) which prohibits the dispensing or any prescription which contains any significant error, omission, irregularity, uncertainty, ambiguity or alteration

p. Respondent Chappell is subject to disciplinary action for unprofessional conduct under Code section 4301, subsections (j) and (o), and Code section 4306.5 in that her conduct while serving as the PIC of the Pharmacy reflected an inappropriate exercise of her education, training, or experience as a pharmacist and she failed to exercise or implement her best professional judgment and properly run and manage the pharmacy according to pharmacy laws and regulations.

q. Respondent Chappell, the owner and PIC of Respondent Pharmacy, is subject to disciplinary action for unprofessional conduct under Code sections 4301, subsections (f), (j), and (o), and 4060 as well as Health and Safety Code section 11170, in that she falsified prescriptions and prescribed controlled substances to herself in violation of Pharmacy Laws and Regulations.

///

///

///

///

///

///

///

///

///

///

///

///

ORDER

IT IS SO ORDERED that Pharmacy Permit No. PHY 46288, issued to Respondent Sixth Avenue Pharmacy, and Pharmacist License Number RPH 27119, issued to Respondent Chappell, are revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondents may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective at 5:00 p.m. on August 2, 2018.

It is so ORDERED on July 3, 2018.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By _____
Victor Law, R.Ph.
Board President

71449856.DOCX
DOJ Matter ID:SD2016701558

Attachment:
Exhibit A: Accusation

Exhibit A

Accusation

XAVIER BECERRA
Attorney General of California
JAMES M. LEDAKIS
Supervising Deputy Attorney General
DIANE DE KERVOR
Deputy Attorney General
State Bar No. 174721
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9415
Facsimile: (619) 645-2061
Attorneys for Complainant

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

In the Matter of the Accusation Against: **SIXTH AVENUE PHARMACY** **2121 Fifth Avenue** **San Diego, CA 92101** **Pharmacy Permit No. PHY 46288,** **and** **ALMA JEAN LOECHLER CHAPPELL** **6641 Bluefield Court** **San Diego, CA 92120** **Pharmacist License No. RPH 27119** Respondents.	Case No. 5194 **ACCUSATION**

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 June 6, 2003, the Board of Pharmacy issued Pharmacy Permit Number PHY 46288 to Sixth Avenue Pharmacy (Respondent Pharmacy). The Pharmacy Permit expired on June 1, 2014, and has not been renewed.

///

3. On or about June 9, 1971, the Board of Pharmacy issued Pharmacist License Number RPH 27119 to Alma Jean Loechler Chappell (Respondent Chappell). The Pharmacist License expired on October 31, 2015, and has not been renewed.

JURISDICTION

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

5. Section 4300 of the Code states:

> (a) Every license issued may be suspended or revoked.
>
> (b) The board shall discipline the holder of any license issued by the board, whose default has been entered or whose case has been heard by the board and found guilty, by any of the following methods:
>
> (1) Suspending judgment.
>
> (2) Placing him or her upon probation.
>
> (3) Suspending his or her right to practice for a period not exceeding one year.
>
> (4) Revoking his or her license.
>
> (5) Taking any other action in relation to disciplining him or her as the board in its discretion may deem proper.
>
> . . .
>
> (e) The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code, and the board shall have all the powers granted therein. The action shall be final, except that the propriety of the action is subject to review by the superior court pursuant to Section 1094.5 of the Code of Civil Procedure.

6. Section 4300.1 of the Code states:

> The expiration, cancellation, forfeiture, or suspension of a board-issued license by operation of law or by order or decision of the board or a court of law, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee shall not deprive the board of jurisdiction to commence or proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license.

///

///

STATUTORY AUTHORITY

7. Section 4022 of the Code states

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

8. Section 4059 of the Code states in pertinent part:

(a) A person may not furnish any dangerous drug, except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7. A person may not furnish any dangerous device, except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7.

9. Section 4060 states:

A person shall not possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to Section 4052.1, 4052.2, or 4052.6. This section does not apply to the possession of any controlled substance by a manufacturer, wholesaler, third-party logistics provider, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse practitioner, or physician assistant, if in stock in containers correctly labeled with the name and address of the supplier or producer.

This section does not authorize a certified nurse-midwife, a nurse practitioner, a physician assistant, or a naturopathic doctor, to order his or her own stock of dangerous drugs and devices.

10. Section 4073 states:

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

(b) In no case shall a selection be made pursuant to this section if the prescriber personally indicates, either orally or in his or her own handwriting, Do not substitute,

or words of similar meaning. Nothing in this subdivision shall prohibit a prescriber from checking a box on a prescription marked Do not substitute; provided that the prescriber personally initials the box or checkmark. To indicate that a selection shall not be made pursuant to this section for an electronic data transmission prescription as defined in subdivision (c) of Section 4040, a prescriber may indicate Do not substitute, or words of similar meaning, in the prescription as transmitted by electronic data, or may check a box marked on the prescription Do not substitute. In either instance, it shall not be required that the prohibition on substitution be manually initialed by the prescriber.

(c) Selection pursuant to this section is within the discretion of the pharmacist, except as provided in subdivision (b). The person who selects the drug product to be dispensed pursuant to this section shall assume the same responsibility for selecting the dispensed drug product as would be incurred in filling a prescription for a drug product prescribed by generic name. There shall be no liability on the prescriber for an act or omission by a pharmacist in selecting, preparing, or dispensing a drug product pursuant to this section. In no case shall the pharmacist select a drug product pursuant to this section unless the drug product selected costs the patient less than the prescribed drug product. Cost, as used in this subdivision, is defined to include any professional fee that may be charged by the pharmacist.

(d) This section shall apply to all prescriptions, including those presented by or on behalf of persons receiving assistance from the federal government or pursuant to the California Medical Assistance Program set forth in Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code.

(e) When a substitution is made pursuant to this section, the use of the cost-saving drug product dispensed shall be communicated to the patient and the name of the dispensed drug product shall be indicated on the prescription label, except where the prescriber orders otherwise.

11. Section 4081, subsection (a), states:

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

12. Section 4105, subsection (a), of the Code states:

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

13. Section 4169 of the Code states in relevant part:

(a) A person or entity shall not do any of the following:

. . .

(2) 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.

(3) Purchase, trade, sell, or transfer dangerous drugs that the person knew or reasonably should have known were misbranded, as defined in Section 111335 of the Health and Safety Code.

(4) Purchase, trade, sell, or transfer dangerous drugs or dangerous devices after the beyond use date on the label.

14. Section 4301 of the Code states in relevant part:

The board shall take action against any holder of a license who is guilty of unprofessional conduct or whose license has been procured by fraud or misrepresentation or issued by mistake. Unprofessional conduct shall include, but is not limited to, any of the following:

. . . .

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

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

(h) The administering to oneself, of any controlled substance, or the use of any dangerous drug or of alcoholic beverages to the extent or in a manner as to be dangerous or injurious to oneself, to a person holding a license under this chapter, or to any other person or to the public, or to the extent that the use impairs the ability of the person to conduct with safety to the public the practice authorized by the license.

. . . .

(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.

. . . .

(q) Engaging in any conduct that subverts or attempts to subvert an investigation of the board.

15. Section 4306.5 of the Code states in relevant part:

Unprofessional conduct for a pharmacist may include any of the following:

(a) Acts or omissions that involve, in whole or in part, the inappropriate exercise of his or her education, training, or experience as a pharmacist, whether or not the act or omission arises in the course of the practice of pharmacy or the ownership, management, administration, or operation of a pharmacy or other entity licensed by the board.

(b) Acts or omissions that involve, in whole or in part, the failure to exercise or implement his or her best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances, dangerous drugs, or dangerous devices, or with regard to the provision of services.

(c) Acts or omissions that involve, in whole or in part, the failure to consult appropriate patient, prescription, and other records pertaining to the performance of any pharmacy function.

(d) Acts or omissions that involve, in whole or in part, the failure to fully maintain and retain appropriate patient-specific information pertaining to the performance of any pharmacy function.

. . . .

16. Section 4307 of the Code states:

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

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

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

(b) "Manager, administrator, owner, member, officer, director, associate, partner, or any other person with management or control of a license" as used in

this section and Section 4308 , may refer to a pharmacist or to any other person who serves in such capacity in or for a licensee.

(c) The provisions of subdivision (a) may be alleged in any pleading filed pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code. However, no order may be issued in that case except as to a person who is named in the caption, as to whom the pleading alleges the applicability of this section, and where the person has been given notice of the proceeding as required by Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code. The authority to proceed as provided by this subdivision shall be in addition to the board's authority to proceed under Section 4339 or any other provision of law.

17. Section 4342 of the Code states:

(a) 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).

(b) Any knowing or willful violation of any regulation adopted pursuant to Section 4006 shall be subject to punishment in the same manner as is provided in Sections 4321 and 4336.

18. Health and Safety Code section 11165, subsection (d) states:

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

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

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

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

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

(5) Quantity of the controlled substance dispensed.

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

(7) Number of refills ordered.

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

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

19. Health and Safety Code section 11170 provides that "No person shall prescribe, administer, or furnish a controlled substance for himself."

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

21. Health and Safety Code section 111255 provides that "Any 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."

22. 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."

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

24. 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."

REGULATIONS

25. California Code of Regulations, title 16, section 1714, states in relevant part:

(a) All pharmacies (except hospital inpatient pharmacies as defined by Business and Professions Code section 4029 which solely or predominantly furnish drugs to inpatients of the hospital) shall contain an area which is suitable for confidential patient counseling.

(b) Each pharmacy licensed by the board shall maintain its facilities, space, fixtures, and equipment so that drugs are safely and properly prepared, maintained, secured and distributed. The pharmacy shall be of sufficient size and unobstructed

area to accommodate the safe practice of pharmacy.

(c) The pharmacy and fixtures and equipment shall be maintained in a clean and orderly condition. The pharmacy shall be dry, well-ventilated, free from rodents and insects, and properly lighted. The pharmacy shall be equipped with a sink with hot and cold running water for pharmaceutical purposes.

(d) Each pharmacist while on duty shall be responsible for the security of the prescription department, including provisions for effective control against theft or diversion of dangerous drugs and devices, and records for such drugs and devices. Possession of a key to the pharmacy where dangerous drugs and controlled substances are stored shall be restricted to a pharmacist.

. . . .

26. California Code of Regulations, title 16, section 1715, subsection (a), states:

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

27. California Code of Regulations, title 16, section 1715.6 states:

The owner shall report to the Board within thirty (30) days of discovery of any loss of the controlled substances, including their amounts and strengths.

28. California Code of Regulations, title 16, section 1716 states:

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 Business and Professions Code.

Nothing in this regulation is intended to prohibit a pharmacist from exercising commonly-accepted pharmaceutical practice in the compounding or dispensing of a prescription.

29. California Code of Regulations, title 16, section 1761 states:

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

(b) Even after conferring with the prescriber, a pharmacist shall not compound or dispense a controlled substance prescription where the pharmacist knows or has objective reason to know that said prescription was not issued for a legitimate medical purpose.

COSTS

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

DRUGS

31. The following medications are at issue in this matter:

BRAND NAME	GENERIC NAME	DANGEROUS DRUG PER B & PC 4022	CONTROLLED SUBSTANCE PER H & SC	INDICATIONS FOR USE
Lortab, Norco, Vicodin	Hydrocodone	Yes	Yes- HSC 11056(e)(4)	Pain
Oxycontin	Oxycodone Controlled Release	Yes	Yes- HSC 11055(b)(1)(M)	Pain
Duragesic	Fentanyl	Yes	Yes- HSC 11055(c)(8)	Pain
Zestril	Lisinopril	Yes	No	High blood pressure
Ambien	Zolpidem	Yes	Yes- HSC 11057 (d)(32)	Sleep
Suboxone	Buprenorphine Hydrochloride/Naloxone Hydrochloride	Yes	Yes- CFR 1308.13(e)(2)(i)	Drug dependence
Subutex	Buprenorphine Hydrochloride	Yes	Yes	Drug Dependence
Valtrex	Valacyclovir	Yes	No	Viral Infection
Lidoderm	Lidocaine	Yes	No	Pain
Combivir	Lamivudine/Zidovudine	Yes	No	HIV infection
Viramune	Nevirapine	Yes	No	HIV Infection
Testim	Testosterone	Yes	Yes- HSC 11056(f)(30)	Hormone Replacement

Viagra	Sildenafil Citrate	Yes	No	Erectile Dysfunction
Percocet	Oxycodone/APAP	Yes	11055 (b)(1)(M)	Severe pain

FACTS SUPPORTING CAUSES FOR DISCIPLINE

32. On June 6, 2003, the Board issued pharmacy permit PHY 46288 to Sixth Avenue Pharmacy ("Pharmacy") located at 2121 Fifth Avenue in San Diego, CA 92101. Respondent Chappell was the sole owner of the pharmacy, was associated as its pharmacist-in-charge (PIC), and remained in that position until the pharmacy closed.[1]

Robbery

33. On October 22, 2012, the Pharmacy was robbed by a patient known to the Pharmacy Technician employed at the pharmacy, KV. The patient walked into the pharmacy, demanded all of the controlled substances, and had the staff empty the safe and pull the drugs off of the shelf. Based upon KV's report to the police, the patient was subsequently arrested, with the drugs in his possession. On December 7, 2012, the police returned the previously stolen drugs.

34. Respondent Chappell never reported the pharmacy's robbery and failed to transmit CURES information to the Board or the Drug Enforcement Agency (DEA). Although a handwritten list of allegedly stolen drugs was presented to the police, there was never an accurate inventory done of the specific drugs that were stolen that day or of the drugs that were returned by the police.

35. The storage and care of the medications while they were in the custody of the thief and the police was not known. Nonetheless, Respondent Chappell sold the drugs that were recovered from the police to her customers. Pharmacy Technician KV reported the resale of the

[1] The Pharmacy's records and drugs were sold to CVS on September 19, 2013, and the license expired on June 1, 2014.

adulterated drugs to the DEA. The DEA alerted the Pharmacy Board, which commenced this investigation.

36. On March 11, 2013 Respondent Chappell was sick and could not make it to the pharmacy. On that day, she ordered Pharmacy Technician KV to go to the pharmacy and bring a container of Percocet and 14 Flagyl tablets to her home. No prescription was filled for these medications.

Flooding and Construction

37. On June 3, 2013, the building that housed the pharmacy was flooded with sewage and contaminated water. The building had to undergo significant construction for several months. Respondent Chappell decided to keep the pharmacy open during the construction, despite the construction firm's recommendation that the pharmacy close.

38. On or around June 28, 2013, the Board was notified by the DEA that it was performing an inspection of the pharmacy on July 1, 2013. The board conducted the first part of its inspection on the same day and conducted several additional visits over the following months.

39. The pharmacy was housed in a hot and dirty active construction site which smelled of must and dirty water and lacked a functional sink. The pharmacy permit was posted in the rear side of the pharmacy and not visible to the public. The notice to consumer posters were also posted out of the view of the consumer.

40. The pharmacy's controlled substances and records were being stored in a locked closet in a room right near the active construction site and outside of the actual pharmacy because there was no narcotics safe at the pharmacy. Security cameras were in the pharmacy, but they were not functional due to the construction.

41. Because of the construction, during hours of operation, the medication was moved to the small front portion of the pharmacy where nonprescription medications were normally kept. When the Board's inspector arrived, Pharmacist HW and Pharmacy Technician KV arrived at the

pharmacy pulling a red wagon containing the pharmacy's controlled substances, which were stored in brown paper bags and boxes.

Falsified Prescriptions

42. Pharmacy Technician KV reported that Respondent Chappel was falsifying insurance forms so that patients' insurance paid for medication they never picked up. Respondent Chappell would bill a fake prescription to the patients' insurance in order to cover the copay of a prescribed medication. The Inspector took the patients' records (many hard prescriptions were not in the file), called the prescribing physicans to confirm the prescriptions, and found the following fraudulent prescriptions and billings:

a.

Patient/DOB	Prescription	Drug	Filled on	Authorized?
TI 5/14/1951[2]	381927	Valacyclovir 1 gm	5/7/13, 4/8/13, 3/15/13, 2/6/13, 1/6/13	NO
TI 5/14/1951	381634	Valtrex 1 gm	1/9/13	NO
TI 5/14/1951	381368	Testosterone Cypionate 200mg/ml	3/28/13	NO- Rx expired or not authorized
JS 10/10/1964[3]	382170	Nevirapine 200mg	6/2/13, 5/1/13, 4/1/13, 3/1/13	NO, therapeutic duplication
JK 2/21/1981[4]	383030	Promethazine	6/14/13	NO

[2] Dr. S. indicated prescription 381927 for valacyclovir 1 gram was not authorized, thus this drug was billed fraudulently. He also indicated the last time he prescribed testosterone was on 8/29/12. Since controlled substances are only good for 6 months, prescription 381368 for testosterone on 3/28/13 on TI's profile was either provided after the prescription had expired or was provided without a prescription.

[3] Dr. S. indicated he had not been contacted by PIC Chappell to substitute medications for JS. Prescription 382170 for nevirapine 200mg was not authorized and noted the prescription was a therapeutic duplication with the Viramune XR 400mg which he did prescribe. Nevirapine (generic Viramune) is a used to control HIV infection and has potentially serious or fatal liver and skin adverse effects. By either providing both prescription's (nevirapine and Viramune), or only the less potent nevirapine 200mg, Respondent risked harming patient JS.

[4] Dr. M. indicated he prescribed Suboxone films, he did not recall PIC Chappell ever contacting him to substitute or change patient JK's prescriptions but his patient reported that his medication was switched. Respondent was providing generic buprenorphine (#379070 for Buprenorphine 8mg tablets) rather than the brand Suboxone films (#379355 for Suboxone 8mg film) prescribed. Both prescriptions were billed on 7/18/12, 6/18/12, and 5/18/12. However, the

		12.5mg		
JK 2/21/1981	383029	Prochlorperazine 5mg	6/14/13	NO
KF 6/22/1956[5]	382584	Lidoderm 5% patch	4/24/13	NO

b. Patient JC, DOB 8/26/70, is HIV positive and does not pick up his medications regularly. Nonetheless, Respondent Chappell billed his insurance company for medications on a monthly basis, even when they were not picked up. When JC came into the pharmacy, Respondent Chappell would have patient JC sign the signature slip for large numbers of prescriptions that were not dispensed at the time. During inspection, his patient file revealed large numbers of prescription sheets of his medications indicating the bottles of medications were likely never dispensed, because the label was never attached to the bottle. For instance, the records of his February medications show two prescriptions were signed for on 3/6/2013, despite being processed on 2/6/2013. Review of his patient profile shows these medications were billed to insurance each month.

c. For Patient JS, DOB 10/10/64, Respondent Chappell billed more expensive brand name Viramune XR 400mg, but dispensed generic nevirapine 200 mg. She also billed Combivir brand name under a "Do Not Substitute" prescription, but dispensed generic lamivudine/zidovudine. PIC Chappell also billed but did not dispense Testim 1% gel in order to pay for Viagra 100mg that was dispensed. In the patient's file were intact labels for Testim 1% gel, Viramune XR 400mg, and Combivir brand name. These labels were signed for, but still had the bottle label attached, indicating they were not dispensed. Also in the file were labels for nevirapine, lamivudine/zidovudine, and Viagra which were signed for with the bottle label removed, indicating that they were dispensed. Further, in JS's patient profile notes section in the computer

---

Suboxone Film was billed to commercial insurance, versus the buprenorphine was billed as private pay/cash. This would allow PIC Chappell to obtain the higher reimbursement from the brand name Suboxone, but obtain a label for the cheaper generic buprenorphine to dispense to the patient, without the insurance knowing PIC Chappell had filled the duplicative buprenorphine. Respondent admitted to the Inspector that she believed it was acceptable to substitute generic buprenorphine for brand name Suboxone.

[5] Dr. L. did not prescribe both Cialis 20mg and Lidoderm 5% patches to patient KF. Cialis is prescribed, but at a different pharmacy. Lidoderm was not authorized. Respondent Chappell billed fraudulent Lidoderm 5% patch and Cialis 20mg tablets. No hard copies were found for prescription #382583 Cialis 10 mg, #382584 Lidoderm 5% patch, or #382585 Cialis 20mg.

was a page noting on April 1, 2013, generic Viramune 200mg had been dispensed but brand name Viramune XR 400mg had been billed, Viagra 100mg had been dispensed, and Testim had been billed, but not dispensed. On January 23, 2013, the note detailed generic Viramune 200mg had been dispensed but brand name Viramune XR 400mg had been billed; brand name Combivir under a "Do Not Substitute" prescription had been billed, but generic had been dispensed; Viagra 100mg #5 tablets had been dispensed, but #8 tablets had been billed, and Testim had been billed. On October 26, 2012, the note detailed generic Viramune 200mg had been dispensed, but brand name Viramune XR 400mg had been billed; and brand name Combivir under a "Do Not Substitute" prescription had been billed, but generic had been dispensed. On August 31, 2012 the note detailed generic Viramune 200mg had been dispensed, but brand name Viramune XR 400mg had been billed; brand name Combivir under a "Do Not Substitute" prescription had been billed, but generic had been dispensed; and Viagra 100mg #5 tablets had been dispensed but #8 tablets had been billed, and Testim had been billed.

d. For patient JK, DOB 2/21/1981, Respondent Chappell billed more costly Suboxone 8mg sublingual films, but dispensed generic buprenorphine tablets. Review of prescription files found prescription #381994 for Suboxone 8mg sublingual films, but not prescription #381995 for generic buprenorphine tablets. Respondent Chappell admitted to fraudulently billing the brand name Suboxone 8mg sublingual films but dispensing generic buprenorphine (Subutex) tablets for patient JK, thus improperly filling the prescription. Respondent Chappell indicated she felt that there was nothing wrong with this practice because "they were the same drug." Suboxone is buprenorphine/naloxone, whereas Subutex is buprenorphine -- they are not the same drug.

43. A stock on hand audit with Pharmacist HW revealed that multiple bottles of the same medication were combined into one bottle. For instance, there were greater than 100 tablets in a stock bottle of 100, which had been opened, as follows:

a. Oxycontin 30mg: 100 tablets

b. Oxycodone 15mg: 829 tablets

c. Oxycodone 30mg: 736 tablets

d. Oxycodone/Acetaminophen 10/325: 273 tablets

44. Pharmacy Technician KV provided the Board's Inspectors with the following statements regarding Respondent Chappell's prescription practices that she found concerning:

a. There has been many times where Jean has been helping herself to drugs here at the pharmacy. There has been many times she has asked me to get her percocets from the locked cupboard. In October 2012 she told me she took an Ambien instead of her lisinopril. She slept most of the day in her wheelchair then that same day she poked herself with a needle after giving one of our HIV patients a flu shot. She also has one of her doctor friends write her narcotic medications after she has already taken them. On 3/11/13 she called me at home, told me to come to the store and get her flagyl and a bottle of Percocet. On 6/28/13 while at work she told me she was hurting and was going to take an ASA (aspirin) but spilled the bottle of Percocet on the floor. This is a daily thing where she takes Percocet.

b. On October 22nd 2012 Sixth Ave Pharmacy was robbed by one of our patients. All of our narcotics and some of our controlled medications were taken. On Dec 7th, 2012 we were able to receive the medications back. However Jean has dispensed the medications even though we were not suppose to. She did not want to spend the money on the cost of replacing them because of how expensive they were. There was also no insurance claim filed, nor was the state board notified. A number of times I stated that we needed to do the insurance claim and we can not dispense the medications and she said it was ok because it wasn't opened. So everything that was taken during the robbery has been dispensed.

c. On June 3rd, 2013, Sixth Avenue Pharmacy & the Loechler Building sustained major sewage damage. The pharmacy had a small spot of damaged tile by the antibiotics. She was convinced the water came to the natic (?sic) area. Since then we do not have a working sink, air conditioner, and hotter than hell in here. She was offered the chance to move upstairs but she said no cause she did not want to loose her customers. Upstairs has air cond. While they are remodeling the building we have been working out of the front half and nothing is secured here in the pharmacy.

d. After being here for almost two years it finally came all together how she was billing for patients ahead of time and also creative billing for patients. She will give the patient what she wants and then bill for something to cover the copay. In the patient comment fields she will put what she bills for and dispensed for. Also for patient JC DOB 8/26/70 he doesn't get his meds all the time but she bills each month for him and has him sign when he comes in. JK DOB 2/21/1981 bills for suboxone but gives out subutex. KF DOB 6/22/56 pt wants Cialis and bills for Lidoderm patches. JS DOB 10/10/64 bills for Testim for copay.

45. On July 5, 2013, the Board's inspector and an investigator from the Food and Drug Branch of the California Department of Public Health inspected Sixth Avenue Pharmacy to determine if there was evidence of the sewage flood contamination of medications. The Board's Inspectors determined that the medication was not contaminated. The Board's Inspectors issued Respondent Chappell an inspection report and requested that she provide the board with the police report for theft, an inventory of all medication lost in the theft, and an inventory of all medication returned by law enforcement to the pharmacy.

46. On August 1, 2013, the Board's inspectors returned to the Pharmacy. The controlled substances were still located in the wagon, and were currently in a back room of the pharmacy which was under construction and smelled strongly of mildew and mothballs and was not in the control of Respondent Chappell. Respondent was instructed to move the medication into the main area of the pharmacy where it was under her control and did not smell like mold.

47. The Board's inspectors also located evidence of prescription tampering, including multiple patient profiles that had prescription numbers corresponding to prescriptions added to the computer system recently in the last couple months, but had been back dated much later than they were typed.

Dr. S's Prescription Pads

48. The inspectors also located blank controlled substance prescription pads from Dr. RS, Mobile Medical Group, which had been used to write numerous prescriptions, some for Respondent or other patient profiles, for narcotics with dates that varied drastically despite being from the same pad of prescriptions. Some of the prescriptions were years older than a different prescription that had been written after them on the prescription pad, as follows:

Patient	Prescription Number	RX Blank Serial Number	Date Typed For	Drug	Quantity
Rod C	383226	879901	1/30/12	Percocet 10/325	240
Miguel O	383237	879904	7/9/13	Fentanyl patch 75mcg	15
Rod C	383298	879906	12/1/11	Percocet 10/325	240
Jean Chappell	383301	879908	11/10/11	Percocet 10/325	240
Jean Chappell	383302	879909	1/3/12	Percocet 10/325	180
Steve B	383304	879910	1/22/13	Percocet 10/325	120
Miguel O	383300	879911	9/6/12	Percocet 10/325	240
Miguel O	383305	879912	8/15/12	Percocet 10/325	240
Steve B	383303	879913	9/2/11	Percocet 10/325	120
Jean Chappell	383227	879867	4/1/12	Percocet 10/325	240
Jerome P	380896	879868	10/22/12	Percocet 10/325	90
Miguel O	380926	879869	10/24/2012	Fentanyl Patch 50	5
Miguel O	381202	879870	10/26/2012	Fentanyl Patch	5

				50	
Miguel O	380982	879871	10/29/12	Fentanyl Patch 75	15
William D	378733	879874	2/2/12	Hydromorphone 2	120
Sean O	379783	879875	6/11/12	Percocet 5/325	90
William D	378503	879877	1/4/12	Dilaudid 2	120

49. Dr. S. was interviewed and reported that he never left his blank prescription pads at Respondent's pharmacy and was not sure how Respondent Chappell would have been in possession of them. He reported that Respondent would call him and that he would come to the pharmacy to write the prescriptions for various patients at the direction of Respondent Chappell. These prescriptions were not valid because there was no prescriber exam.

50. The Inspectors reviewed several prescriptions with Dr. S, who confirmed that at least 26 prescriptions at Respondent Pharmacy were not authorized by him. Dr. S. also reported that he had only prescribed Percocet for Respondent Chappell on two occasions, which indicates that the other prescriptions on her profile were fraudulent.[6]

///

///

Sale of Expired and Potentially Adulterated Drugs

51. On September 16, 2013, Pharmacy Technician KV contacted the Inspector and reported that Respondent had just sold "majorly expired" methadone to a patient. Shortly thereafter, the Inspector arrived at the pharmacy, walked through the front entrance and into the back area which was under construction and where multiple narcotics were in plain view on a ledge and not monitored. Other controlled substances were still in the cart and out of the control of a pharmacist.

52. The Inspector located Respondent Chappell and the Pharmacy Technician in the pharmacy in front of 8 bottles of methadone, all which expired in March of 2008. Respondent claimed she planned to send the expired medication for destruction and tried to hide the filled prescription from the Inspector. When asked about the expired methadone in conjunction with

[6] On July 18 and July 25, 2013, a review of Respondent's personal patient profile revealed altered prescriptions with invalid DEA numbers.

the prescription for MK, Respondent changed her story first stating the prescription for MK hadn't been dispensed, then stating that the bottle with the methadone for the patient was empty and the medication was on order, and finally admitting that dispensing the methadone was an error when the Inspector pointed out the medication had a signed pick-up slip.

53. The inspector instructed Respondent to immediately call the patient and ask him to not use the expired drug, that a Quality Assurance Report needed to be completed and the prescriber notified, and that a new bottle of methadone must be immediately ordered to replace patient MK's expired drug.

54. A subsequent patient profile for MK was printed out showing the medication was filled and billed on September 16, 2013. Although the Inspector requested copies of documentation of these remedial efforts, Respondent never submitted them to the board.

55. During the inspection, the Inspector asked Respondent Chappell about the robbery. Respondent Chappell admitted she re-dispensed the medication that was stolen during the robbery to her patients because the stolen medication was only in the possession of the thief for a short time and then in the possession of the police. When questioned, Respondent did not seem concerned the medication had not been in the possession of a licensed individual on a licensed premise.

56. Although advised to do so, Respondent did not have air conditioning installed in the pharmacy. The temperature was exceeding 80 degrees, which was be too hot for some of the medications stored at the pharmacy.

57. On a previous inspection, the Board's inspectors inspected a small refrigerator in the pharmacy which had numerous expired vaccines (some from 2006, 2008, and 2012) and injections. Respondent Chappell admitted she had not returned them for destruction.

Interference with Inspection

58. On September 18, 2013, Respondent Chappell gave Pharmacy Technician KV a list of prescription numbers to reverse out of the computer. The Board's Inspector stopped the Pharmacy Technician from reversing the prescriptions. Some of the prescriptions slated to be reversed were previously identified altered controlled substance prescriptions for patients GN and

DW, included DW's HPAP prescription that had been altered to 240 tablets instead of the prescribed 40.

59. During the course of the investigation, Respondent called patient DW and told the patient to not speak with any authorities (Board of Pharmacy or DEA) if they called him asking him about prescriptions received from the Pharmacy. DW then called Pharmacy Technician KV to report the contact and ask what he should do. Pharmacy Technician KV reported to the Inspector that she told Patient DW to cooperate with the investigation.

60. During the September 27, 2013 meeting, Dr. S. confirmed that Patient DW had also called him and asked him what he should do if authorities contacted him regarding controlled substance prescriptions he received from the Pharmacy. DW reported to Dr. S that Respondent Chappell had instructed him to not speak to authorities regarding the pharmacy.

Fraudulent Prescriptions Written on Dr. S.'s Controlled Substances Prescription Pad

61. Dr. S. also confirmed that DW did not take oral controlled substances. He was prescribed Demerol. Accordingly, the HPAP prescriptions listed under DW's name at the pharmacy were falsified. Dr. S. also stated he did not write controlled substance pain medication prescriptions for patient JP. Accordingly, those prescriptions were also falsified.

62. Of the list of 94 prescriptions filled at the pharmacy for controlled substances with Dr. S. prescriptions, Dr. S. reported that he was certain that 22 were not authorized by him. The falsified prescription for patient DW was included in that list. Dr. S. was uncertain about 49 of the prescriptions. 32 of those 49 were for patient MO. The inspector verified that several of those prescriptions were falsified because the prescription number corresponded to a date in 2013, but the prescriptions were dated in 2012, indicating they were fraudulently created. Accordingly, unauthorized prescriptions were used to dispense a minimum of 4170 tablets of hydrocodone/ acetaminophen 10/325mg, 2460 tablets of oxycodone/acetaminophen 10/325 mg, 60 hydromorphone 8mg, and 30 tablets of diazepam 30mg.

Pharmacy Closed, DEA Fine, and Investigation Conclusions

63. On September 27, 2013, the board's Inspector traveled to the pharmacy to confirm that it was closed. The door was locked, signs on the pharmacy stated that the store was closed and prescription records had been transferred to CVS pharmacy located at 510 C Street, San Diego, California.

64. Upon the conclusion of its investigation, on July 1, 2014, the DEA fined Respondent Chappell $147,500 for her controlled substance violations substantiated during their investigation.

65. The Inspection determined that Respondent Chappell was dispensing controlled substances to herself, falsifying prescriptions, added false prescriptions, and falsified her patient profile and other patient profiles.

66. An audit of the two drugs that seemed to be the focus of the record falsification and diversion, not including the numerous falsified prescriptions created by Respondent, revealed that the Pharmacy could not account for the loss of at least 2667 tablets of oxycodone/ Acetaminophen 10/325mg and 5412 tablets of hydrocodone/acetaminophen 10/325mg, as follows:[7]

Drug	Beginning Inventory, Date	Acquisition	Disposition	Ending Inventory, Date	Variance
Oxycodone/ Acetaminophen 10/325mg	25, 8/18/2011	9900	6985	273, 7/1/13	-2667
Hydrocodone/ Acetaminophen 10/325mg	932, 8/18/2011	23500	18120	900, 5/30/13	-5412

67. Respondent Chappell billed for medications not dispensed and substituted cheaper drugs for the prescribed medications, apparently for her personal monetary gain.

68. Respondent Chappell willfully created at least 32 fraudulent prescriptions on the pharmacy computer system. At least 24 of these prescriptions were added after the July 1, 2013

[7] When asked to perform her own audit, Respondent only calculated a loss of 9 and 21 tablets, which was given no weight by the investigators.

inspection, presumably to hide the controlled substance diversion and/or they were self prescribed. Below are those fraudulent prescriptions that she prescribed to herself:

Prescription Number:	Date	Medication	Quantity
383246	11/10/11	Oxycodone/APAP 10/325mg	240
383245	1/3/12	Oxycodone/APAP 10/325mg	180
383227	4/1/12	Oxycodone/APAP 10/325mg	240
339609	1/29/02	Prevident 500 Plus Cream	1 tube

69. Based upon their investigation, the inspectors concluded that the following fraudulent oxycodone/acetaminophen and hydrocodone/acetaminophen 10/325 mg prescriptions were distributed from Respondent Pharmacy:

Prescription	Medication	Date	Quant.	Patient
383243	oxycodone/ APAP	9/2/11	120	SB
383247	oxycodone/ APAP	10/5/11	180	RC
383242	oxycodone/ APAP	10/20/11	90	JP
383248	oxycodone/ APAP	12/1/11	240	RC
383298	oxycodone/ APAP	12/1/11	240	RC
383303	oxycodone/ APAP	1/3/12	120	SB
383226	oxycodone/ APAP	1/30/12	240	RC
383250	oxycodone/ APAP	8/15/12	240	MO
383249	oxycodone/ APAP	9/6/12	240	MO
383300	oxycodone/ APAP	9/11/12	240	MO
383244	oxycodone/ APAP	1/22/13	120	SB
383357	oxycodone/ APAP	3/1/13	180	JP
383413	hydrocodone/ APAP	9/20/12	120	IK
383414	hydrocodone/ APAP	9/20/12	150	JP
383414	hydrocodone/ APAP	1/22/13	150	JP
383414	hydrocodone/	2/21/13	150	JP

	APAP			
383355	hydrocodone/ APAP	4/4/13	120	GN
383355	hydrocodone/ APAP	5/4/13	120	GN
383355	hydrocodone/ APAP	6/4/13	120	GN
383355	hydrocodone/ APAP	7/3/13	120	GN
383346	hydrocodone/ APAP	12/11/11	60	RM

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Failure to Report Theft of Controlled Substances)

70. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsections (j) and (o), and California Code of Regulations section 1715.6 for failing to report the theft of controlled substances to the Board within 30 days, including amounts and strengths, from the date that the Pharmacy was robbed. Respondent never reported the robbery of medications, including controlled substances, from the pharmacy to the Board or the DEA. The facts supporting this cause are specified in paragraphs 32-69 above and incorporated herein by reference.

///

SECOND CAUSE FOR DISCIPLINE
(Unprofessional Conduct – Dispensing Adulterated Drugs)

71. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsections (j) and (o), 4169, subsection (a)(2), and 4342 as well as Health and Safety Code sections 111255 and 111295 in that Respondents re-dispensed medication that had been stolen when the pharmacy was robbed, held by the thief for some time, held by the police for some time, and then returned to the pharmacy in a potentially adulterated form, rather than sending them for destruction. Respondent Chappell admitted to re- dispensing the medications after their return by the police. These medications' storage and care while with these unlicensed

entities is unknown, leading to the medications being deemed adulterated. The drugs may have been contaminated, rendered injurious, and may have lacked the quality and strength of the original medication and they should have been destroyed. The facts supporting this cause are specified in paragraphs 32-70 above and incorporated herein by reference.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Dispensing Expired Drugs)

72. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsection (j) and (o), 4169, subsection (a)(4), and section 4342, subsections (a) and (b), as well as Health and Safety Code sections 111330 and 111440 in that Respondents deliberately dispensed expired medication. On September 16, 2013, the Inspector arrived at the pharmacy moments after 10 tablets of 10mg methadone, which had expired in March of 2008, were sold to patient MK. Respondent Chappell falsely told the Inspector that she did not have any methadone in stock that was not expired and that the expired methadone on the counter was to go for destruction. Respondent attempted to hide the signed patient prescription slip for MK by placing it behind a computer and lied to the Inspector indicating the prescription had not been dispensed. After showing Respondent the prescription form showing that prescription had been sold and picked up, Respondent Chappell admitted the expired medication should not have been dispensed. The facts supporting this cause are specified in paragraphs 32-71 above and incorporated herein by reference.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Holding Misbranded Drugs)

73. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsections (j) and (o) and 4169, subsection (a)(3), in that DEA Diversion Investigators located prescription medication bottles of oxycodone containing more tablets in the bottle than the label stated. Accordingly, Respondents were holding misbranded[8] medication.

[8] Health and Safety Code sections 111440 (forbids any person to manufacture, sell, deliver, hold, or offer for sale any drug or device that is misbranded), 11445 (unlawful for any person to misbrand any drug or device), and 111340 (any drug or device is misbranded unless it bears a label containing all of the following information: (a) The name and place of business of

The facts supporting this cause are specified in paragraphs 32-72 above and incorporated herein by reference.

FIFTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct – Failure to Maintain Security of Controlled Substances and to Secure Drugs from Theft or Loss)

74. Respondents are subject to disciplinary action for unprofessional conduct under Code sections 4301, subsections (j) and (o), and title 16, California Code of Regulations, section 1714(b) and 1714(d), for failing to maintain effective control over drugs and secure drugs against theft/loss as well. The Pharmacy was robbed on October 22, 2012. Even after the robbery, controlled substances were maintained in an unsecured room in a construction site, in the front area of the pharmacy where nonprescription drugs are typically maintained, in a cart that was moved around the pharmacy which was under construction, and in plain view in a room where the Inspector was able to walk in, unannounced, and examine them without the pharmacist even being aware of his presence. Dangerous drugs, and especially controlled substances, must be maintained in a secure manner during open and closed hours to prevent theft and tampering. Furthermore, Respondent Chappell could not account for the loss of 5,412 tablets of hydrocodone/acetaminophen 10/325mg from August 18, 2011 to May 30, 2013 and 2,667 tablets of oxycodone/acetaminophen 10/325mg between August 18, 2011 and July 1, 2013. The facts supporting this cause are specified in paragraphs 32-73 above and incorporated herein by reference.

SIXTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct – Failure to Maintain a Current Inventory of Controlled Substances)

75. Respondents are subject to disciplinary action for unprofessional conduct under Code sections 4301, subsections (j) and (o), and Business and Professions Codes 4081(a) and 4105(a) which requires a current inventory be kept by the pharmacy. The Pharmacy did not keep a current inventory and could not account for the loss of 5,412 tablets of hydrocodone/

---

the manufacturer, packer, or distributor, (b) An accurate statement of the quantity of the contents in terms of weight, measure, or numerical count).

acetaminophen 10/325mg from August 18, 2011 to May 30, 2013. The Pharmacy also could not account for theft/loss of 2,667 tablets of oxycodone/acetaminophen 10/325mg between August 18, 2011 and July 1, 2013. The facts supporting this cause are specified in paragraphs 32-74 above and incorporated herein by reference.

SEVENTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct – Failure to Maintain Clean and Orderly Pharmacy)

76. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsection (j) and (o), and California Code of Regulations, title 16, section 1714, subsection (c) in that multiple inspections revealed the pharmacy to be dirty, dusty, and musty smelling. Respondents maintained the pharmacy open after a sewage spill into the building, during flood abatement construction, and prior to confirming that the condition of the building was safe for employees of the pharmacy and for customers. No sink with running hot and cold water was present in the pharmacy so employees could not wash their hands and one employee felt ill working in the dirty facility. Temperatures were recorded in excess of 80 degrees and Respondents failed to fix the air conditioning despite approaching the maximum recommend temperature for some medications. The facts supporting this cause are specified in paragraphs 32-75 above and incorporated herein by reference.

EIGHTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct – Creating False Prescription Documents to Obtain Controlled Substances by Acts Involving Dishonesty, Fraud, Deceit & Corruption)

77. Respondent Chappell has subjected her license to discipline under section 4301, subdivisions (f) and (g) of the Code for unprofessional conduct in that Respondent created fraudulent prescriptions to obtain narcotics from the pharmacy using fraud, deceit, and dishonesty. During various inspections, the Inspectors confirmed the allegations in the complaint filed by a pharmacy employee that false prescriptions were being created and filled. The facts supporting this cause are specified in paragraphs 32-76 above and incorporated herein by reference.

NINTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Subverting the Board's Investigation)

78. Respondent Chappell has subjected her license to discipline under section 4301, subdivisions (q) of the Code for unprofessional conduct in that Respondent attempted to subvert the board's investigation by creating false prescriptions and a fake audit, altering prescription records, lying to Board Inspectors, attempting to hide prescriptions, not producing requested records, and telling patient DW to not cooperate with authorities. The facts supporting this cause are specified in paragraphs 32-77 above and incorporated herein by reference.

TENTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct – Failure to Submit CURES Reports)

79. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsections (j) and (o), in that Respondents failed to submit California Utilization Review and Evaluation System (CURES) reports on their controlled substance data on a weekly basis as required by Health and Safety Code 11165(d). A September 19, 2013 compliance report revealed the pharmacy only reported on 4 weeks for 2013. 2012 data was reported nearly entirely in 2013, and for only three weeks. Data for 2011 was reported for only three weeks. As the PIC, Respondent Chappell was responsible for the filing of these reports. The facts supporting this cause are specified in paragraphs 32-78 above and incorporated herein by reference.

ELEVENTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct – Failure to Complete Self Assessments)

80. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsections (j) and (o), in that Respondents failed to complete self assessment reports pursuant to California Code of Regulations 1715 (a), which requires a self-assessment be completed by July 1 of every odd numbered year. Respondent Pharmacy did not have completed 2011 and 2013 self-assessments for review at the Inspection. As the PIC, Respondent Chappell was responsible for maintaining these assessments. The facts supporting this cause are specified in paragraphs 32-79 above and incorporated herein by reference

TWELFTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct – Possessed and Furnished

Dangerous Drugs Without a Prescription)

81. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsections (j) and (o), 4059, subdivision (a), and section 4060 for unprofessional conduct in that they possessed and furnished dangerous drugs and controlled substances to patients without a valid prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor. The facts supporting this cause are specified in paragraphs 32-80 above and incorporated herein by reference.

THIRTEENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Moral Turpitude, Dishonesty, False Documentation)

82. Respondents subjected their licenses to discipline under section 4301 which states in pertinent part the Board shall take action against any holder of a license who is guilty of unprofessional conduct including: (f) The commission of any act involving moral turpitude, dishonesty, fraud, deceit or corruption; and (g) knowing making or signing a document that falsely represents the existence or nonexistence of a state of facts. Specifically, Respondent Chappell and Respondent Pharmacy:

a. forged prescriptions for patients,

b. substituted medications without prescriber approval,

c. lied to Board Inspectors,

d. instructed patient DW to lie to authorities,

e. attempted to hide evidence and altered prescription records,

f. dispensed potentially adulterated medications without patient knowledge,

g, possessed and used blank controlled substance forms,

h. possessed medication obtained by forged prescriptions,

h. failed to maintain and/or refused to produce required documentation to the Inspectors, and

i. produced false records to the Inspectors.

The facts supporting this cause are specified in paragraphs 32-81 above and incorporated herein by reference.

FOURTEENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Substitution of Generic Drug and Variation from Prescription)

83. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsections (j) and (o), Code section 4073, California Code of Regulation Section 1716, and in that Respondents substituted generic drugs and/or varied the medication that was dispensed from that listed on the prescription, as follows:

a. Respondent substituted generic nevirapine for brand name Viramune (a more expensive drug) for patient JS on prescription number 382170, when the physician indicated the patient should be prescribed brand name Viramune.

b. Respondent Chappell admitted to dispensing generic buprenorphine tablets for patient JK on multiple occasions when the prescriber indicated the patient should be prescribed brand name Suboxone Films (a more expensive drug) thereby improperly filling the prescription. Respondent Chappell indicated she felt that there was nothing wrong with this practice because "they were the same drug." Suboxone is buprenorphine/naloxone, whereas Subutex is buprenorphine -- they are not the same drug.

The facts supporting this cause are specified in paragraphs 32-82 above and incorporated herein by reference.

FIFTEENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Filling of Uncertain or Erroneous Prescriptions)

84. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subsections (j) and (o), and California Code of Regulations 1761(a) and (b) which prohibits the dispensing or any prescription which contains any significant error, omission, irregularity, uncertainty, ambiguity or alteration. Upon receipt of any uncertain prescription, a pharmacist should contact the prescriber to obtain the information needed to validate the

prescription. Even after conferring with the prescriber, a pharmacist shall not compound or dispense a controlled substance prescription where the pharmacist knows or has objective reason to know that said prescription was not issued for a legitimate medical purpose. The fraudulent prescriptions filled by Respondents were filled without consulting the prescriber and without having a legitimate medical purpose. The facts supporting this cause are specified in paragraphs 32-83 above and incorporated herein by reference.

SIXTEENTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct – Misuse of Education and Failure to Implement Professional Judgment)

85. Respondent Chappell is subject to disciplinary action for unprofessional conduct under Code section 4301, subsections (j) and (o), and Code section 4306.5 in that her conduct while serving as the PIC of the Pharmacy reflected an inappropriate exercise of her education, training, or experience as a pharmacist and she failed to exercise or implement her best professional judgment and properly run and manage the pharmacy according to pharmacy laws and regulations. Respondent Chappell, who was acting as the PIC at the Pharmacy, failed to use her education, training, and judgment in her operation of the Pharmacy when she re-dispensed adulterated medications held by unlicensed individuals, dispensed expired medication, provided and billed medications without prescriptions, failed to close the pharmacy following a sewage spill and construction, substituted medications without provider approval, and failed to maintain proper records and documentation of prescriptions. The facts supporting this cause are specified in paragraphs 32-84 above and incorporated herein by reference.

SEVENTEENTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct – Prescribing Controlled Substances to Self)

86. Respondent Chappell, the owner and PIC of Respondent Pharmacy, is subject to disciplinary action for unprofessional conduct under Code sections 4301, subsections (f), (j), and (o), and 4060 as well as Health and Safety Code section 11170, in that she falsified prescriptions and prescribed controlled substances to herself in violation of Pharmacy Laws and Regulations. Her conduct involved moral turpitude, dishonesty, fraud or deceit. From July 1 to August 1,

2013, as evidenced by her prescription profiles and CURES reports, Respondent Chappell obtained a total of 660 tablets of oxycodone/apap 10/325mg under Rx number 383227 falsely dated 4/01/12, Rx 383245 falsely dated 1/3/12, and Rx 383246 falsely dated 11/10/11. Pharmacist Chappell obtained the oxycodone/apap 10/325mg tablets without any authorization. The facts supporting this cause are specified in paragraphs 32-85 above and incorporated herein by reference.

OTHER MATTERS

87. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 46288 issued to Sixth Avenue Pharmacy, Sixth Avenue Pharmacy shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 46822 is placed on probation or until Pharmacy Permit Number PHY 46822 is reinstated if it is revoked.

88. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 46288 issued to Sixth Avenue Pharmacy, and Respondent Chappell, while acting as the manager, administrator, owner, member, officer, director, associate, or partner of Respondent Pharmacy, had knowledge of, or knowingly participated in any conduct for which Pharmacy Permit Number PHY 46288 was revoked, suspended or placed on probation, Respondent Chappell shall be prohibited from serving as manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy permit Number PHY 46288 issued to Respondent Pharmacy is placed on probation, or until Pharmacy Permit Number PHY 46288 issued to Respondent Pharmacy is reinstated, if Pharmacy Permit Number PHY 46288 is revoked.

PRAYER

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

1. Revoking or suspending Pharmacy Permit Number PHY 46288, issued to Sixth Avenue Pharmacy;

2. Revoking or suspending Pharmacist License Number RPH 27119, issued to Alma Jean Loechler Chappell;

3. Prohibiting Sixth Avenue Pharmacy from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 46288 is placed on probation or until Pharmacy Permit Number PHY 46288 is reinstated if Pharmacy Permit Number 46288 issued to Sixth Avenue Pharmacy;

4. Prohibiting Alma Jean Loechler Chappell from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 46288 is placed on probation or until Pharmacy Permit Number PHY 46288 is reinstated if Pharmacy Permit Number PHY 46288 issued to Sixth Avenue Pharmacy is revoked;

5. Ordering Sixth Avenue Pharmacy and Alma Jean Loechler Chappell to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

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

DATED: 4/5/18

Virginia Herold

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

SD2016701558
81831597.docx