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

In the Matter of the Accusation Against: **WESTSIDE PLAZA PHARMACY** **SUWONNEE PONGNORSING,** **OWNER/PHARMACIST-IN-CHARGE,** Original Permit No. PHY 45161 and SUWONNEE PONGNORSING, Original Pharmacist License No. RPH 35104 Respondents.	Case No. 5355 OAH No. 2015090738

ORDER DENYING RECONSIDERATION

The California State Board of Pharmacy (Board) issued a Decision and Order (Decision) in this matter on August 19, 2016. The Decision was made effective on September 19, 2016.

By letter dated August 19, 2016, respondent timely filed a petition for reconsideration of the Board's Decision of the same date. Complainant filed an opposition to the petition on or about August 30, 2016. Respondent filed a Reply for Petition for Reconsideration on or about September 8, 2016. On September 12, 2016, pursuant to section 11521 of the Government Code, the effective date of the Board's Decision was stayed to allow the Board time to consider the petition.

The Board, having read and considered the petition, the opposition to the petition filed by the complainant and respondent's reply, hereby denies the petition.

The August 19, 2016, Decision, which was stayed to allow time for the Board to consider the petition, is the Board's final decision in this matter and will become effective at the end of the stay, that is, at 5:00 p.m. on September 29, 2016.

IT IS SO ORDERED this 26th day of September, 2016.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By _____
Amy Gutierrez, Pharm.D.
Board President

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

In the Matter of the Accusation Against: WESTSIDE PLAZA PHARMACY SUWONNEE PONGNORSING, OWNER/PHARMACIST-IN-CHARGE, Original Permit No. PHY 45161 and SUWONNEE PONGNORSING, Original Pharmacist License No. RPH 35104 Respondents.	Case No. 5355 OAH No. 2015090738 10-DAY STAY ORDER OF EFFECTIVE DATE OF DECISION

ORDER STAYING EFFECTIVE DATE

Respondents Westside Plaza Pharmacy and Suwonnee Pongnorsing timely requested reconsideration of the decision in the above-entitled matter pursuant to section 11521 of the Government Code. In order to allow the board additional time to consider the petition, in accordance with the provisions of section 11521 of the Government Code,

IT IS HEREBY ORDERED that the effective date of the Decision and Order, in the above-entitled matter is stayed until 5 p.m. on September 29, 2016.

IT IS SO ORDERED this 12th day of September 2016.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

Virginia Herold

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

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

In the Matter of the Accusation Against: WESTSIDE PLAZA PHARMACY SUWONNEE PONGNORSING, OWNER/PHARMACIST-IN-CHARGE, Original Permit No. PHY 45161 and SUWONNEE PONGNORSING, Original Pharmacist License No. RPH 35104 Respondents.	Case No. 5355 OAH No. 2015090738

DECISION AND ORDER

The attached Proposed Decision of the Administrative Law Judge 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 September 19, 2016.

It is so ORDERED on August 19, 2016.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By _____
Amy Gutierrez, Pharm.D.
Board President

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

In the Matter of the Accusation Against: WESTSIDE PLAZA PHARMACY SUWONNEE PONGNORSING, OWNER/PHARMACIST-IN-CHARGE, Original Permit No. PHY 45161 Respondent and SUWONNEE PONGNORSING, Original Pharmacist License No. RPH 35104 Respondent.	Case No. 5355 OAH No. 2015090738

PROPOSED DECISION

Administrative Law Judge Coren D. Wong, Office of Administrative Hearings, State of California, heard this matter on June 13 through 16, 2016, in Sacramento, California.

Phillip L. Arthur, Deputy Attorney General, represented complainant Virginia K. Herold, Executive Officer of the Board of Pharmacy (Board), Department of Consumer Affairs (Department), State of California.

Attorney Gregory P. Matzen of the Law Offices of Gregory P. Matzen represented respondents Westside Plaza Pharmacy and Suwonnee Pongnorsing. Ms. Pongnorsing was present throughout the hearing, and was provided interpreting services by Thai interpreter John Johnson.

Evidence was received, the record was closed, and the matter was submitted for decision on June 16, 2016.

SUMMARY

Complainant seeks to discipline Westside Plaza Pharmacy's permit because it violated numerous federal and state laws and regulations regarding pharmacy. And since Ms. Pongnorsing was the pharmacist-in-charge of Westside Plaza Pharmacy when those violations occurred, discipline of her license is also sought. Additionally, she violated her corresponding duty with regard to numerous prescriptions for Schedule II controlled substances written by a physician whose office was in Fresno, California. Cause for discipline was established by clear and convincing evidence. Ms. Pongnorsing did not introduce evidence of her continued fitness to perform the duties of a pharmacist, even on a restricted basis. Therefore, Westside's permit and Ms. Pongnorsing's license should both be revoked.

FACTUAL FINDINGS

Procedural Matters

1. On December 12, 1979, the Board issued Original Pharmacist License No. RPH 35104 to respondent Suwonnee Pongnorsing. Effective March 12, 1992, the license was revoked, revocation was stayed, and the license was placed on probation, subject to terms and conditions including an actual suspension of 30 days, based on Ms. Pongnorsing's criminal conviction for furnishing a dangerous drug pursuant to an invalid prescription, her engaging in the underlying criminal conduct, and the presence of misbranded drugs in Westside Plaza Pharmacy. Ms. Pongnorsing successfully completed probation, and her license was fully restored. The license expires November 30, 2017, unless renewed or revoked.

2. On October 2, 2001, the Board issued Original Permit No. PHY 45161 to Ms. Pongnorsing to do business as respondent Westside Plaza Pharmacy (Westside) at 314 I Street, Modesto, California.[1] The license was canceled on January 8, 2016. Ms. Pongnorsing was listed as the individual licensed owner and the pharmacist-in-charge for the entire duration of the permit. There is no history of prior discipline of the permit.

3. Complainant, acting solely in her official capacity, signed the Accusation on May 28, 2015. The Accusation seeks to discipline Ms. Pongnorsing's license and Westside's permit based on numerous violations of federal and state laws and regulations governing pharmacy.

[1] Respondent Westside Plaza Pharmacy was operated at a different location and pursuant to a different permit than the "Westside Plaza Pharmacy" Ms. Pongnorsing owned and at which she worked when her license was previously disciplined. She subsequently sold the original Westside Plaza Pharmacy.

The Board's Investigation

4. In October 2012, investigators from the United States Drug Enforcement Administration (DEA) contacted Joseph Wong, Pharm.D., an investigator with the Board, to request the Board's assistance with inspecting several pharmacies with regard to their dispensing of controlled substances, including Westside. The agents explained Westside's history of purchasing controlled substances from several different wholesalers and filling a large amount of prescriptions for controlled substances written by Terrill Brown, M.D., a physician in Fresno, California, had come to the attention of the DEA.

5. Dr. Wong agreed to assist the DEA, and requested two CURES reports for the time period of November 1, 2009, through November 2, 2012 – one showing all controlled substances dispensed by Westside and another showing all controlled substances dispensed by Westside pursuant to prescriptions written by Dr. Brown.[2] The information contained in those reports showed Westside filled more prescriptions written by Dr. Brown than any other pharmacy – a total of 8,461 prescriptions. The pharmacy that filled the second most prescriptions written by Dr. Brown filled only 862 prescriptions (Oakdale Pharmacy), and the one that filled the third most only 718 prescriptions (Medicine Shoppe)[3].

6. The CURES reports also showed the following pattern for prescribing Schedule II controlled substances by Dr. Brown:

Patient Name	Drug	Quantity	Date of Rx	Date Filled
S.C.	Oxycodone 30 mg[4]	120	8/16/2011	8/16/2011
S.E.	Oxycodone 30 mg	120	8/16/2011	8/16/2011

[2] The Controlled Substance Utilization Review and Evaluation System (CURES) is a computer database that stores information about each prescription for a Schedule II, III, and IV controlled substance dispensed in California. The information stored includes the patient's name, date of birth, and address; the prescriber's name and DEA number; the pharmacy's name and license number; the date the prescription was dispensed; the prescription number; the drug name; the quantity and strength; and the number of refills remaining for each prescription. Any person or entity who dispenses a Schedule II through IV controlled substance in California is required to submit such information to the database. A user of the system may print a report, sorting the information reported by the pharmacy that dispensed the medication, the physician that prescribed it, or the patient for whom it was prescribed.

[3] Walgreens as a whole filled more prescriptions than Medicine Shoppe (796 prescriptions), but no one Walgreens location filled more than 718 prescriptions (the largest filled 332).

[4] Oxycodone is a Schedule II controlled substance. (Health & Saf. Code, § 11055, subd. (b)(1)(M).)

C.Y.	Oxycodone 30 mg	120	9/10/2011	9/12/2011
Ch.Y.	Oxycodone 30 mg	120	9/10/2011	9/12/2011
I.G.	Oxycodone 30 mg	120	9/10/2011	9/12/2011
R.C.	Oxycodone 30 mg	120	9/10/2011	9/12/2011
S.C.	Oxycodone 30 mg	120	9/10/2011	9/16/2011
S.E.	Oxycodone 30 mg	120	9/10/2011	***
C.Y.	Oxycodone 30 mg	150	10/7/2011	10/11/2011
Ch.Y.	Oxycodone 30 mg	150	10/7/2011	10/11/2011
Cha.Y.	Oxycodone 30 mg	120	10/7/2011	10/11/2011
I.G.	Oxycodone 30 mg	150	10/7/2011	10/11/2011
R.C.	Oxycodone 30 mg	150	10/7/2011	10/10/2011
Sd.C.	Oxycodone 30 mg	150	10/7/2011	10/21/2011
Ch.Y.	Opana ER 40 mg[5]	120	11/9/2011	11/11/2011
Cha.Y.	Opana ER 40 mg	120	11/9/2011	11/10/2011
I.G.	Opana ER 40 mg	120	11/9/2011	11/11/2011
S.C.	Opana ER 40 mg	210	11/9/2011	12/6/2011
S.E.	Opana ER 40 mg	120	11/9/2011	11/11/2011
Sd.C.	Opana ER 40 mg	120	11/9/2011	11/21/2011
S.C.	Oxycodone 30 mg	240	12/7/2011	1/6/2012
S.C.	Norco 10mg/325 mg[6]	150	12/7/2011	1/6/2012
C.Y.	Oxycodone 30 mg	180	1/11/2012	1/11/2012
Ch.Y.	Oxycodone 30 mg	180	1/11/2012	1/11/2012
I.G.	Oxycodone 30 mg	180	1/11/2012	1/11/2012
R.C.	Oxycodone 30 mg	180	1/11/2012	1/11/2012
S.C.	Oxycodone 30 mg	240	1/11/2012	2/6/202
S.E.	Oxycodone 30 mg	210	1/11/2012	2/8/2012
C.Y.	Oxycodone 30 mg	180	2/15/2012	3/1/2012
L.H.C.	Oxycodone 30 mg	180	2/15/2012	***

7. The CURES reports further showed Westside filled the following prescriptions for Schedule II controlled substances written by Dr. Brown for patients who lived outside Westside's "normal trade area:"[7]

[5] "Opana" is a brand name for oxymorphone, a Schedule II controlled substance. (Health & Saf. Code, § 11055, subd. (b)(1)(N).)

[6] "Norco" is a brand name for hydrocodone with acetaminophen, a Schedule II controlled substance. (Health & Saf. Code, § 11055, subd. (b)(1)(I).)

Rx	Patient's City & Zip Code	Drug	Date Filled	Approximate Distance (Patient to Westside)
656977	Santa Rosa, 95403	APAP/Hydrocodone Bitartrate[8]	11/18/2011	144 miles
656977	Santa Rosa, 95403	APAP/Hydrocodone Bitartrate	12/16/2011	144 miles
656977	Santa Rosa, 95403	APAP/Hydrocodone Bitartrate	1/16/2012	144 miles
656977	Santa Rosa, 95403	APAP/Hydrocodone Bitartrate	2/20/2012	144 miles
667560	Santa Rosa, 95403	APAP/Hydrocodone Bitartrate	3/27/2012	144 miles
667560	Santa Rosa, 95403	APAP/Hydrocodone Bitartrate	4/24/2012	144 miles
656978	Santa Rosa, 95403	APAP/Hydrocodone Bitartrate	11/18/2011	144 miles
656978	Santa Rosa, 95403	APAP/Hydrocodone Bitartrate	12/16/2011	144 miles
656978	Santa Rosa, 95403	APAP/Hydrocodone Bitartrate	1/16/2012	144 miles
656978	Santa Rosa, 95403	APAP/Hydrocodone Bitartrate	2/20/2012	144 miles
669241	Santa Rosa, 95403	APAP/Hydrocodone Bitartrate	4/13/2012	144 miles
655292	Fresno, 93704	APAP/Hydrocodone Bitartrate	10/28/2011	91 miles
655292	Fresno, 93704	APAP/Hydrocodone Bitartrate	12/3/2011	91 miles
655292	Fresno, 93704	APAP/Hydrocodone Bitartrate	1/6/2012	91 miles
655292	Fresno, 93704	APAP/Hydrocodone Bitartrate	2/2/2012	91 miles

[7] Dr. Wong explained at hearing that all pharmacies have a "normal trade area," a geographical area surrounding the pharmacy in which its customers generally live. The presentation of a prescription by a patient who resides outside a pharmacy's normal trade area should raise the pharmacist's suspicions as explained further below. Dr. Wong did not, however, explain the size of a typical normal trade area. Nonetheless, a reasonable inference is drawn from the evidence that Westside's "normal trade area" is smaller than an 80 mile radius from the pharmacy.

[8] Generic for Vicodin, a Schedule II controlled substance. (Health & Saf. Code, § 11055, subd. (b)(1)(I).)

654203	Mecca, 92254	Oxycodone	10/12/2011	458 miles
656497	Mecca, 92254	Opana ER	11/14/2011	458 miles
664634	Mecca, 92254	Oxycodone	2/22/2012	458 miles
666229	Mecca, 92254	Oxycodone	3/10/2012	458 miles
656507	Mecca, 92254	Opana ER	11/14/2011	458 miles
664750	Mecca, 92254	Oxycodone	2/23/2012	458 miles
656406	Long Beach, 90813	Opana ER	11/12/2011	334 miles
655772	Norwalk, 90650	Opana ER	11/3/2011	326 miles
663562	Norwalk, 90650	Oxycodone	2/8/2012	326 miles
667328	Norwalk, 90650	Oxycodone	3/23/2012	326 miles
661770	San Francisco, 94115	Oxycodone	1/19/2012	95 miles
668322	San Francisco, 94115	Oxycodone	4/4/2012	95 miles
655769	Long Beach, 90806	Opana ER	11/3/2011	334 miles
665334	Long Beach, 90806	Oxycodone	3/1/2012	334 miles
661113	Long Beach, 90813	Oxycodone	1/11/2012	334 miles
650299	Oakland, 94606	Oxycodone	8/22/2011	81 miles
651318	Oakland, 94606	Oxycodone	9/7/2011	81 miles
653623	Oakland, 94606	Oxycodone	10/6/2011	81 miles
652432	San Francisco, 94102	Oxycodone	9/20/2011	95 miles
658576	San Francisco, 94102	Oxycodone	12/8/2011	95 miles
660803	San Francisco, 94102	APAP/Hydrocodone Bitartrate	1/7/2012	95 miles
661277	San Francisco, 94102	Oxycodone	1/13/2012	95 miles
666224	San Francisco, 94102	Oxycodone	3/10/2012	95 miles
660803	San Francisco, 94102	APAP/Hydrocodone Bitartrate	3/13/2012	95 miles
660803	San Francisco, 94102	APAP/Hydrocodone Bitartrate	4/10/2012	95 miles
670454	San Francisco, 94102	Oxycodone	4/30/2012	95 miles
660803	San Francisco, 94102	APAP/Hydrocodone Bitartrate	6/1/2012	95 miles
681028	San Francisco, 94102	APAP/Hydrocodone Bitartrate	10/3/2012	95 miles

654208	Mecca, 92254	Oxycodone	10/12/2011	458 miles
656498	Mecca, 92254	Opana ER	11/14/2011	458 miles
656795	Long Beach, 90804	Opana ER	11/17/2011	334 miles
664748	Long Beach, 90804	Oxycodone	2/23/2012	334 miles
657871	Fresno, 97322	APAP/Hydrocodone Bitartrate	12/1/2011	91 miles
657871	Fresno, 97322	APAP/Hydrocodone Bitartrate	12/30/2011	91 miles
657871	Fresno, 97322	APAP/Hydrocodone Bitartrate	1/30/2012	91 miles
657871	Fresno, 97322	APAP/Hydrocodone Bitartrate	3/2/2012	91 miles
667968	Fresno, 97322	APAP/Hydrocodone Bitartrate	3/31/2012	91 miles
667968	Fresno, 97322	APAP/Hydrocodone Bitartrate	4/30/2012	91 miles
667968	Fresno, 97322	APAP/Hydrocodone Bitartrate	6/23/2012	91 miles
667968	Fresno, 97322	APAP/Hydrocodone Bitartrate	7/21/2012	91 miles
654202	Mecca, 92254	Oxycodone	10/12/2011	458 miles
656408	Mecca, 92254	Opana ER	11/12/2011	458 miles
664826	Mecca, 92254	Oxycodone	2/24/2012	458 miles
655765	Long Beach, 90805	Opana ER	11/3/2011	334 miles
664380	Long Beach, 90805	Oxycodone	2/17/2012	334 miles
668378	Long Beach, 90805	Oxycodone	4/4/2012	334 miles
653046	Long Beach, 90804	Oxycodone	9/28/2011	334 miles
656623	Long Beach, 90804	Oxycodone	11/15/2011	334 miles
664632	Long Beach, 90804	Oxycodone	2/22/2012	334 miles
664387	Long Beach, 90813	Oxycodone	2/17/2012	334 miles
653050	Long Beach, 90804	Oxycodone	9/28/2011	334 miles
656620	Long Beach, 90804	Oxycodone	11/15/2011	334 miles
664510	Long Beach,	Oxycodone	2/21/2012	334 miles

	90804			
652520	San Jose, 95122	Oxycodone	9/21/2011	83 miles
655284	San Jose, 95122	Oxycodone	10/28/2011	83 miles
653045	Long Beach, 90805	Oxycodone	9/28/2011	334 miles
656622	Long Beach, 90805	Oxycodone	11/15/2011	334 miles
664379	Long Beach, 90805	Oxycodone	2/17/2012	334 miles
655753	Long Beach, 90806	Opana ER	11/3/2011	334 miles
664386	Long Beach, 90806	Oxycodone	2/17/2012	334 miles
655781	Signal Hill, 90755	Opana ER	11/3/2011	333 miles
663565	Signal Hill, 90755	Oxycodone	2/8/2012	333 miles
668379	Signal Hill, 90755	Oxycodone	4/4/2012	333 miles
655757	Norwalk, 90650	Opana ER	11/3/2011	326 miles
657765	Norwalk, 90650	Oxycodone	11/30/2011	326 miles
664385	Norwalk, 90650	Oxycodone	2/17/2012	326 miles
654205	Winchester, 92596	Oxycodone	10/12/2011	393 miles
656359	Winchester, 92596	Opana ER	11/11/2011	393 miles
656464	Long Beach, 90806	Opana ER	11/14/2011	334 miles
659661	Long Beach, 90806	APAP/Hydrocodone Bitartrate	12/23/2011	334 miles
659663	Long Beach, 90806	Oxycodone	12/23/2011	334 miles
654207	Mecca, 92254	Oxycodone	10/12/2011	458 miles
656494	Mecca, 92254	Opana ER	11/14/2011	458 miles
658553	San Jose, 95133	Oxycodone	12/8/2011	83 miles
658265	Fresno, 93706	APAP/Hydrocodone Bitartrate	2/8/2012	91 miles
664382	Long Beach, 90804	Oxycodone	2/17/2012	334 miles
667331	Long Beach, 90804	Oxycodone	3/23/2012	334 miles
655743	Signal Hill, 90755	Opana ER	11/3/2011	333 miles
664383	Signal Hill, 90755	Oxycodone	2/17/2012	333 miles
652789	Long Beach, 90806	Oxycodone	9/24/2011	334 miles
655285	Long Beach, 90806	Oxycodone	10/28/2011	334 miles
664384	Long Beach, 90806	Oxycodone	2/17/2012	334 miles

667325	Long Beach, 90806	Oxycodone	3/23/2012	334 miles
663568	Long Beach, 90813	Oxycodone	2/8/2012	334 miles
666226	Long Beach, 90813	Oxycodone	3/10/2012	334 miles
669015	Monterey, 93940	APAP/Hydrocodone Bitartrate	4/11/2012	121 miles
669015	Monterey, 93940	APAP/Hydrocodone Bitartrate	7/3/2012	121 miles
669015	Monterey, 93940	APAP/Hydrocodone Bitartrate	8/8/2012	121 miles
653043	Long Beach, 90804	Oxycodone	9/28/2011	334 miles
656618	Long Beach, 90804	Oxycodone	11/15/2011	334 miles
656407	Long Beach, 90804	Opana ER	11/12/2011	334 miles
663564	Long Beach, 90804	Oxycodone	2/8/2012	334 miles
666227	Long Beach, 90804	Oxycodone	3/10/2012	334 miles
656625	Long Beach, 90813	Opana ER	11/15/2011	334 miles

8. Dr. Wong checked the California Medical Board's website to determine if there were any restrictions on Dr. Brown's license to practice medicine. He discovered Dr. Brown's license was publicly reprimanded in August 2007, but there were no restrictions on his ability to practice medicine or prescribe controlled substances.

December 11, 2012 accountability audit

9. On December 11, 2012, Dr. Wong and his colleague, Board investigator Manisha Patel, Pharm.D., joined investigators from the DEA and the Internal Revenue Service (IRS) in attempting to conduct an accountability audit of Westside. Upon their arrival, the investigators contacted the pharmacist on duty at the time, Nada Vicijan, who informed them Ms. Pongnorsing was not present. Ms. Vicijan telephoned Ms. Pongnorsing at home, and Ms. Pongnorsing agreed to come to the pharmacy.

10. Upon Ms. Pongnorsing's arrival, the investigators explained the purpose of their visit, and she agreed to assist them with conducting the accountability audit. Ms. Pongnorsing was asked where she kept Westside's controlled substance records and inventory, and she brought the investigators back to her office. Controlled substances were located in numerous drawers throughout the office.

11. Investigators asked for a copy of Westside's most recent biennial inventory of all controlled substances to determine the audit period, and Ms. Pongnorsing produced two handwritten memo books containing the count of Schedule III, IV, and V controlled substances as of May 27, 2011. The two memo books did not constitute a proper biennial inventory because there was no indication whether the inventory was taken at the opening or close of business on May 27, 2011, and there was no indication of the form in which each drug counted existed, i.e., pill, capsule, or liquid.

12. Ms. Pongnorsing also produced a "perpetual log"[9] listing all Schedule II controlled substances. The log did not constitute a proper biennial inventory because the drug counts were not conducted on the same day and there was no indication of the form in which each drug counted existed.

13. Investigators reviewed several bundles of invoices from drug wholesalers from whom Westside purchased controlled substances. They discovered 252 separate occasions on which Westside failed to record the date on which the particular drug or drugs were received as follows:

Supplier	**Number of Violations**
McKesson Corporation	80
Harvard Drug	90
Top RX Inc.	14
HD Smith Wholesale	67
Masters Pharmaceutical	1
Total:	252

Investigators also discovered 21 separate occasions on which Westside received controlled substances from McKesson Corporation, but failed to record the number of packages received, the date received, or both on the Form DEA-222. There were three instances where Westside did not maintain complete and accurate records of each controlled substance received, sold, or delivered.

14. Investigators ultimately determined they could not conduct a proper accountability audit due to the deficiencies in Westside's recordkeeping with regard to controlled substances. Therefore, they shifted their focus to conducting a general inspection of the pharmacy.

15. Investigators discovered the following prescriptions, which had been filled but not dispensed to the patients for whom they were written, some dating as far back as February 2012. They checked the particular patient profiles in Westside's computer database

[9] A log which separately itemized each Schedule II controlled substance in Westside, the quantity of the particular drug before each transaction, the quantity dispensed, and the remaining balance.

and learned insurance claims were submitted and subsequently paid for each prescription, but never reversed to reflect the medication as never having been picked up by the patient.

Patient Name	RX No.	Date Filled	Drug
B.Kh.	678455	9/25/2012	Ibuprofen 800 mg
B.K.	678456	9/25/2012	Simvastatin 20 mg
B.S.	674876	6/26/2012	Omeprazole 40 mg
B.S.	674277	7/31/2012	Diphenhydramine 50 mg
B.Ke.	677822	11/23/2012	Hydroxyzine 10 mg
B.Ke.	677823	11/23/2012	Triamcinolone 0.1% cream
J.S.	670876	6/28/2012	Ferrous Sulfate 220mg/5ml ellxlr
J.S.	670876	8/31/2012	Ferrous Sulfate 220 mg/5 ml ellxlr
J.S.	670877	8/31/2012	Multi-Vitamin with Fluoride 1 mg
J.S.	670877	6/28/2012	Multi—Vitamin with Fluoride 1 mg
K.P.	679212	9/4/2012	Hctz 12.5 mg
K.K.	676431	10/16/2012	Cionidine 0.2 mg
L.B.	675949	7/12/2012	Morphine-ER 30 mg
L.K.	674941	11/3/2012	Citalopram 20 mg
L.K.	670458	11/3/2012	Tramadol 50 mg
L.K.	670457	11/3/2012	Meloxicam 15 mg
L.H.	666853	9/20/2012	Melformin 500 mg
L.H.	680300	9/20/2012	Triamterene 75 mg/Hctz 50 mg
L.H.	680299	9/20/2012	Benzapril 20 mg
M.D., Sr.	655831	2/7/2012	Baclofen 10 mg
R.N.	678213	8/16/2012	Fluoxetine 20 mg
R.R.	682821	10/31/2012	Fluticasone Nasal Spray
S.Se.	683427	11/13/2012	ProAir 90 mcg
S.Sa.	647810	6/20/2012	Meloxicam 15 mg
S.Sa.	659154	6/20/2012	Diovan Hct 160mg/12.5 mg
S.Sa.	659154	7/26/2012	Divan Hct 160 mg/12.5 mg
S.Sa.	659158	7/26/2012	Levothyroxine 150 mcg
T.T.	674579	6/26/2012	Amphetamine 10 mg
T.T.	677743	8/9/2012	Amphetamine 10 mg

Ms. Pongnorsing was instructed to reverse the insurance claims and credit the money back for each of the above prescriptions.

16. Investigators also discovered the following prescriptions, which were labeled as having been dispensed by "Paradise Drugs" and delivered to Westside for delivery to the patients. Each bottle was labeled for dispensing to a particular patient and insurance claims were submitted and subsequently paid for each. Ms. Pongnorsing never informed Paradise Drugs the prescriptions were not picked up or that the insurance claims should be reversed.

RX No.	Patient	Drug	Date Filled	Pick-Up Record
C950908	L.K.	Hydrocodone/APAP 5 mg/500 mg	12/06/2012	Signed for by S.D. of Westside on 12/07/2012
C948393	NYR	Lyrica 300 mg	11/19/2012	Signed for by C. of Westside on 11/19/2012
C949610	U.C.	Hydrocodone/APAP 5 mg/500 mg	11/28/2012	Signed for by L. of Westside on 11/30/2012
C950910	C.K.	Hydrocodone/APAP 5 mg/500 mg	12/06/2012	Signed for by S.D. of Westside on 12/07/2012
C948667	N.T.	Zolpidem 10 mg	11/21/2012	Signed for by C. of Westside on 11/19/2012
C950909	Y.Y.	Zolpidem 10 mg	12/06/2012	Signed for by S.D. of Westside on 12/07/2012

17. At the conclusion of the inspection, an investigator from the DEA asked Ms. Pongnorsing whether she was interested in surrendering her DEA registration, which allowed her to possess controlled substances. Ms. Pongnorsing requested an opportunity to discuss the proposal in private with Ms. Vicijan, and the investigator obliged. Afterward, Ms. Pongnorsing agreed to surrender her DEA registration, and the investigator seized all controlled substances in the pharmacy.

Follow up investigation by the Board

18. On August 21, 2014, Ms. Pongnorsing sent updated patient profiles for those patients whose prescriptions were found during the December 11, 2012 inspection of Westside and for which Dr. Wong instructed Ms. Pongnorsing to reverse the insurance claims discussed in Factual Finding 15. The updated patient profiles indicated she reversed the claims for all prescriptions found, except seven prescriptions for five patients, as follows:

Patient Name	RX No.	Date Filled	Drug	Reversed
B.Kh.	678455	9/25/2012	Ibuprofen 800 mg	Yes
B.K.	678456	9/25/2012	Simvastatin 20 mg	Yes
B.S.	674876	6/26/2012	Omeprazole 40 mg	Yes
B.S.	674277	7/31/2012	Diphenhydramine 50 mg	Yes
B.Ke.	677822	11/23/2012	Hydroxyzine 10 mg	Yes
B.Ke.	677823	11/23/2012	Triamcinolone 0.1% cream	Yes
J.S.	**670876**	**6/28/2012**	**Ferrous Sulfate 220mg/5ml ellxlr**	**No**

J.S.	**670876**	**8/31/2012**	**Ferrous Sulfate 220 mg/5 ml ellxlr**	**No**
J.S.	670877	8/31/2012	Multi-Vitamin with Fluoride 1 mg	Yes
J.S.	670877	6/28/2012	Multi—Vitamin with Fluoride 1 mg	Yes
K.P.	679212	9/4/2012	Hctz 12.5 mg	Yes
K.K.	676431	10/16/2012	Cionidine 0.2 mg	Yes
L.B.	**675949**	**7/12/2012**	**Morphine-ER 30 mg**	**No**
L.K.	674941	11/3/2012	Citalopram 20 mg	Yes
L.K.	670458	11/3/2012	Tramadol 50 mg	Yes
L.K.	670457	11/3/2012	Meloxicam 15 mg	Yes
L.H.	666853	9/20/2012	Melformin 500 mg	Yes
L.H.	680300	9/20/2012	Triamterene 75 mg/Hctz 50 mg	Yes
L.H.	680299	9/20/2012	Benzapril 20 mg	Yes
M.D., Sr.	**655831**	**2/7/2012**	**Baclofen 10 mg**	**No**
R.N.	678213	8/16/2012	Fluoxetine 20 mg	Yes
R.R.	682821	10/31/2012	Fluticasone Nasal Spray	Yes
S.Se.	**683427**	**11/13/2012**	**ProAir 90 mcg**	**No**
S.Sa.	647810	6/20/2012	Meloxicam 15 mg	Yes
S.Sa.	659154	6/20/2012	Diovan Hct 160mg/12.5 mg	Yes
S.Sa.	659154	7/26/2012	Divan Hct 160 mg/12.5 mg	Yes
S.Sa.	659158	7/26/2012	Levothyroxine 150 mcg	Yes
T.T.	**674579**	**6/26/2012**	**Amphetamine 10 mg**	**No**
T.T.	**677743**	**8/9/2012**	**Amphetamine 10 mg**	**No**

Respondent's Evidence

Background

19. Ms. Pongnorsing was born and raised in Bangkok, Thailand, and first learned to speak English in high school. She explained at hearing she studied English "continually every week," but studied mostly in Thai. After graduating high school, she attended Centro Escolar University in Manila, Philippines, where she was taught exclusively in English. She graduated in 1967 with a degree in pharmacy.

20. Ms. Pongnorsing emigrated to the United States in 1974, and settled near Burlingame, California. She enrolled in the Vocational Nursing Program at San Francisco Community College, obtained her degree, and was issued a license by the Board of Vocational Nursing and Psychiatric Technicians on September 6, 1984. Her license remained active as of the date of hearing.

21. Ms. Pongnorsing did not need to attend further courses in pharmacy prior to being licensed by the Board, but she explained she had to perform 1,500 hours as an intern pharmacist. She performed those hours at San Mateo Community Pharmacy, after which she took and passed the pharmacist exam and was issued a license to practice pharmacy.

22. Shortly after licensure, Ms. Pongnorsing opened Modesto Pharmacy in Modesto, California. She closed that pharmacy after opening Westside, the year in which that happened she could not recall at hearing.[10] Ms. Pongnorsing sold Westside to Nada Vicijan in May or June 2015, and Ms. Vicijan renamed the pharmacy "West Modesto Pharmacy." Ms. Pongnorsing works at West Modesto Pharmacy as a staff pharmacist, but explained at hearing she anticipates retiring from the practice of pharmacy in the not-too-distant future.[11]

December 11, 2012 accountability audit

23. Ms. Pongnorsing recalled at hearing being contacted at home by Ms. Vicijan and being told investigators from the DEA, IRS, and the Board were at Westside requesting to conduct an accountability audit on December 11, 2012. Ms. Pongnorsing explained she was "shocked and surprised" over the presence of the investigators when she arrived at Westside, and said she "couldn't even think" during the audit. She further explained investigators asked her for various documents, and she did not understand some of the questions asked of her because investigators spoke to her in English. Ms. Pongnorsing conceded at hearing, however, she did not tell any of the investigators she was having difficulty understanding them or request a translator.

24. Ms. Pongnorsing explained she maintained the perpetual log of Schedule II controlled substances in Westside's inventory discussed in Factual Finding 12 because she thought she was required to keep records of those drugs on a daily basis. She subsequently prepared an inventory of all Schedule II controlled substances in Westside's inventory as of May 31, 2009, and May 31, 2011, based solely on the information contained in the perpetual log, and an investigator from the DEA confirmed at hearing those records would have satisfied the biennial inventory requirement had they been produced on December 11, 2012.

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[10] As previously mentioned, Ms. Pongnorsing's prior discipline as a pharmacist occurred while she was the owner and pharmacist-in-charge of the original Westside Plaza Pharmacy, which was located at a different location and operated under a different permit than respondent Westside. The decision imposing discipline stated Ms. Pongnorsing sold the original Westside Plaza Pharmacy. No evidence of whether respondent Westside was a reincarnation of the original Westside Plaza Pharmacy at a different location was introduced.

[11] Ms. Pongnorsing owns the building out of which West Modesto Pharmacy operates.

25. Ms. Pongnorsing agreed at hearing the insurance claims for the prescriptions discussed in Factual Finding 15 needed to be reversed at the time of the inspection, and explained she did not reverse those claims that day because she was in "panic mode" over the presence of the investigators. She repeatedly testified she refunded all the claims the following day, and explained Exhibit R was an example of a reversed claim. She claimed to have other documents at hearing evidencing the reversal of all those claims, but did not offer any of them into evidence.

Corresponding duty

26. Ms. Pongnorsing explained at hearing she fulfilled her "corresponding duty" before filling prescriptions for Schedule II controlled substances written by Dr. Brown. While she did not discuss her efforts, if any, to confirm the legitimacy of any of the prescriptions discussed in Factual Findings 6 and 7, she explained the efforts she made in general starting in 2012. For example, she began contacting Dr. Brown and inquiring about the patient's disease or condition for which the prescription was written. She also recalled contacting the pharmacists at Costco and CVS and asking whether they were also receiving prescriptions for Schedule II controlled substances written by Dr. Brown. She checked the Medical Board of California's website to determine the status of Dr. Brown's license and whether there was any discipline pending against it. While she read his license was subject to a public reprimand, there were no restrictions on his ability to practice medicine or prescribe controlled substances.

27. Ms. Pongnorsing estimated she stopped filling Dr. Brown's prescriptions for Schedule II controlled substances in May or June 2012 because "I didn't feel comfortable about it." But she either could not or would not explain what about Dr. Brown's prescriptions made her uncomfortable with filling them, instead stating "I wasn't comfortable and because I wasn't comfortable I stopped filling them," "I wasn't comfortable regarding Schedule IIs" so I stopped filling them, and "I just wasn't comfortable."

Discussion

Acts involving moral turpitude, dishonesty, fraud, deceit, or corruption

28. On December 11, 2012, Westside was in possession of 28 prescriptions which had been filled for patients and billed to their respective insurance companies, but not dispensed as discussed in Factual Finding 15. One such prescription had been filled more than 10 months earlier. Ms. Pongnorsing was instructed to refund all monies Westside had received for those prescriptions, and as of August 21, 2014, she had done so for all except seven prescriptions as explained in Factual Finding 18.

At hearing, Ms. Pongnorsing claimed to have documentation showing she issued refunds for each of the prescriptions. However, she did not offer that documentation into evidence, and her testimony was not credible. (Evid. Code. § 412 ["If weaker and less satisfactory evidence is offered when it was within the power of the party to produce stronger

and more satisfactory evidence, the evidence offered should be viewed with distrust"].) Therefore, the evidence established Westside engaged in acts involving moral turpitude, dishonesty, fraud, deceit, or corruption.

29. Westside was also in possession of the six prescriptions discussed in Factual Finding 16, which were filled by Paradise Drugs and delivered to Westside for delivery to the patients. None of those prescriptions were delivered to the patients, and Westside never notified Paradise Drugs of that fact or that the insurance claims should be reversed. Therefore, the evidence established Westside engaged in acts involving moral turpitude, dishonesty, fraud, deceit, or corruption.

Violation of federal and state laws and regulations pertaining to pharmacy

30. The evidence established Westside failed to record on the invoices the dates on which the particular shipments of controlled substances were received on 252 separate occasions as explained in Factual Finding 13. Westside also failed to record the number of packages of controlled substances received, the date the packages were received, and/or both on 21 separate occasions. Westside further failed to maintain a complete and accurate record of each controlled substance it received, sold, or delivered on three instances. The evidence further established Westside failed to make a biennial inventory of all Schedule II through V controlled substances it maintained as explained in Factual Findings 11 and 12.

While Ms. Pongnorsing explained she had difficulty understanding some of the questions the investigators asked her on December 11, 2012, her violations of federal and state laws and regulations pertaining to pharmacy were not based on her answers to any of those questions, but rather the facts that existed as of December 11, 2012. Additionally, she never told any of the investigators she was having trouble understanding them or requested a translator; she understood enough English and had sufficient sophistication to ask to discuss privately with Ms. Vicijan the DEA's proposal that she surrender her DEA registration before agreeing to do so; and she learned English in high school, was taught pharmacy in college exclusively in English, and completed the vocational nursing program in English. At hearing, Ms. Pongnorsing testified through a Thai interpreter, but responded to several questions in English prior to them being translated into Thai. Therefore, Ms. Pongnorsing's claim of having a limited understanding of the English language was suspect at best.

Corresponding duty

31. Ms. Pongnorsing owes a corresponding duty as a pharmacist to identify each prescription she fills as having been written for a legitimate medical purpose as explained in more detail in the Legal Conclusions. While her corresponding duty does not make her a guarantor that every prescription filled was in fact written for a legitimate medical purpose, it requires her to exercise professional judgment in assessing the legitimacy of each prescription presented. If Ms. Pongnorsing still holds doubt as to the legitimacy of a prescription after making reasonable attempts to verify its legitimacy, she is obligated to reject the prescription and not fill it.

32. Information regarding the prescriptions described in Factual Findings 6 and 7 revealed multiple "red flags" that should have raised Ms. Pongnorsing's suspicions about each prescription. Specifically, each was written for a Schedule II controlled substance, the most addicting of all controlled substances and a commonly abused drug. Therefore, Dr. Brown's practice of prescribing the same or similar Schedule II controlled substance multiple times in the same day was suspicious. Additionally, the fact that patients purportedly travelled more than 80 miles from their homes, several traveling more 400 miles, to have their prescriptions filled as Westside was suspicious. And that the prescriptions were written by a physician whose office was more than 90 miles from Westside was suspicious, as was the fact that most of the patients did not live in or near Fresno.

33. Despite these red flags, Ms. Pongnorsing did not fulfill her corresponding duty by taking steps to confirm the legitimacy of the prescriptions. While none of the red flags by themselves constituted conclusive evidence of a fraudulent prescription, each was sufficient to raise enough suspicion such that Ms. Pongnorsing was obligated to make a reasonable inquiry to determine the legitimacy of the prescription. Depending on the particular circumstances, that inquiry may have been as simple as contacting Dr. Brown's office and asking what type of practice he operated to determine whether it was one that would often necessitate writing multiple prescriptions for a Schedule II controlled substance in the same day, such as a pain management practice.[12] Ms. Pongnorsing should have also inquired about why the patients were traveling such seemingly long distances to obtain their prescriptions from Dr. Brown and have them filled at Westside.

Ms. Pongnorsing explained she began contacting Dr. Brown in 2012 and asking what conditions the prescriptions were being written for, and she eventually stopped filling his prescriptions for Schedule II controlled substances altogether in May or June 2012. But many of the red flags described in Factual Findings 6 and 7 existed prior to 2012. Furthermore, she was either unable or unwilling to articulate what made her "uncomfortable" about filling Dr. Brown's prescriptions when she stopped, which raised questions about the truthfulness of her testimony. And even if her testimony was believed, she did not discuss any explanations she received for why patients traveled such long distances to obtain their prescriptions and have them filled.

34. The evidence established Ms. Pongnorsing did not fulfill her corresponding duty with regard to numerous prescriptions for Schedule II controlled substances written by Dr. Brown and submitted to Westside between May 18, 2011, and October 3, 2012.[13]

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[12] Oxycodone, Opana, and Vicodin are opioids commonly prescribed for the treatment of severe pain.

[13] Complainant alleged the prescriptions were written for 63 different patients, and Dr. Brown's licensure status constituted a red flag. But information identifying the particular patients was redacted from most of the evidence regarding those prescriptions. Additionally, the evidence established there were no restrictions on Dr. Brown's ability to practice medicine or to prescribe medication during the relevant timeframe. And while his license

Summary

35. Cause exists to discipline Westside's permit for the reasons explained further in the Legal Conclusions. And since a pharmacy can act only through its authorized agents and Ms. Pongnorsing was the designated pharmacist-in-charge, cause also exists to discipline her license. Furthermore, she failed to perform her corresponding duty with regard to numerous prescriptions for Schedule II controlled substances written by Dr. Brown between May 18, 2011, and October 3, 2012.

When all the evidence is considered, Ms. Pongnorsing failed to introduce evidence of her continued fitness for licensure, even on a restricted basis. Of particular concern was the lack of evidence of any inquiry by her about the legitimacy of the prescriptions written for those patients who traveled from Mecca (458 miles), Winchester (393 miles), Long Beach (334 miles), Signal Hill (333 miles), or Norwalk (326 miles) to have their prescriptions filled at Westside. Additionally, Ms. Pongnorsing asked at one point during cross-examination "what have I done wrong" and "why are they trying to take it [her license] from me," which demonstrated a complete lack of insight into her wrongdoing. Therefore, Westside's permit and Ms. Pongnorsing's license should both be revoked.

Costs of Investigation and Enforcement

36. Complainant requested costs of investigation and enforcement in the total amount of $40, 929.25 pursuant to Business and Professions Code section 125.3. This amount consisted of costs incurred directly by the Board ($20,949.25), as well as costs incurred by the Office of the Attorney General and billed to the Board ($19,980). At hearing, complainant introduced her signed Certification of Costs of Investigation and Prosecution by Agency Executive Officer in Case No. 5355. The Certification states the Board's investigative costs consist of "Inspector's costs for **109.00** hours at **$102.00** per hour" and "Inspector's costs for **81.75** hours at **$121.00** per hour," for total costs of $20,949.25.[14] (Emphasis original.)

Complainant also introduced a Certification of Investigative Costs: Declaration of Manisha Patel, in which Dr. Patel declared she spent a total of 72.50 hours investigating this matter and billed her time at an hourly rate of $121. The Board incurred costs for her time in the amount of $8,772.50. Dr. Patel itemized her time as follows: 16 hours of investigation,

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was subject to public reprimand in August 2007, that information was insufficient to raise any suspicions about the legitimacy of any of his prescriptions.

[14] This amount purported to be the sum of 109 hours multiplied by $102 per hours and 81.75 hours multiplied by $121 per hour. But the total number of investigative hours billed at the hourly rate of $121 was only 81.25 as explained further below. That mathematical error is moot, however, as explained further below.

3.25 hours of travel, 45.25 of report preparing, and 8 hours of hearing preparation.[15] At hearing, Dr. Patel explained she inadvertently included time spent on a related investigation in her cost declaration. She actually spent only 17.75 hours investigating this matter, and that time is itemized as follows: 8 hours of investigation, 3.25 hours of travel, 3 hours of report preparing, 3.5 hours of hearing preparing. Therefore, the Board incurred costs in the amount of $2,147.75 only for her time investigating this matter.

Complainant also introduced a Certification of Investigation Costs: Declaration of Joseph Wong, in which Dr. Wong declared he spent 109 hours investigating this matter, for which he billed an hourly rate of $102. He spent an additional 8.75 hours investigating this matter, for which he billed an hourly rate of $121. The Board incurred costs for his time in the total amount of $12,176.75, and those costs were itemized as follows: 38 hours of investigation, 4.75 hours of travel, 62.50 hours of report preparation, and 12.50 hours of hearing preparation.[16]

Lastly, complainant introduced a Certification of Prosecution Costs: Declaration of Phillip L. Arthur, which requested costs in the amount of $19,980. Attached to the Certification is a printout of a Matter Time Activity by Professional Type, which described tasks performed by the Office of the Attorney General in the total amount of $19,980.

Respondent did not object to any of complainant's evidence of costs of investigation and enforcement, and did not introduce any evidence of her inability to pay those costs.

Under the particular circumstances of this matter, and for the reasons explained further in Legal Conclusion 15 below, the Board's entire costs of investigation, as amended by Dr. Patel's hearing testimony ($14,324.50), are reasonable. But costs of enforcement in the amount of $15,000 only are reasonable.

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[15] She described "investigation" as including: reviewing and prioritizing assignment upon receipt, communicating with complainant, contacting and interviewing witness(es) and/or the licensee, preparing correspondence and/or declarations, collecting, organizing, and evaluating documentation and other physical evidence, performing audit(s), inspection, research, conferring with supervisor, and other. There was a line after "other" which contained no information. "Travel" was described as the time spent traveling to and from the places for performing the "investigation." "Report preparation" included organizing the file, preparing the draft investigation report, and editing and preparing the final investigation report. "Hearing preparation" was time spent reviewing the file and preparing for hearing with the Office of the Attorney General.

[16] Dr. Wong included the same description of the itemized tasks as Dr. Patel.

LEGAL CONCLUSIONS

Applicable Standard/Burden of Proof

1. Complainant has the burden of proving each of the grounds for discipline alleged in the Accusation, and must do so by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856 [the standard of proof applicable to proceedings for the discipline of professional licenses is clear and convincing evidence to a reasonable certainty].) "The courts have defined clear and convincing evidence as evidence which is so clear as to leave no substantial doubt and as sufficiently strong to command the unhesitating assent of every reasonable mind. [Citations.] It has been said that a preponderance calls for probability, while clear and convincing proof demands a *high probability* [citations]." (*In re Terry D.* (1978) 83 Cal.App.3d 890, 899; italics original.)

Applicable Law

Duties of a pharmacist-in-charge

2. "'Pharmacist-in-charge' means a pharmacist proposed by a pharmacy and approved by the board as the supervisor or manager responsible for ensuring the pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy." (Bus. & Prof. Code, § 4036.5.)

3. Business and Professions Code section 4113, subdivision (c), provides the following with regard to the duties of the pharmacist-in-charge: "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."

A pharmacist's corresponding duty

4. Health and Safety Code section 11153 imposes a corresponding duty on pharmacists to confirm prescriptions for controlled substances are issued only for legitimate medical purposes as follows:

> A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. Except as authorized by this division, the following are not legal prescriptions: (1) an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research;

> or (2) an order for an addict or habitual user of controlled substances, which is issued not in the course of professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use.

California Code of Regulations, title 16, section 1761, defines a pharmacist's corresponding duty as follows:

> (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.

5. The Board said the following about a pharmacist's corresponding duty in the precedential decision *In the Matter of the Accusation Against Pacifica Pharmacy; Thang Tran* (Agency No. 3802; OAH No. 2011010644; Precedential Decision No. 2013-01):

> While the responsibility for the proper prescribing of a controlled substance is upon the prescriber, a corresponding responsibility rests with the pharmacist who dispenses a prescription; in other words, a pharmacist does not meet the standard of care simply by selecting the proper pharmaceutical product, accurately labeling that product for use, and counseling the patient. Reasonable inquiry is required.
>
> When a pharmacist is presented with a prescription, the pharmacist must first look at the four corners of the prescription to determine whether the prescription is valid. The prescription must be on security paper; it must be complete; and it must be signed. Nothing should appear on the face of the prescription that makes it questionable. If something appears wrong with the prescription, a pharmacist must call the prescriber to verify that the prescriber has issued the prescription as set forth on the face of the prescription.
>
> After the pharmacist determines that the prescription is valid on its face, the pharmacist should verify that the person presenting

the prescription is the patient or the patient's legitimate representative. If the patient is new to the pharmacy, the standard of care requires that some evidence be produced to show that the person picking up the prescription is the patient or is entitled to do so on the patient's behalf. It is helpful for the pharmacist at this point to observe where the patient lives and where the prescriber's office is located, as these matters may be red flags that indicate that a prescription may not have been issued for a legitimate medical purpose. It is also helpful to determine the patient's age, because some medications may not be age appropriate and because a patient's relative youth may suggest the possibility of misuse or diversion.

[¶] ... [¶]

The pharmacist should evaluate whether the drug therapy is appropriate. In some instances, especially where large amounts of narcotics are being prescribed, the pharmacist should know something about the prescriber's medical practice; the pharmacist should make inquiry about that if the prescriber is unknown. The pharmacist must look at the number and kinds of medications that have been prescribed to determine whether additional inquiry is required to make the determination that the prescription is for a legitimate medical purpose. There should be some logical relationship between the drugs that have been prescribed and the condition that is being treated.

There are a number of warning signs – red flags – that should put a reasonable and prudent dispensing pharmacist on notice that a prescription may not have been issued for a legitimate medical purpose. For example, there may be missing information on the script (e.g. a DEA number); the script may be written for an unusually large quantity of drugs; the script(s) may be written for medications that address the same medical problem and appear unreasonably duplicative; the same combination of drugs may be written by the same prescriber for a number of different patients; concern exists when a prescriber starts a patient on OxyContin 80 mg because that is not a usual starting dose; the prescriber's office or the pharmacy may be located a long distance from the patient's home; patients living at the same address who present prescriptions for the same drugs is a cause of concern; young patients presenting prescriptions for chronic pain medications without any explanation raises cause for concern; large cash payments is a

red flag; and patients who requests early refills without any good reason is problematic.

The standard of care requires a pharmacist to consider these matters before dispensing a controlled substance. At some point, when reasonable concerns reach a critical mass, the pharmacist must not fill the prescription without making inquiry and resolving those matters.

Existence of Legal Cause for Discipline

Acts involving moral turpitude, dishonesty, fraud, deceit, or corruption

6. A permit or license may be disciplined if the permit holder or licensee has engaged in unprofessional conduct, which includes "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." (Bus. & Prof. Code, § 4301, subd. (f).) Westside engaged in such conduct by not refunding money received for the prescriptions described in Factual Findings 18 and 28, even though the prescriptions were never given to the patients. Therefore, cause exists to discipline Westside Plaza Pharmacy's permit pursuant to Business and Professions Code section 4301, subdivision (f). And because Suwoneee Pongnorsing was the pharmacist-in-charge of Westside, cause also exists to discipline her license pursuant to Business and Professions Code section 4301, subdivision (f), as that statute relates to Business and Professions Code sections 4036.5 and 4113, subdivision (c).

7. Westside committed an act "involving moral turpitude, dishonesty, fraud, deceit, or corruption" also when it failed to notify Paradise Drugs the prescriptions described in Factual Findings 16 and 29 were never picked up by the patients and Paradise Drugs should reverse the insurance claims. Therefore, cause exists to discipline Westside Plaza Pharmacy's permit pursuant to Business and Professions Code section 4301, subdivision (f). And because Suwoneee Pongnorsing was the pharmacist-in-charge of Westside, cause also exists to discipline her license pursuant to Business and Professions Code section 4301, subdivision (f), as that statute relates to Business and Professions Code sections 4036.5 and 4113, subdivision (c).

Violations of federal and state laws and regulations governing pharmacy

8. A permit or license may be disciplined if the permit holder or licensee violates, attempts to violate, conspires to violate, or assists or abets the violation of any federal or state law or regulation regarding pharmacy. (Bus. & Prof. Code, § 4301, subd. (o).) A pharmacy is required to record on the particular invoices the date on which each shipment of a controlled substance is received. (21 C.F.R. § 1304.21(d).) Westside failed to record the dates shipments were received on 252 occasions as discussed in Factual Findings 13 and 30. Therefore, cause exists to discipline Westside Plaza Pharmacy's permit pursuant to Business

and Professions Code section 4301, subdivision (o), as that statute relates to 21 Code of Federal Regulations part 1304.21(d). And because Suwoneee Pongnorsing was the pharmacist-in-charge of Westside, cause also exists to discipline her license pursuant to Business and Professions Code section 4301, subdivision (o), as that statute relates to 21 Code of Federal Regulations part 1304.21(d) and Business and Professions Code sections 4036.5 and 4113, subdivision (c).

9. For all purchases of controlled substances, a pharmacy is required to record on DEA Form 222 the number of packages of controlled substances received and the dates on which the packages were received. (21 C.F.R. § 1305.13(e).) Westide failed to record the number of packages received and/or the dates on which they were received for 21 purchases as discussed in Factual Findings 13 and 30. Therefore, cause exists to discipline Westside Plaza Pharmacy's permit pursuant to Business and Professions Code section 4301, subdivision (o), as that statute relates to 21 Code of Federal Regulations part 1305.13(e). And because Suwoneee Pongnorsing was the pharmacist-in-charge of Westside, cause also exists to discipline her license pursuant to Business and Professions Code section 4301, subdivision (o), as that statute relates to 21 Code of Federal Regulations part 1305.13(e) and Business and Professions Code sections 4036.5 and 4113, subdivision (c).

10. A pharmacy is required to make a biennial inventory of all controlled substances it maintains. (21 C.F.R. § 1304.11(c).) The inventory shall include the name of each drug, the form in which it is kept (e.g., pill, capsule, or liquid), the number of units or volume of each drug, and the number of commercial containers of each drug. (21 C.F.R. § 1304.11(e)(1)(iii), (6).) As of December 11, 2012, Westside failed to make a biannual inventory of all controlled substances it maintained as explained in Factual Findings 11, 12, and 30. Therefore, cause exists to discipline Westside Plaza Pharmacy's permit pursuant to Business and Professions Code section 4301, subdivision (o), as that statute relates to 21 Code of Federal Regulations part 1304.11(c). And because Suwoneee Pongnorsing was the pharmacist-in-charge of Westside, cause also exists to discipline her license pursuant to Business and Professions Code section 4301, subdivision (o), as that statute relates to 21 Code of Federal Regulations part 1304.11(c) and Business and Professions Code sections 4036.5 and 4113, subdivision (c).

11. A pharmacy is required to maintain complete and accurate records of each controlled substance it receives, sells, or delivers. (21 C.F.R. § 1304.21(a).) Westside failed to maintain such records on three occasions as explained in Factual Findings 13 and 30. Therefore, cause exists to discipline Westside Plaza Pharmacy's permit pursuant to Business and Professions Code section 4301, subdivision (o), as that statute relates to 21 Code of Federal Regulations part 1304.21(a). And because Suwoneee Pongnorsing was the pharmacist-in-charge of Westside, cause also exists to discipline her license pursuant to Business and Professions Code section 4301, subdivision (o), as that statute relates to 21 Code of Federal Regulations part 1304.21(a) and Business and Professions Code sections 4036.5 and 4113, subdivision (c).

Corresponding duty

12. Suwonee Pongnorsing failed to perform her corresponding duty with regard to numerous prescriptions for Schedule II controlled substances written by Dr. Brown between May 18, 2011, and October 3, 2012, as discussed in Factual Findings 6, 7, and 31 through 34. Therefore, cause exists to discipline her license pursuant to Business and Professions Code section 4301, subdivision (o), as that statute relates to Health and Safety Code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, subdivision (b).

13. The corresponding duty is a duty owed by the pharmacist filling a prescription, not the pharmacy at which the pharmacist works. There was no evidence Westside Plaza Pharmacy violated, attempted to violate, conspired to violate, or assisted or abetted Ms. Pongnorsing in her failure to perform her corresponding duty with regard to numerous prescriptions for Schedule II controlled substances written by Dr. Brown between May 18, 2011, and October 3, 2012, as discussed in Factual Findings 6, 7, and 31 through 34. Therefore, no cause exists to discipline Westside's permit pursuant to Business and Professions Code section 4301, subdivision (o), as that statute relates to Health and Safety Code section 11153, subdivision (a), or California Code of Regulations, title 16, section 1761, subdivision (b),

Conclusion

14. Cause exists to discipline Westside Plaza Pharmacy's original permit by way of Legal Conclusions 6 through 12, individually and collectively. Cause also exists to discipline Suwonnee Pongnorsing's original pharmacist license by way of Legal Conclusions 6 through 13, individually and collectively. When all the evidence is considered, Ms. Pongnorsing did not introduce evidence of her continued fitness to perform the duties of a pharmacist in a manner consistent with public health, safety, and welfare, even on a restricted basis, for the reasons explained in Factual Finding 35. Therefore, Westside permit and Ms. Pongnorsing's license should both be revoked.

Award of Costs

15. Business and Professions Code section 125.3, subdivision (a), states:

> Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may 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.

California Code of Regulations, title 1, section 1042, subdivision (b), states the following about cost recovery:

> Except as otherwise provided by law, proof of costs at the Hearing may be made by Declarations that contain specific and sufficient facts to support findings regarding actual costs incurred and the reasonableness of the costs, which shall be presented as follows:
>
> (1) For services provided by a regular agency employee, the Declaration may be executed by the agency or its designee and shall describe the general tasks performed, the time spent on each task and the method of calculating the cost. For other costs, the bill, invoice or similar supporting document shall be attached to the Declaration.
>
> (2) For services provided by persons who are not agency employees, the Declaration shall be executed by the person providing the service and describe the general tasks performed, the time spent on each task and the hourly rate or other compensation for the service. In lieu of this Declaration, the agency may attach to its Declaration copies of the time and billing records submitted by the service provider.

In *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth factors to be considered in determining the reasonableness of the costs sought pursuant to statutory provisions like Business and Professions Code section 125.3. Those factors include: 1) the licentiate's success in getting the charges dismissed or reduced; 2) the licentiate's subjective good faith belief in the merits of his or her position; 3) whether the licentiate raised a colorable challenge to the proposed discipline; 4) the licentiate's financial ability to pay; and 5) whether the scope of the investigation was appropriate in light of the alleged misconduct. (*Id.*, at p. 45.)

16. After considering the relevant evidence and the pertinent *Zuckerman* factors, costs of investigation in the amount of $14,324.50 and costs of enforcement in the amount of $15,000 are reasonable and are awarded as set forth in the Order below.

ORDER

1. Original Permit License No. PHY 45161 issued to respondent Westside Plaza Pharmacy, Suwonnee Pongnorsing owner and pharmacist-in-charge, is REVOKED.

2. Original Pharmacist License No. RPH 35104 issued to respondent Suwonnee Pongnorsing is REVOKED.

3. Respondents are jointly and severally liable for the Board's costs of investigation and enforcement in the total sum of $29,324.50.

DATED: July 12, 2016

DocuSigned by:
Coren D. Wong
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COREN D. WONG
Administrative Law Judge
Office of Administrative Hearings

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

In the Matter of the Accusation Against: **WESTSIDE PLAZA PHARMACY** **SUWONNEE PONGNORSING,** **OWNER/PHARMACIST-IN-CHARGE** **314 I Street** **Modesto, CA 95351** **Original Permit Number No. PHY 45161** **and** **SUWONNEE PONGNORSING** **307 Pauline Avenue** **Modesto, CA 95358** **Original Pharmacist License No. RPH 35104** Respondents.	Case No. 5355 **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 ("Board"), Department of Consumer Affairs.

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

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

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

STATUTORY AND REGULATORY PROVISIONS

5. Code section 4300 states, in pertinent part:

> (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 . . . .

6. Code section 4300.1 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.

7. Code section 4301 states, in pertinent part:

> The board shall take action against any holder of a license who is guilty of unprofessional conduct or whose license has been procured by fraud or misrepresentation or issued by mistake. Unprofessional conduct shall include, but is not limited to, any of the following:
>
> . . .
>
> (f) The commission of any act involving moral turpitude, dishonesty, fraud, deceit, or corruption, whether the act is committed in the course of relations as a licensee or otherwise, and whether the act is a felony or misdemeanor or not.
>
> . . .
>
> (o) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any provision or term of this chapter or of the applicable federal and state laws and regulations governing pharmacy, including regulations established by the board or by any other state or federal regulatory agency . . . .

8. Code section 4113, subdivision (c), states that, "[t]he pharmacist-in-charge shall be responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy."

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

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

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

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

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

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

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

. . .

(c) Biennial inventory date. After the initial inventory is taken, the registrant shall take a new inventory of all stocks of controlled substances on hand at least every two years. The biennial inventory may be taken on any date which is within two years of the previous biennial inventory date . . .

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

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

. . .

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

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

14. California Code of Regulations, title 16, section 1761, subdivision (b), states that, "[e]ven 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."

COST RECOVERY

15. Code section 125.3 provides, in pertinent part, that a 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.

CONTROLLED SUBSTANCES

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

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

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

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

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

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

BACKGROUND

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

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

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

AUDIT/INSPECTION OF DECEMBER 11, 2012

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

///

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

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

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

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

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

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

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

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

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

ADDITIONAL INVESTIGATION CONDUCTED BY THE BOARD

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

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

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

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

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

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

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

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

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

41. Board Inspector J. W. analyzed the DUR for Westside and found that they had dispensed a number of prescriptions to patients who were located outside of the pharmacy's normal trade area by as many as 453 miles (Mecca, California). Westside had dispensed prescriptions for Norco, Opana, and oxycodone to patients whose addresses were listed in Long Beach, Mecca, Monterey, Murrieta, Norwalk, Oakland, Riverside, Sacramento, San Francisco, San Jose, Santa Rosa, Signal Hill, Wesley, and Winchester. The prescriptions had all been issued

by Dr. Brown, whose office was located (Fresno) approximately eighty-nine miles from Westside.

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

FIRST CAUSE FOR DISCIPLINE

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

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

a. In and between February and November 2012, Respondent failed to reverse the claims on the prescriptions identified below or adjust the billings on the claims even though Respondent had not dispensed the medications to the patients (or had dispensed only a portion of the medications) and had received payment for the drugs from the patients' insurance companies[2]:

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

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

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

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

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

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

SECOND CAUSE FOR DISCIPLINE

(Violations of Federal and State Regulations Governing Pharmacy)

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

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

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

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

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

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

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

MATTERS IN AGGRAVATION

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

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

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

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

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

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 Original Permit Number PHY 45161, issued to Suwonnee Pongnorsing, doing business as Westside Plaza Pharmacy;

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

3. Ordering Suwonnee Pongnorsing, individually, and doing business as Westside Plaza Pharmacy, 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

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

DATED: 5/28/15

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

SA2014119516