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

In the Matter of the Accusation Against:

DRATE PHARMACY, KENNETH ETUMUDON OKWUEGBE,
Sole Owner and Pharmacist-in-Charge,
Original Permit No. PHY 53329; and

DRATE PHARMACY, KENNETH ETUMUDON OKWUEGBE,
Sole Owner and Pharmacist-in-Charge,
Original Permit No. PHY 50789; and

ROCKFORTH PHARMACY, KENNETH ETUMUDON OKWUEGBE,
Sole Owner and Pharmacist-in-Charge,
Original Permit No. PHY 51512; and

KENNETH ETUMUDON OKWUEGBE,
Pharmacist License No. RPH 59510,

Respondents

Agency Case No. 5588 & 5914

OAH No. 2020020317

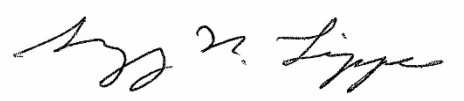
DECISION AND ORDER

The attached Stipulated Surrender of License and Order is hereby adopted by the Board of Pharmacy, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective at 5:00 p.m. on August 26, 2020.

It is so ORDERED on July 27, 2020.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA



By

Greg Lippe
Board President

XAVIER BECERRA
Attorney General of California
CHAR SACHSON
Supervising Deputy Attorney General
MICHAEL B. FRANKLIN
Deputy Attorney General
State Bar No. 136524
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3455
Facsimile: (415) 703-5480
Attorneys for Complainant

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

In the Matter of the Accusation Against**:** **DRATE PHARMACY** **KENNETH ETUMUDON OKWUEGBE,** **Sole Owner and Pharmacist-in-Charge** 3219 Adeline Street Berkeley, CA 94703, **Original Permit No. PHY 53329,** **DRATE PHARMACY** **KENNETH ETUMUDON OKWUEGBE,** **Sole Owner and Pharmacist-in-Charge** 2930 Shattuck Ave., Suite 304, Berkeley CA, 94705, **Original Permit No. PHY 50789,** **ROCKFORTH PHARMACY;** **KENNETH ETUMUDON OKWUEGBE-** **Sole Owner and Pharmacist in Charge** 10500A International Blvd, Oakland, CA 94603, **Original Permit No. PHY 51512,** **KENNETH ETUMUDON OKWUEGBE** 25158 Valley Oak Drive, Castro Valley, CA 94552, **Pharmacist License No. RPH 59510**, Respondents.	Case No. 5588 OAH No. 2020020317 **STIPULATED SURRENDER OF LICENSE AND ORDER** Case No. 5914

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Anne Sodergren (Complainant) is the Executive Officer of the Board of Pharmacy (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Michael B. Franklin, Deputy Attorney General.

2. Kenneth Etumudon Okwuegbe (Respondent), Drate Pharmacy and Rockforth Pharmacy are represented in this proceeding by attorney Natalia Mazina, whose address is: 100 Pine Street, Suite 1250, San Francisco, CA 94111-5235.

3. On or about April 19, 2007, the Board of Pharmacy issued Pharmacist License Number RPH 59510 to Kenneth Etumudon Okwuegbe (Respondent). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2022, unless renewed.

4. On or about October 14, 2011, the Board of Pharmacy issued Original Permit Number PHY 50789 to Drate Pharmacy located at 2930 Shattuck Ave., Suite 304, Berkeley CA, 94705. Respondent Okwuegbe was the sole owner of Drate Pharmacy and the Pharmacist-in-Charge at all times relevant to this Accusation. The Original Permit expired on March 6, 2015, due to a change in location. Drate Pharmacy moved to 3219 Adeline St., Berkeley, CA 94703.

5. On or about March 6, 2015, the Board of Pharmacy issued Original Permit Number PHY 53329 to Drate Pharmacy located at 3219 Adeline St., Berkeley, CA 94703. Respondent Okwuegbe is the sole owner of Drate Pharmacy and the Pharmacist-in-Charge at all times relevant to this Accusation. However, the license was cancelled on November 29, 2018.

6. On or about July 30, 2013, the Board of Pharmacy issued Original Permit Number PHY 51512 to Rockforth Pharmacy located at 10500A International Blvd, Oakland, CA 94603. The Original Permit was in full force and effect at all times relevant to the charges brought herein. However, the license was cancelled on June 19, 2017. Respondent Okwuegbe was the

sole owner of Rockforth Pharmacy and the Pharmacist-in-Charge at all times relevant to this Accusation.

JURISDICTION

7. Accusation No. 5588 and No. 5914 was filed before the Board, and is currently pending against Respondent's Pharmacist License Number RPH 59510, as well as his Original Permit Number PHY 50789 issued to Drate Pharmacy, his Original Permit Number PHY 53329 issued to Drate Pharmacy at a second location, and his Original Permit Number PHY 51512 issued to Rockforth Pharmacy. The Accusation and all other statutorily required documents were properly served on Respondent on September 26, 2018. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 5588 and No. 5914 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

8. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 5588 and No. 5914. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

9. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

10. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

11. Respondent understands that the charges and allegations in Accusation No. 5588 and No. 5914, if proven at a hearing, constitute cause for imposing discipline upon his Pharmacist License Number RPH 59510, as well as for his Original Permit Number PHY 50789 issued to

Drate Pharmacy, his Original Permit Number PHY 53329 issued to Drate Pharmacy at a second location, and his Original Permit Number PHY 51512 issued to Rockforth Pharmacy.

12. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

13. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Pharmacist License Number RPH 59510, his Original Permit Number PHY 50789 issued to Drate Pharmacy, his Original Permit Number PHY 53329 issued to Drate Pharmacy at a second location, and his Original Permit Number PHY 51512 issued to Rockforth Pharmacy, without further process.

RESERVATION

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

CONTINGENCY

15. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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

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

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

ORDER

IT IS HEREBY ORDERED that Pharmacist License No. RPH 59510, Original Permit Number PHY 50789, Original Permit Number PHY 53329, and Original Permit Number PHY 51512, all issued to Respondent Kenneth Etumudon Okwuegbe, are surrendered and accepted by the Board.

1. The surrender of Respondent's Pharmacist License No. RPH 59510, Original Permit Number PHY 50789, Original Permit Number PHY 53329, and Original Permit Number PHY 51512 and the acceptance of the surrendered licenses by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a pharmacist in California as of the effective date of the Board's Decision and Order.

3. Respondent shall lose all rights and privileges as a pharmacy in California as of the effective date of the Board’s Decision and Order.

4. Respondent shall cause to be delivered to the Board his pocket licenses and, if one was issued, his wall certificates on or before the effective date of the Decision and Order.

5. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a new application for licensure. Respondent must comply with all the laws, regulations and procedures for licensure in effect at the time the application or petition is filed, and all of the charges and allegations contained in Accusation No. 5588 and No. 5914 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the application.

6. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $30,000.00 prior to issuance of a new or reinstated license.

7. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation No. 5588 and No. 5914 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

8. Respondent may not apply, reapply, or petition for any licensure or registration of the Board for three (3) years from the effective date of the Decision and Order.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney Natalia Mazina. I understand the stipulation and the effect it will have on my Pharmacist License No. RPH 59510, Original Permit Number PHY 50789, Original Permit Number PHY 53329, and Original Permit Number PHY 51512. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: _____

_____
KENNETH ETUMUDON OKWUEGBE
Respondent

5. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a new application for licensure. Respondent must comply with all the laws, regulations and procedures for licensure in effect at the time the application or petition is filed, and all of the charges and allegations contained in Accusation No. 5588 and No. 5914 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the application.

6. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $30,000.00 prior to issuance of a new or reinstated license.

7. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation No. 5588 and No. 5914 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

8. Respondent may not apply, reapply, or petition for any licensure or registration of the Board for three (3) years from the effective date of the Decision and Order.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney Natalia Mazina. I understand the stipulation and the effect it will have on my Pharmacist License No. RPH 59510, Original Permit Number PHY 50789, Original Permit Number PHY 53329, and Original Permit Number PHY 51512. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: 06/26/2020

KENNETH ETUMUDON OKWUEGBE
Respondent

I have read and fully discussed with Respondent Kenneth Etumudon Okwuegbe the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: _____ _____
NATALIA MAZINA
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Board of Pharmacy of the Department of Consumer Affairs.

DATED: _____

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
CHAR SACHSON
Supervising Deputy Attorney General

MICHAEL B. FRANKLIN
Deputy Attorney General
Attorneys for Complainant

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I have read and fully discussed with Respondent Kenneth Etumudon Okwuegbe the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: June 26, 2020

NATALIA MAZINA
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Board of Pharmacy of the Department of Consumer Affairs.

DATED: 6/26/2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
CHAR SACHSON
Supervising Deputy Attorney General

MICHAEL B. FRANKLIN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 5588 and No. 5914

XAVIER BECERRA
Attorney General of California
FRANK H. PACOE
Supervising Deputy Attorney General
JUSTIN R. SURBER
Deputy Attorney General
State Bar No. 226937
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 355-5437
Facsimile: (415) 703-5480
Attorneys for Complainant

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

In the Matter of the Accusation Against**:** **DRATE PHARMACY** **3219 Adeline Street** **Berkeley, CA 94703** **KENNETH ETUMUDON OKWUEGBE, Sole Owner and Pharmacist-in-Charge** **Original Permit No. PHY 53329** **DRATE PHARMACY** **2930 Shattuck Ave., Suite 304,** **Berkeley CA, 94705** **KENNETH ETUMUDON OKWUEGBE, Sole Owner and Pharmacist-in-Charge** **Original Permit No. PHY 50789** **ROCKFORTH PHARMACY;** **10500A International Blvd,** **Oakland, CA 94603** **KENNETH ETUMUDON OKWUEGBE- Sole Owner and Pharmacist in Charge** **Original Permit No. PHY 51512** **KENNETH ETUMUDON OKWUEGBE** **25158 Valley Oak Drive,** **Castro Valley, CA 94552.** **Pharmacist License No. RPH 59510** Respondents.	Case No. 5588 **A C C U S A T I O N** Case No. 5914 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about April 19, 2007, the Board of Pharmacy issued Pharmacist License Number RPH 59510 to Kenneth Etumudon Okwuegbe (Respondent Okwuegbe). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2018, unless renewed.

3. On or about October 14, 2011, the Board of Pharmacy issued Original Permit Number PHY 50789 to Drate Pharmacy located at 2930 Shattuck Ave., Suite 304, Berkeley CA, 94705. Respondent Okwuegbe was the sole owner of Drate Pharmacy and the Pharmacist-in-Charge at all times relevant to this Accusation. The Original Permit expired on March 6, 2015, due to a change in location. Drate Pharmacy moved to 3219 Adeline St., Berkeley, CA 94703.

4. On or about March 6, 2015, the Board of Pharmacy issued Original Permit Number PHY 53329 to Drate Pharmacy located at 3219 Adeline St., Berkeley, CA 94703. Respondent Okwuegbe is the sole owner of Drate Pharmacy and the Pharmacist-in-Charge at all times relevant to this Accusation. The Original Permit will expire on March 1, 2019, unless renewed.

5. On or about July 30, 2013, the Board of Pharmacy issued Original Permit Number PHY 51512 to Rockforth Pharmacy located at 10500A International Blvd, Oakland, CA 94603. The Original Permit was in full force and effect at all times relevant to the charges brought herein. However, the license was cancelled on June 19, 2017. Respondent Okwuegbe was the sole owner of Rockforth Pharmacy and the Pharmacist-in-Charge at all times relevant to this Accusation.

JURISDICTION AND STATUTORY AUTHORITY

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

/ / /

7. Section **733** of the Code states:

"(a) A licentiate shall not obstruct a patient in obtaining a prescription drug or device that has been legally prescribed or ordered for that patient. A violation of this section constitutes unprofessional conduct by the licentiate and shall subject the licentiate to disciplinary or administrative action by his or her licensing agency.

. . .

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

9. Section **4036.5** of the Code states:

"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."

10. Section **4059.5** of the Code states:

"(a) Except as otherwise provided in this chapter, dangerous drugs or dangerous devices may only be ordered by an entity licensed by the board and shall be delivered to the licensed premises and signed for and received by a pharmacist. Where a licensee is permitted to operate through a designated representative, the designated representative shall sign for and receive the delivery.

. . .

11. Section **4063** of the Code states:

No prescription for any dangerous drug or dangerous device may be refilled except upon authorization of the prescriber. The authorization may be given orally or at the time of giving the original prescription. No prescription for any dangerous drug that is a controlled substance may be designated refillable as needed.

12. Section **4076** of the Code states:

"(a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:

"(1) Except when the prescriber or the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6 orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

. . .

13. Section **4077** of the Code states:

"(a) Except as provided in subdivisions (b) and (c), no person shall dispense any dangerous drug upon prescription except in a container correctly labeled with the information required by Section 4076.

. . .

14. Section **4078** of the Code states:

"(a)(1) No person shall place a false or misleading label on a prescription.

. . .

15. Section **4080** of the Code states:

"All stock of any dangerous drug or dangerous device or of shipments through a customs broker or carrier shall be, at all times during business hours, open to inspection by authorized officers of the law."

16. Section **4081** of the Code states:

"(a) All records of manufacture and of sale, acquisition, receipt, shipment, or disposition of dangerous drugs or dangerous devices shall be at all times during business hours open to inspection by authorized officers of the law, and shall be preserved for at least three years from the date of making. A current inventory shall be kept by every manufacturer, wholesaler, third-

party logistics provider, pharmacy, veterinary food-animal drug retailer, outsourcing facility, physician, dentist, podiatrist, veterinarian, laboratory, clinic, hospital, institution, or establishment holding a currently valid and unrevoked certificate, license, permit, registration, or exemption under Division 2 (commencing with Section 1200) of the Health and Safety Code or under Part 4 (commencing with Section 16000) of Division 9 of the Welfare and Institutions Code who maintains a stock of dangerous drugs or dangerous devices.

. . .

17. Section **4104** of the Code states:

"(a) Every pharmacy shall have in place procedures for taking action to protect the public when a licensed individual employed by or with the pharmacy is discovered or known to be chemically, mentally, or physically impaired to the extent it affects his or her ability to practice the profession or occupation authorized by his or her license, or is discovered or known to have engaged in the theft, diversion, or self-use of dangerous drugs."

(b) Every pharmacy shall have written policies and procedures for addressing chemical, mental, or physical impairment, as well as theft, diversion, or self-use of dangerous drugs, among licensed individuals employed by or with the pharmacy.

(c) Every pharmacy shall report and provide to the board, within 14 days of the receipt or development thereof, the following information with regard to any licensed individual employed by or with the pharmacy:

(1) Any admission by a licensed individual of chemical, mental, or physical impairment affecting his or her ability to practice.

(2) Any admission by a licensed individual of theft, diversion, or self-use of dangerous drugs.

(3) Any video or documentary evidence demonstrating chemical, mental, or physical impairment of a licensed individual to the extent it affects his or her ability to practice.

(4) Any video or documentary evidence demonstrating theft, diversion, or self-use of dangerous drugs by a licensed individual.

/ / /

(5) Any termination based on chemical, mental, or physical impairment of a licensed individual to the extent it affects his or her ability to practice.

(6) Any termination of a licensed individual based on theft, diversion, or self-use of dangerous drugs.

. . .

18. Section **4105** of the Code states:

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

. . .

"(c) The records required by this section shall be retained on the licensed premises for a period of three years from the date of making.

. . .

19. Section **4113, subsection (c),** of the Code states:

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

20. Section **4300** of the Code states:

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

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

"(1) Suspending judgment.

"(2) Placing him or her upon probation.

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

"(4) Revoking his or her license.

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

. . .

"(e) The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code, and the board shall have all the powers granted therein. The action shall be final, except that the propriety of the action is subject to review by the superior court pursuant to Section 1094.5 of the Code of Civil Procedure."

21. Section **4300.1** of the Code states:

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

22. Section **4301** of the Code states:

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

. . .

"(d) The clearly excessive furnishing of controlled substances in violation of subdivision (a) of Section 11153 of the Health and Safety Code.

"(e) The clearly excessive furnishing of controlled substances in violation of subdivision (a) of Section 11153.5 of the Health and Safety Code. Factors to be considered in determining whether the furnishing of controlled substances is clearly excessive shall include, but not be limited to, the amount of controlled substances furnished, the previous ordering pattern of the customer (including size and frequency of orders), the type and size of the customer, and where and to whom the customer distributes its product.

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

/ / /

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

. . .

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

. . .

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

. . .

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

. . .

23. Section **4306.5** of the Code states:

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

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

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

. . .

24. Section **4307, subsection (a),** of the Code provides:

"Any person who has been denied a license or whose license has been revoked or is under suspension, or who has failed to renew his or her license while it was under suspension, or who

has been a manager, administrator, owner, member, officer, director, associate, partner, or any other person with management or control of any partnership, corporation, trust, firm, or association whose application for a license has been denied or revoked, is under suspension or has been placed on probation, and while acting as the manager, administrator, owner, member, officer, director, associate, partner, or any other person with management or control had knowledge of or knowingly participated in any conduct for which the license was denied, revoked, suspended, or placed on probation, shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee as follows:

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

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

25. Section **4342**, subsection (a), of the Code provides:

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

26. Health and Safety Code section **11153** states:

"(a) 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.

. . .

27. Health and Safety Code section **11164** states:

"Except as provided in Section 11167, no person shall prescribe a controlled substance, nor shall any person fill, compound, or dispense a prescription for a controlled substance, unless it complies with the requirements of this section.

"(a) Each prescription for a controlled substance classified in Schedule II, III, IV, or V, except as authorized by subdivision (b), shall be made on a controlled substance prescription form as specified in Section 11162.1 and shall meet the following requirements:

. . .

"(2) The prescription shall also contain the address of the person for whom the controlled substance is prescribed. If the prescriber does not specify this address on the prescription, the pharmacist filling the prescription or an employee acting under the direction of the pharmacist shall write or type the address on the prescription or maintain this information in a readily retrievable form in the pharmacy.

. . .

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

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

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

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

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

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

"(5) Quantity of the controlled substance dispensed.

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

"(7) Number of refills ordered.

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

"(9) Date of origin of the prescription.

"(10) Date of dispensing of the prescription.

. . .

29. Health and Safety Code section **11206** states:

"Filed prescriptions shall constitute a transaction record that, together with information that is readily retrievable in the pharmacy pursuant to Section 11164 shall show or include the following:

"(a) The name(s) and address of the patient(s).

. . .

30. Health and Safety Code section **11285** states:

"Any drug or device is adulterated if its strength differs from, or its purity or quality is below, that which it is represented to possess."

/ / /

31. Health and Safety Code section **11295** states:

"It is unlawful for any person to manufacture, sell, deliver, hold, or offer for sale any drug or device that is adulterated."

REGULATORY AUTHORITY

32. California Code of Regulations, title 16, section **1707.1**, states:

"(a) A pharmacy shall maintain medication profiles on all patients who have prescriptions filled in that pharmacy except when the pharmacist has reasonable belief that the patient will not continue to obtain prescription medications from that pharmacy.

"(1) A patient medication record shall be maintained in an automated data processing or manual record mode such that the following information is readily retrievable during the pharmacy's normal operating hours.

"(A) The patient's full name and address, telephone number, date of birth (or age) and gender;

"(B) For each prescription dispensed by the pharmacy:

"1. The name, strength, dosage form, route of administration, if other than oral, quantity and directions for use of any drug dispensed;

"2. The prescriber's name and where appropriate, license number, DEA registration number or other unique identifier;

"3. The date on which a drug was dispensed or refilled;

"4. The prescription number for each prescription; and

"5. The information required by section 1717.

"(C) Any of the following which may relate to drug therapy: patient allergies, idiosyncracies, current medications and relevant prior medications including nonprescription medications and relevant devices, or medical conditions which are communicated by the patient or the patient's agent.

"(D) Any other information which the pharmacist, in his or her professional judgment, deems appropriate.

/ / /

"(2) The patient medication record shall be maintained for at least one year from the date when the last prescription was filled."

33. California Code of Regulations, title 16, section **1707.2**, states:

"(a) A pharmacist shall provide oral consultation to his or her patient or the patient's agent in all care settings:

"(1) upon request; or

"(2) whenever the pharmacist deems it warranted in the exercise of his or her professional judgment.

"(b)(1) In addition to the obligation to consult set forth in subsection (a), a pharmacist shall provide oral consultation to his or her patient or the patient's agent in any care setting in which the patient or agent is present:

"(A) whenever the prescription drug has not previously been dispensed to a patient;

. . .

"(2) When the patient or agent is not present (including but not limited to a prescription drug that was shipped by mail) a pharmacy shall ensure that the patient receives written notice:

"(A) of his or her right to request consultation; and

"(B) a telephone number from which the patient may obtain oral consultation from a pharmacist who has ready access to the patient's record.

. . .

34. California Code of Regulations, title 16, section **1707.3**, states:

"Prior to consultation as set forth in section 1707.2, a pharmacist shall review a patient's drug therapy and medication record before each prescription drug is delivered. The review shall include screening for severe potential drug therapy problems."

35. California Code of Regulations, title 16, section **1707.5, subsection (d),** states:

"(d) The pharmacy shall have policies and procedures in place to help patients with limited or no English proficiency understand the information on the label as specified in subdivision (a) in the patient's language. The pharmacy's policies and procedures shall be specified in writing and shall include, at minimum, the selected means to identify the patient's language and to provide

interpretive services and translation services in the patient's language. The pharmacy shall, at minimum, provide interpretive services in the patient's language, if interpretive services in such language are available, during all hours that the pharmacy is open, either in person by pharmacy staff or by use of a third-party interpretive service available by telephone at or adjacent to the pharmacy counter.

. . .

36. California Code of Regulations, title 16, section **1707.6, subsection (c),** states:

"(c) Every pharmacy, in a place conspicuous to and readable by a prescription drug consumer, at or adjacent to each counter in the pharmacy where dangerous drugs are dispensed or furnished, shall post or provide a notice containing the following text:

"Point to your language. Interpreter services will be provided to you upon request at no cost.

"This text shall be repeated in at least the following languages: Arabic, Armenian, Cambodian, Cantonese, Farsi, Hmong, Korean, Mandarin, Russian, Spanish, Tagalog, and Vietnamese.

"Each pharmacy shall use the standardized notice provided or made available by the board, unless the pharmacy has received prior approval of another format or display methodology from the board. The board may delegate authority to a committee or to the Executive Officer to give the approval.

"The pharmacy may post this notice in paper form or on a video screen if the posted notice or video screen is positioned so that a consumer can easily point to and touch the statement identifying the language in which he or she requests assistance. Otherwise, the notice shall be made available on a flyer or handout clearly visible from and kept within easy reach of each counter in the pharmacy where dangerous drugs are dispensed or furnished, available at all hours that the pharmacy is open. The flyer or handout shall be at least 8 1/2 inches by 11 inches."

37. California Code of Regulations, title 16, section **1711**, states:

"(a) Each pharmacy shall establish or participate in an established quality assurance program which documents and assesses medication errors to determine cause and an appropriate response as part of a mission to improve the quality of pharmacy service and prevent errors.

"(b) For purposes of this section, "medication error" means any variation from a prescription or drug order not authorized by the prescriber, as described in Section 1716. Medication error, as defined in the section, does not include any variation that is corrected prior to furnishing the drug to the patient or patient's agent or any variation allowed by law.

(c)(1) Each quality assurance program shall be managed in accordance with written policies and procedures maintained in the pharmacy in an immediately retrievable form.

. . .

"(d) Each pharmacy shall use the findings of its quality assurance program to develop pharmacy systems and workflow processes designed to prevent medication errors. An investigation of each medication error shall commence as soon as is reasonably possible, but no later than 2 business days from the date the medication error is discovered. All medication errors discovered shall be subject to a quality assurance review.

"(e) The primary purpose of the quality assurance review shall be to advance error prevention by analyzing, individually and collectively, investigative and other pertinent data collected in response to a medication error to assess the cause and any contributing factors such as system or process failures. A record of the quality assurance review shall be immediately retrievable in the pharmacy. The record shall contain at least the following:

"1. the date, location, and participants in the quality assurance review;

"2. the pertinent data and other information relating to the medication error(s) reviewed and documentation of any patient contact required by subdivision (c);

"3. the findings and determinations generated by the quality assurance review; and,

"4. recommend changes to pharmacy policy, procedure, systems, or processes, if any.

The pharmacy shall inform pharmacy personnel of changes to pharmacy policy, procedure, systems, or processes made as a result of recommendations generated in the quality assurance program.

. . .

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38. California Code of Regulations, title 16, section **1712**, states

"(a) Any requirement in this division for a pharmacist to initial or sign a prescription record or prescription label can be satisfied by recording the identity of the reviewing pharmacist in a computer system by a secure means. The computer used to record the reviewing pharmacist's identity shall not permit such a record to be altered after it is made.

"(b) The record of the reviewing pharmacist's identity made in a computer system pursuant to subdivision (a) of this section shall be immediately retrievable in the pharmacy."

12. California Code of Regulations, title 16, section **1714**, states, in pertinent part:

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

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

. . .

39. California Code of Regulations, title 16, section **1715**, states:

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

"(b) In addition to the self-assessment required in subdivision (a) of this section, the pharmacist-in-charge shall complete a self-assessment within 30 days whenever:

"(1) A new pharmacy permit has been issued, or

"(2) There is a change in the pharmacist-in-charge, and he or she becomes the new pharmacist-in-charge of a pharmacy.

"(3) There is a change in the licensed location of a pharmacy to a new address.

. . .

"(d) Each self-assessment shall be kept on file in the pharmacy for three years after it is performed."

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

"Pharmacists shall not deviate from the requirements of a prescription except upon the prior consent of the prescriber or to select the drug product in accordance with Section 4073 of the Business and Professions Code.

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

41. California Code of Regulations, title 16, section **1717**, states:

"(a) No medication shall be dispensed on prescription except in a new container which conforms with standards established in the official compendia.

"Notwithstanding the above, a pharmacist may dispense and refill a prescription for non-liquid oral products in a clean multiple-drug patient medication package (patient med pak), provided:

"(1) a patient med pak is reused only for the same patient;

"(2) no more than a one-month supply is dispensed at one time; and

"(3) each patient med pak bears an auxiliary label which reads, "store in a cool, dry place."

"(b) In addition to the requirements of Business and Professions Code section 4040, the following information shall be maintained for each prescription on file and shall be readily retrievable:

"(1) The date dispensed, and the name or initials of the dispensing pharmacist. All prescriptions filled or refilled by an intern pharmacist must also be initialed by the supervising pharmacist before they are dispensed.

"(2) The brand name of the drug or device; or if a generic drug or device is dispensed, the distributor's name which appears on the commercial package label; and

"(3) If a prescription for a drug or device is refilled, a record of each refill, quantity dispensed, if different, and the initials or name of the dispensing pharmacist.

"(4) A new prescription must be created if there is a change in the drug, strength, prescriber or directions for use, unless a complete record of all such changes is otherwise maintained.

"(c) Promptly upon receipt of an orally transmitted prescription, the pharmacist shall reduce it to writing, and initial it, and identify it as an orally transmitted prescription. If the prescription is then dispensed by another pharmacist, the dispensing pharmacist shall also initial the prescription to identify him or herself. All orally transmitted prescriptions shall be received and transcribed by a pharmacist prior to compounding, filling, dispensing, or furnishing. Chart orders as defined in section 4019 of the Business and Professions Code are not subject to the provisions of this subsection.

"(d) A pharmacist may furnish a drug or device pursuant to a written or oral order from a prescriber licensed in a State other than California in accordance with Business and Professions Code section 4005.

"(e) A pharmacist may transfer a prescription for Schedule III, IV or V controlled substances to another pharmacy for refill purposes in accordance with Title 21, Code of Federal Regulations, section 1306.25.

Prescriptions for other dangerous drugs which are not controlled substances may also be transferred by direct communication between pharmacists or by the receiving pharmacist's access to prescriptions or electronic files that have been created or verified by a pharmacist at the transferring pharmacy. The receiving pharmacist shall create a written prescription; identifying it as a transferred prescription; and record the date of transfer and the original prescription number. When a prescription transfer is accomplished via direct access by the receiving pharmacist, the receiving pharmacist shall notify the transferring pharmacy of the transfer. A pharmacist at the transferring pharmacy shall then assure that there is a record of the prescription as having been transferred, and the date of transfer. Each pharmacy shall maintain inventory accountability and pharmacist accountability and dispense in accordance with the provisions of section 1716 of this Division. Information maintained by each pharmacy shall at least include:

"(1) Identification of pharmacist(s) transferring information;

"(2) Name and identification code or address of the pharmacy from which the prescription was received or to which the prescription was transferred, as appropriate;

"(3) Original date and last dispensing date;

"(4) Number of refills and date originally authorized;

"(5) Number of refills remaining but not dispensed;

"(6) Number of refills transferred.

"(f) The pharmacy must have written procedures that identify each individual pharmacist responsible for the filling of a prescription and a corresponding entry of information into an automated data processing system, or a manual record system, and the pharmacist shall create in his/her handwriting or through hand-initializing a record of such filling, not later than the beginning of the pharmacy's next operating day. Such record shall be maintained for at least three years."

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

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

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

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

"(a) No pharmacist shall compound or dispense any prescription which contains any significant error, omission, irregularity, uncertainty, ambiguity or alteration. Upon receipt of 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."

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44. California Code of Regulations, title 16, section **1764**, states:

"No pharmacist shall exhibit, discuss, or reveal the contents of any prescription, the therapeutic effect thereof, the nature, extent, or degree of illness suffered by any patient or any medical information furnished by the prescriber with any person other than the patient or his or her authorized representative, the prescriber or other licensed practitioner then caring for the patient, another licensed pharmacist serving the patient, or a person duly authorized by law to receive such information."

45. California Code of Regulations, title 16, section **1793.7**, **subsection (d)**, states:

".(d) Any pharmacy employing or using a pharmacy technician shall develop a job description and written policies and procedures adequate to ensure compliance with the provisions of Article 11 of this Chapter, and shall maintain, for at least three years from the time of making, records adequate to establish compliance with these sections and written policies and procedures.

46. Code of Federal Regulations, title 21, section **1301.75**, subsection (b), states,

"(b) Controlled substances listed in Schedules II, III, IV, and V shall be stored in a securely locked, substantially constructed cabinet. However, pharmacies and institutional practitioners may disperse such substances throughout the stock of noncontrolled substances in such a manner as to obstruct the theft or diversion of the controlled substances.

47. Code of Federal Regulations, title 21, section **1304.04**, subsection (f), states:

"(f) Each registered manufacturer, distributor, importer, exporter, narcotic treatment program and compounder for narcotic treatment program shall maintain inventories and records of controlled substances as follows:

(1) Inventories and records of controlled substances listed in Schedules I and II shall be maintained separately from all of the records of the registrant; and

(2) Inventories and records of controlled substances listed in Schedules III, IV, and V shall be maintained either separately from all other records of the registrant or in such form that the information required is readily retrievable from the ordinary business records of the registrant."

48. Code of Federal Regulations, title 21, 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.

"(b) Initial inventory date. Every person required to keep records shall take an inventory of all stocks of controlled substances on hand on the date he/she first engages in the manufacture, distribution, or dispensing of controlled substances, in accordance with paragraph (e) of this section as applicable. In the event a person commences business with no controlled substances on hand, he/she shall record this fact as the initial 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.

COSTS

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

enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

PRIMARY DRUGS INVOLVED

50. Hydrocodone/APAP is a Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(4), is a Schedule II controlled substance under federal law, as of October 6, 2014. Prior to October 6, 2014, Hydrocodone/APAP was a Secedule III controlled substance under federal law. It is a dangerous drug as designated by Code section 4022.

51. Promethazine with Codeine is an antihistamine/antitussive, narcotic analgesic, and sleep aid containing Codeine, a Schedule V controlled substance as designated by Health and Safety Code section 11058(c)(1), and a dangerous drug as designated by Code section 4022.

NOVEMBER 5, 2014 INSPECTION

52. On or about November 5, 2014, a Board inspector conducted an inspection of Drate Pharmacy located at 2930 Shattuck Ave., Suite 304, Berkeley CA, 94705. The inspection revealed that controlled substances and/or dangerous drugs were delivered to Drate Pharmacy and that pharmacy technicians signed the invoice/orders and received those controlled substances and/or dangerous drugs as follows:

a. A pharmacy technician signed for a delivery for invoice 4944530 from APIRX dated July 24, 2013. The delivery contained controlled substances and/or dangerous drugs.

b. A pharmacy technician signed for a delivery for invoice 4948900 from APIRX dated July 30, 2013. The delivery contained controlled substances and/or dangerous drugs.

FIRST CAUSE FOR DISCIPLINE

(Signature Requirements)

53. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301, subsections (j) and/or (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of section 4059.5, subdivision (a), of the Code, a state law governing pharmacy, controlled substances, and/or dangerous drugs. Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation section 4059.5, subdivision (a),

by having a pharmacy technician, and not a pharmacist, sign for and receive dangerous drugs/controlled as described in paragraph 52, above.

SECOND CAUSE FOR DISCIPLINE

(Signature Requirements)

54. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsections (j) and/or (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of section 4059.5, subdivision (a), of the Code, a state law governing pharmacy, controlled substances, and/or dangerous drugs. Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation section 4059.5, subdivision (a), by having a pharmacy technician, and not a pharmacist, sign for and receive dangerous drugs/controlled as described in paragraph 52, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

CONSUMER COMPLAINT

55. On or about July 15, 2013, the Board received a complaint from"VD" [1] that claimed she was provided the wrong medication at Drate Pharmacy. On or about April of 2013, Drate Pharmacy incorrectly filled VD's prescription. VD was prescribed amlodipine 5mg. However, Drate Pharmacy filled the prescription with amlodipine 10mg.

56. VD ingested the wrong prescription for 27 days and suffered side effects. When confronted with the error, Respondent Okwuegbe told VD to "stop being a damn baby and take your medicine." After being informed of the medication error, neither Drate Pharmacy nor Respondent Okwuegbe completed a quality assurance report. This medication error was not mentioned in any quality assurance documentation. There was no record of a quality assurance review during a Board inspection on January 6, 2014.

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[1] Full consumer names will be provided in discovery.

THIRD CAUSE FOR DISCIPLINE

(Variation from Prescription)

57. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301, subsection (o), of the Code in in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1716 by deviating from the requirements of VD's prescription as described in paragraphs 55-56, above.

FOURTH CAUSE FOR DISCIPLINE

(Quality Assurance Programs)

58. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301, subsection (o), of the Code in in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1711, subsections (a), (d), and/or (e), by failing to investigate and document in a quality assurance report VD's prescription error as described in paragraphs 55-56, above.

FIFTH CAUSE FOR DISCIPLINE

(Variation from Prescription)

59. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1716 by deviating from the requirements of VD's prescription as described in paragraphs 55-56, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

SIXTH CAUSE FOR DISCIPLINE

(Quality Assurance Programs)

60. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1711, subsections (a), (d), and or (e), by failing to investigate and document in a quality assurance report

VD's prescription error as described in paragraphs 55-56, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

JANUARY 2014 INSPECTIONS

61. On or about January 6, 2014, a Board inspector conducted an inspection of Drate Pharmacy located at 2930 Shattuck Ave., Suite 304, Berkeley CA, 94705. The pharmacy was cluttered with bags of prescriptions that were lined up on the floors of the pharmacy. There was an open and unlocked safe that was being used to store Schedule II controlled substances. The safe remained unlocked after the inspector requested that it be closed and locked.

62. The January 6, 2014, inspection revealed that Drate Pharmacy had no policies and procedures in place to help patients with limited or no English proficiency. In addition, Drate pharmacy had not posted a "point to your language" consumer poster.

63. During the January 6, 2014, inspection, the inspector inspected a break room that was outside of Drate Pharmacy but in the same building complex. The break room was not locked and could be accessed by the public. Drate Pharmacy used the break room for storage. It contained numerous boxes that contained Protected Health Information under HIPAA (the Health Insurance Portability and Accountability Act). Drate Pharmacy also stored boxes that contained numerous prescription bottles containing controlled substances and/or dangerous drugs. Some of the prescription drugs had expired. The inspector was informed that Drate Pharmacy stored the items in the break room because the Pharmacy itself was too small.

64. Drate Pharmacy staff informed the inspector that the items in the break room were "duplicate fills." Duplicate fills occur when an employee can not find a specific prescription for a waiting patient. The employee fills the prescription again and prints a duplicate label. Respondent Okwuegbe told the inspector that "all" of the prescriptions in the break room were duplicate fills and the drugs were to be returned to stock. Respondent Okwuegbe later stated that he forgot to reverse the charges to insurance companies. When asked to explain why he would

need to reverse charges when the prescriptions were duplicate fills, Respondent Okwuegbe said almost all were duplicate fills.

65. The inspector was informed that because the items in the break room were duplicate fills, the delivery log would show the patient signed for the duplicate fill when they picked up the prescription. The patient log revealed no such patient signatures.

66. While in the break room, the inspector noticed a metal spiral staircase to another area. The inspector found empty stock bottles (from Drate Pharmacy) in this area.

67. During the inspection, the inspector noticed that all of the prescriptions throughout the pharmacy and break room contained the initials KO, Respondent Okwuegbe's initials. The inspector also noticed the initials at the top of a computer screen that pharmacist Leland Chew (an employee of Drate Pharmacy / Respondent Okwuegbe) was using. Pharmacist Chew informed the inspector that he did not have his own log in and that all prescriptions he filled would be under the initials KO. Leland Chew informed the inspector that he did not initial prescriptions.

68. During the January 6, 2014 inspection, the inspector asked for a community self-assessment for Drate Pharmacy. The inspector was given an assessment dated October 9, 2011. Drate Pharmacy did not have a current self-assessment completed by the Pharmacist-in-Charge, Respondent Okwuegbe.

69. Drate Pharmacy had not completed a beginning inventory when it opened. Drate Pharmacy had also not completed a controlled substance inventory within two years of the beginning inventory date.

70. During the January 6, 2014, inspection, the inspector was given a copy of Drate Pharmacy's Quality Assurance Policies and Procedures. It stated the medication errors would be reported within 24 hours. When asked if Respondent Okwuegbe had reported any errors in the last year, Respondent Okwuegbe stated that there were no medication errors in the last year. This statement was not true.

71. During the inspection, the investigator found a blue tote with 10 label receipts. When asked why theses labels were in the tote, Respondent Okwuegbe stated that they were return to

stock labels. The inspector asked Respondent Okwuegbe to verify this with Drate Pharmacy's computer records. The records revealed only one of the 10 labels had been returned to stock.

72. The inspector found promethazine with Codeine bottles stored in drawers under the pharmacy counter. There were also bags of prescription receipts. The inspector was informed that Respondent Okwuegbe was "keeping the receipts to run another time." Respondent Okwuegbe later informed the inspector that the receipts were identified as billed and not reversed.

73. On or about January 9, 2014, the Board inspector received faxed documents from Respondent Okwuegbe. The documents included the following:

a. A judgement in a case between VD and Drate Pharmacy. The judgment was in favor of Drate Pharmacy but also stated the Drate Pharmacy Filled VD's prescription with the wrong dose of medication. The judgment was dated December, 3, 2013.

b. A community self-assessment.

c. A statement signed by Respondent Okwuegbe under penalty of perjury that stated: "medications in the boxes of the (break room) have been returned to stock and the billing reversed on the insurance." This statement was false.

74. On or about January 13, 2014, two Board inspectors did a follow-up inspection at Drate Pharmacy, located at 2930 Shattuck Ave, Berkeley, CA. Respondent Okwuegbe confirmed that all of the prescriptions found in the break room on January 6, 2014 had been returned to stock and reversed with insurance companies. This statement was not true. A box of filled prescriptions (originally found in the break room during the January 6, 2014 inspection) was found. The medication had not been returned to stock.

75. The inspection revealed hundreds of prescriptions that had not been returned to stock and charges that were not reversed with insurance companies. Respondent Okwuegbe also informed the inspectors that if a prescription was not picked up by a patient within 30 days, the prescription was returned to stock. Moments earlier Respondent Okwuegbe said prescriptions were returned to stock if a patient did not pick up the prescription within 15 days.

76. During the January 13, 2014 inspection, the will call prescription shelves were inventoried; 64 prescriptions over 30 days were found that had not been returned to stock.

77. A box of prescriptions labeled "December deliveries" was found containing 66 prescriptions that had not been delivered. The prescriptions were dated November 25 to December 19, 2013.

78. A box marked "deliveries" was found in the break room. It contained 59 prescriptions (dated November 14- December 26, 2013) that had not been delivered.

79. A bag of receipts was found. Respondent Okwuegbe stated the prescriptions for those receipts had been returned to stock and the billing to insurance companies had been reversed. This was not true. The medications had been placed on hold in the computer system but had not been reversed with the insurance companies. Respondent Okwuegbe then informed the inspectors that he planned to reverse the charges later because he did not have time.

80. A second bag of receipts was found. Respondent Okwuegbe stated the prescriptions for those receipts had been returned to stock and the billing to insurance companies had been reversed. This was not true. In fact, 74 medications had been placed on hold in the computer system but had not been reversed with the insurance companies. Respondent Okwuegbe then informed the inspectors that he planned to reverse the charges later because he did not have time.

81. A large red tote bag of receipts was found. Respondent Okwuegbe explained these were refill labels from auto fill. However, 148 labels had been printed and not filled as early as two weeks prior to the inspection. Most the receipts had already been billed to insurance.

82. During the January 13, 2014 inspection, the inspectors discovered that all prescriptions and computer screen prints had the initials KO. Respondent Okwuegbe stated that Pharmacist Chew did not have a sign in and his initials would not be found on any prescription. Respondent Okwuegbe stated that Pharmacist Leland Chew would sign in as Respondent Okwuegbe and fill prescriptions under Respondent Okwuegbe's name.

83. During January 13, 2014 inspections, two consumers came into Drate Pharmacy and asked for the owner. Respondent Okwuegbe told each consumer that the owner was not there. These statements were not true.

84. On or about January 28, 2014, two Board inspectors performed a follow-up inspection of Drate Pharmacy, located at 2930 Shattuck Ave, Berkeley, CA.

85. During the inspection, the counter was covered with prescription bottles in front of prescription labels. Respondent Okwuegbe explained that these were refills. The Inspectors confirmed that many of the prescriptions were prescriptions that Respondent Okwuegbe was told to return to stock and reverse with insurance during the January 13, 2014 inspection.

86. During the January 28, 2014 inspection, Respondent Okwuegbe gave one of the inspectors several spread sheets that stated numerous prescriptions had been reversed with insurance companies. This information was not true. When ask if these were actually reversed, Respondent Okwuegbe stated they were too old to reverse and were placed on hold.

SEVENTH CAUSE FOR DISCIPLINE

(False/Untrue Statements)

87. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301, subsections (f) and/or (g), in that Drate Pharmacy directly or indirectly committed acts of dishonesty, fraud, deceit or corruption and created documents that falsely represented the existence or nonexistence of a state of facts as follows:

a. On or about January 6, 2014, Respondent Okwuegbe stated that all of the prescriptions in the break room were duplicate fills. This was not true as described in paragraph 64, above.

b. On or about January 6, 2014, Respondent Okwuegbe stated that Drate Pharmacy had no medication errors in the last year, as further described in paragraph 70, above. This was not true as VD's medication error, described in paragraphs 55-56, occurred in the prior year.

c. On or about January 6, 2014, Respondent Okwuegbe made and signed a statement under penalty of perjury that "the medications in the boxes of the (break room) have been returned to stock and the billing reversed on the insurance." This statement was false. The circumstances are further described in paragraph 73, above.

d. During the January 13, 2014 inspection, Respondent Okwuegbe stated that numerous (approximately 928) prescriptions were reversed with insurance companies when in fact the prescriptions were only placed on "hold" in the computer system and not reversed with insurance. The circumstances are further described in paragraphs 74-76, 79-80, and 85-86, above.

e. During the January 13, 2014, inspection, two consumers came into Drate Pharmacy and asked for the owner. Respondent Okwuegbe told each consumer that the owner was not there. These statements were not true. The circumstances are described in paragraph 84, above.

f. The January 6, 13, and 28, 2014 inspections revealed Respondent Okwuegbe billed insurance companies for prescriptions that were not given to patients. Respondent Okwuegbe had not returned prescriptions for credit to the insurance companies within the required 10 to 15 days as outlined by insurance policies and procedures. These billing practices demonstrated Drate Pharmacy obtained monies from insurance companies by means of fraudulent billing practices. The circumstances are further described in paragraphs 61-86, above.

g. On or about January 27, 2014, Respondent Okwuegbe faxed the Board inspector transaction logs that showed prescriptions had been returned to stock when in fact they were not. Instead, the prescriptions were placed on hold and not reversed to the original payor of the claim.

h. On or about January 28, 2014, Respondent Okwuege gave a Board inspector documents that indicated prescriptions had been reversed with insurance companies when in fact they had not been reversed. The circumstances are further described in paragraph 86, above.

EIGHTH CAUSE FOR DISCIPLINE

(Disclosure of Prescription Information)

88. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1764. On or about January 6, 2014, Drate Pharmacy stored prescriptions and protected health information in a break room which was accessible to all employees and to the public. The break room had no door or lock to prevent access by unauthorized personnel or the public. The circumstances are further described in paragraph 63, above.

NINTH CAUSE FOR DISCIPLINE

(Security and Storage of Dangerous Drugs)

89. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or

assisted in or abetted a violation of California Code of Regulations, title 16, section 1714, subsection (b), and Code of Federal Regulations title 21, section 1301.75, subsection (b). Drate Pharmacy failed to maintain its facilities, space, fixtures, and equipment so that drugs were safely and properly prepared, maintained, secured and distributed. Drate Pharmacy was not of sufficient size nor did it contain unobstructed areas that accommodated the safe practice of pharmacy. On or about January 6, 2014, Drate Pharmacy had dangerous drugs stored in an unsecured break room accessible to employees and the public. The reason cited for the storage in the break room was because the pharmacy was too small. On January 6, 2014, Schedule II controlled substances were stored together in an open safe such that the substances were accessible to employees. On January 6, and 13, 2014, Drate Pharmacy had boxes in the aisles and prescription bags on the floors such that impeded movement by staff. The circumstances are further described in paragraphs 61-85, above.

TENTH CAUSE FOR DISCIPLINE

(Delay in Therapy)

90. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301 and 733 in that Drate Pharmacy directly or indirectly committed unprofessional conduct by obstructing patients in obtaining prescription drugs or devices that have been legally prescribed or ordered for those patients. Drate Pharmacy failed to deliver 125 prescriptions (dated November 14, 2013 through December 31, 2013) to consumers. On January 13, 2014, the above mentioned prescriptions were designated for delivery but were 14 to 60 days past due. The circumstances are further described in paragraphs 76-78, above.

ELEVENTH CAUSE FOR DISCIPLINE

(False or Misleading Label on a Prescription)

91. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301, subsection (o), of the Code in in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Code sections 4076, subsection (a), 4077, subsection (a), and/or 4078, subsection (a)(1). Drate Pharmacy dispensed dangerous drugs in containers which were labeled with an incorrect manufacturer. Prescription No. 35848, dated November 27, 2013,

stated the manufacturer was Wockhart when in fact the manufacturer was Greenstone. Prescription No. 43892, dated November 22, 2013, stated the manufacturer was Camber when in fact the manufacturer was Zygen. Prescription No. 49302, dated January 2, 2014, stated the manufacturer was Roxane when in fact the manufacturer was MGP.

TWELFTH CAUSE FOR DISCIPLINE

(Controlled Substance Biennial Inventory)

92. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301, subsection (o), of the Code in in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1718, and/or Code of Federal Regulations, title 21, section 1304.11, subsections (b) and/or (c). By January 6, 2014, Drate Pharmacy had still not completed its initial inventory despite being licensed on October 14, 2011. Nor had Drate Pharmacy completed a controlled substance inventory within two years of the beginning inventory date. The circumstances are further described in paragraph 69, above.

THIRTEENTH CAUSE FOR DISCIPLINE

(Identification of Dispensing Pharmacist)

93. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1712, subsection (b), and/or California Code of Regulations, title 16, section 1717, subsections (b) and/or (f). On and before January 13, 2014, Drate Pharmacy had no specific way to identity whether the Pharmacist-in-Charge, Respondent Okwuegbe, or Pharmacist Chew filled and dispensed prescriptions on any given day. In fact, Respondent Okwuegbe's name and initials were on every prescription dispensed, even when they were filled/dispensed by someone else. Pharmacist Leland Chew had not signed or initialed any prescription he dispensed at Drate Pharmacy. Pharmacist Chew had no personal sign-in to Drate Pharmacy's computer system. Pharmacist Chew used Respondent Okwuegbe's sign-in information. Accordingly, every prescription filled by Pharmacist Chew contained Respondent Okwuegbe's initials or information.

There was no way to review or retrieve Pharmacist Chew's prescriptions in Drate Pharmacy's computer system. The circumstances are further described in paragraphs 67 and 82, above.

FOURTEENTH CAUSE FOR DISCIPLINE

(Interpretive Services)

94. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, sections 1707.5, subsection (d), and/or 1707.6, subsection (c). On or about January 6, 2014, Drate Pharmacy had no policies and procedures in place to help patients with limited or no English proficiency. In addition, Drate Pharmacy had not posted a "point to your language" consumer poster. The circumstances are further described in paragraph 62, above.

FIFTEENTH CAUSE FOR DISCIPLINE

(Cleanliness of Pharmacy)

95. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1714, subsection (c). On January 6, 13, and/or 28, 2014, Drate Pharmacy was observed with prescription bags on the floor, stock out of date, and in disorder to the point that prescriptions were often misplaced or lost. The circumstances are further described in paragraphs 61-85, above.

SIXTEENTH CAUSE FOR DISCIPLINE

(Self-Assessment of Pharmacist -in-Charge)

96. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1715, subsection (a) and/or (d). On or about January 6, 2014, Drate Pharmacy did not have a timely Self-Assessment of Pharmacist-in-Charge available for review. The last available assessment was signed by Respondent Okwuegbe on January 9, 2011. Drate did not have an assessment

performed before July 1, 2013, the next available odd number year following 2011. The circumstances are further described in paragraph 68, above.

SEVENTEENTH CAUSE FOR DISCIPLINE

(False/Untrue Statements)

97. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (f) and/or (g), in that Respondent Okwuegbe committed acts of dishonesty, fraud, deceit or corruption and created documents that falsely represented the existence or nonexistence of a state of facts as follows:

a. On or about January 6, 2014, Respondent Okwuegbe stated that all of the prescriptions in the break room were duplicate fills. This was not true as described in paragraph 64, above.

b. On or about January 6, 2014, Respondent Okwuegbe stated that Drate Pharmacy had no medication errors in the last year, as further described in paragraph 70, above. This was not true as VD's medication error, described in paragraphs 55-56, occurred in the prior year.

c. On or about January 6, 2014, Respondent Okwuegbe made and signed a statement under penalty of perjury that "the medications in the boxes of the (break room) have been returned to stock and the billing reversed on the insurance." This statement was false. The circumstances are further described in paragraph 73, above.

d. During the January 13, 2014 inspection, Respondent Okwuegbe stated that numerous (approximately 928) prescriptions were reversed with insurance companies when in fact the prescriptions were only placed on "hold" in the computer system and not reversed with insurance. The circumstances are further described in paragraphs 74-76, 79-80, and 85-86, above.

e. During the January 13, 2014, inspection, two consumers came into Drate Pharmacy and asked for the owner. Respondent Okwuegbe told each consumer that the owner was not there. These statements were not true. The circumstances are described in paragraph 84, above.

f. The January 6, 13, and 28, 2014 inspections revealed Respondent Okwuegbe billed insurance companies for prescriptions that were not given to patients. Respondent Okwuegbe had not returned prescriptions for credit to the insurance companies within the required 10 to 15

days as outlined by insurance policies and procedures. These billing practices demonstrated Drate Pharmacy obtained monies from insurance companies by means of fraudulent billing practices. The circumstances are further described in paragraphs 61-86, above.

g. On or about January 27, 2014, Respondent Okwuegbe faxed the Board inspector transaction logs that showed prescriptions had been returned to stock when in fact they were not. Instead, the prescriptions were placed on hold and not reversed to the original payor of the claim.

h. On or about January 28, 2014, Respondent Okwuege gave a Board inspector documents that indicated prescriptions had been reversed with insurance companies when in fact they had not been reversed. The circumstances are further described in paragraph 86, above.

98. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph

EIGHTEENTH CAUSE FOR DISCIPLINE

(Disclosure of Prescription Information)

99. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1764. On or about January 6, 2014, Drate Pharmacy exhibited prescriptions and protected health information in a break room which was accessible to all employees and to the public. The break room had no door or lock to prevent access by unauthorized personnel or the public. The circumstances are further described in paragraph 63, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

NINETEENTH CAUSE FOR DISCIPLINE

(Security and Storage of Dangerous Drugs)

100. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1714,

subsection (b) and Code of Federal Regulations title 21, section 1301.75 (b). Drate Pharmacy failed to maintain its facilities, space, fixtures, and equipment so that drugs were safely and properly prepared, maintained, secured and distributed. Drate Pharmacy was not of sufficient size nor did it contain unobstructed areas that accommodated the safe practice of pharmacy. On or about January 6, 2014, Drate Pharmacy stored dangerous drugs in an unsecured break room accessible to employees and the public. The reason cited for the storage in the break room was because the pharmacy was too small. On January 6, 2014, Schedule II controlled substances were stored together in an open safe such that the substances were accessible to employees. On January 6, and 13, 2014, Drate Pharmacy had boxes in the aisles and prescription bags on the floors that impeded movement by staff. The circumstances are further described in paragraphs 61-85, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

TWENTIETH CAUSE FOR DISCIPLINE

(Delay in Therapy)

101. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301 and 733 in that it committed unprofessional conduct by obstructing patients in obtaining prescription drugs or devices that have been legally prescribed or ordered for those patients. Drate Pharmacy failed to deliver 125 prescriptions (dated November 14, 2013 through December 31, 2013) to consumers. On January 13, 20114, the above mentioned prescriptions were designated for delivery but were 14 to 60 days past due. The circumstances are further described in paragraphs 76-78, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

TWENTY-FIRST CAUSE FOR DISCIPLINE

(False or Misleading Label on a Prescription)

102. Respondent Okwuegbe's pharmacist license is are subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or

assisted in or abetted a violation of Code sections 4076, subsection (a), 4077, subsection (a), and/or 4078, subsection (a)(1). Prescription No. 35848, dated November 27, 2013, stated the manufacturer was Wockhart when in fact the manufacturer was Greenstone. Prescription No. 43892, dated November 22, 2013, stated the manufacturer was Camber when in fact the manufacturer was Zygen. Prescription No. 49302, dated January 2, 2014, stated the manufacturer was Roxane when in fact the manufacturer was MGP. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

TWENTY-SECOND CAUSE FOR DISCIPLINE

(Controlled Substance Biennial Inventory)

103. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1718, and/or Code of Federal Regulations, title 21, section 1304.11. By January 6, 2014, Drate Pharmacy had still not completed its initial inventory that was dated October 14, 2011. Nor had Drate Pharmacy completed a controlled substance inventory within two years of the beginning inventory date. The circumstances are further described in paragraph 69, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

TWENTY-THIRD CAUSE FOR DISCIPLINE

(Identification of Dispensing Pharmacist)

104. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1712 and/or California Code of Regulations, title 16, section 1717, subsections (b) and or (f). On and before January 6, 2014, Drate Pharmacy had no specific way to identity whether Respondent Okwuegbe

or Pharmacist Chew filled and dispensed prescriptions on any given day. In fact, Respondent Okwuegbe's name and initials were on every prescription dispensed, even when they were filled by someone else. Pharmacist Chew had not signed or initialed any prescription he dispensed at Drate Pharmacy. Pharmacist Chew had no personal sign-in to Drate Pharmacy's computer system. Pharmacist Chew used Respondent Okwuegbe's sign-in information. Accordingly, every prescription filled by Leland Chew contained Respondent Okwuegbe's initials or information. There was now way to review Pharmacist Chew's prescriptions in Drate Pharmacy's computer system. The circumstances are further described in paragraphs 67 and 82, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

TWENTY-FOURTH CAUSE FOR DISCIPLINE

(Interpretive Services)

105. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, sections 1707.5, subsection (d), and/or 1707.6, subsection (c). On or about January 6, 2014, Drate Pharmacy had no policies and procedures in place to help patients with limited or no English proficiency. In addition, Drate Pharmacy had not posted a "point to your language" consumer poster. The circumstances are further described in paragraph 62, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

TWENTY-FIFTH CAUSE FOR DISCIPLINE

(Cleanliness of Pharmacy)

106. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1714,

subsection (c). On January 6, 13, and/or 28, 2014, Drate Pharmacy was observed with prescription bags on the floor, stock out of date, and in disorder to the point that prescriptions were often misplaced or lost. The circumstances are further described in paragraphs 61-85, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

TWENTY-SIXTH CAUSE FOR DISCIPLINE

(Self-Assessment of Pharmacist-in-Charge)

107. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in that Respondent Okwuegbe directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1715 (a) and/or (d). On or about January 6, 2014, Drate Pharmacy did not have a timely Self-Assessment of Pharmacist-in-Charge available for review. The last available assessment was signed by Respondent Okwuegbe on January 9, 2011. Drate Pharmacy did not have an assessment performed before July 1, 2013, the next available odd number year following 2011. The circumstances are further described in paragraph 68, above. Respondent Okwuegbe either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

CORRESPONDING RESPONSIBILITY/CONTROLLED SUBSTANCES INVESTIGATION OF DRATE PHARMACY

108. As a result of the above violations the Board initiated an investigation into Drate Pharmacy's handling and dispensing of controlled substances.

109. During the January 13, 2014 inspection, Respondent Okwuegbe was asked about his understanding of corresponding responsibility. He showed no clear understanding and was evasive in his responses.

110. On January 30, 2014, a Board inspector did a hand inventory of Hydrocodone APAP and promethazine with Codeine.

111. During the investigation it was discovered the Drate Pharmacy used multiple vendors to obtain controlled substances. Respondent Okwuegbe was asked if his ordering privileges were ever suspended or restricted by any vendor/wholesaler. Respondent Okwuegbe stated that he did not have any vendor restrict his ordering privileges. Respondent Okwuegbe also told the inspector that he switched from wholesaler Amerisource Bergen Corp. to wholesaler Cardinal Health because of pricing. These statements were not true as Amerisource Bergen Corp. refused to sell controlled substances to Drate Pharmacy on or about September 24, 2012, and closed its account with Drate Pharmacy on or about November 20, 2012. Valley Wholesale Drug Co. stopped selling controlled substances to Drate pharmacy in December 2012.

112. The investigation revealed that Drate Pharmacy did not provide any controlled substance dispensing information to CURES (Controlled Substance Utilization Review and Evaluation System) until August 2013 despite opening in December of 2011. Drate Pharmacy dispensed numerous controlled substances in this time period. Drate Pharmacy and Respondent Okwuegbe failed to transmit the required data to CURES despite being informed of the requirement by a Board inspector during the new pharmacy inspection of Drate Pharmacy. Respondent Okwuegbe was present at this new pharmacy inspection. Drate Pharmacy subsequently provided the data to CURES.

113. A review of Drate Pharmacy's data revealed many "red flags" indicating inappropriate dispensing of controlled substances/drugs of abuse. Red flags include but are not limited to:

- prescribers from outside the pharmacy service area
- patients from outside the pharmacy service area
- prescriptions for highly abused drugs alone or in combination with other "drug cocktails"
- prescriptions paid for in cash
- large quantities outside of the normal scope of dispensing
- early dispensing
- a number of patients living at the same address
- sequential filling of prescriptions from a single prescriber for multiple patients for "drug

cocktails"

114. The investigation revealed that from about December, 15, 2011, until about January 30, 2014, Drate Pharmacy dispensed 264,741 tablets of hydrocodone/APAP 10/325mg (346 tablets a day). In the same period, Drate Pharmacy dispensed 1608.6 pints (approximately 2.1-pints/day) of Promethazine with Codeine syrup. 3,226 (18.83%) of the 17,128 prescriptions filled at Drate Pharmacy were for hydrocodone/APAP 10-325mg tablets, it was the most dispensed controlled substance. Hydrocodone containing products accounted for four of the top ten drugs dispensed and totaled 5,634 (32.89%) of the total prescriptions dispensed by Drate Pharmacy. 3,120 (18.22%) of the prescriptions filled at Drate Pharmacy were for Promethazine with Codeine syrup. It was the second most dispensed controlled substance at Drate Pharmacy. The top two controlled substances, both highly abused drugs, accounted for 6,346 (37.05%) of the 17,138 prescriptions dispensed at Drate Pharmacy. 5,485 (32.02%) of the 17,128 controlled substance prescriptions were paid for in cash as opposed to insurance. Typically, a pharmacy will have an average of 80-85% of prescriptions processed by insurance and only 15- 20% by cash.

115. From about December, 15, 2011 until about January 30, 2014, Drate Pharmacy filled a total of 2,270 prescriptions from prescriber Dr. Hai Nguyen. 839 of those prescriptions were for hydrocodone/ APAP 10/325mg totaling 43,100 tablets. 1,119 of those prescriptions were for promethazine with Codeine and totaled 268,733 ml (559.9 pints). Both are highly abused drugs with significant street value. 939 (41.37%) of Dr. Hai Nguyen's 2,270 prescriptions were processed as cash. Furthermore, these two drugs were Dr. Hai Nguyen's most prescribed controlled substances accounting for a total of 1,958 (86.2%) of his 2,270 prescriptions.

116. The investigation revealed that from about December, 15, 2011, until about January 30, 2014, Drate Pharmacy filled a total of 620 prescriptions for various highly abused drugs from prescribers Dr. Tan Nguyen, Dr. Collin Leong, and Dr. Clair Pettinger whose medical licenses were subsequently revoked and or suspended for various reasons, including excessive furnishing of controlled substances, and whose patients were largely using "cash" as a payment method.

117. The investigation revealed that from about December, 15, 2011, until about January 30, 2014, several of Drate Pharmacy's customers traveled significant distances to see the above-mentioned doctors and to use Drate Pharmacy. These patients passed many other pharmacies.

118. Drate Pharmacy dispensed significantly more hydrocodone/APAP 10/325mg and Promethazine with Codeine than several of its nearby competitors that maintained similar or longer operating hours. Drate Pharmacy dispensed 15.6 times more Promethazine with Codeine than a neighboring CVS Pharmacy with longer operating hours. Drate Pharmacy also had a significantly higher percentage of cash payments than several of its neighboring pharmacies.

119. Drate Pharmacy and Respondent Okwuegbe aided in filing medically illegitimate prescriptions. Drate Pharmacy and Respondent Okwuegbe failed to fulfill their corresponding responsibilities when they indiscriminately dispensed controlled substances prescriptions received from Dr. Hai Nguyen and those written by Dr. Tan Nguyen, Dr. Collin Leong, and Dr. Clair Pettinger without verifying if they were written for a legitimate medical purpose. Respondent Okwuegbe and Drate Pharmacy ignored industry "red flags" to verify whether a prescription was issued for a legitimate medical purpose.

120. The investigation revealed that from about December 15, 2011, until about January 30, 2014, Drate Pharmacy had an overage of 1,319 tablets of hydrocodone/APAP 10/325mg and 5 pints of Promethazine with Codeine syrup as determined by an audit conducted by a Board inspector. The records indicated that Drate Pharmacy acquired 264,200 tablets of hydrocodone/APAP 10/325mg, yet dispensed (or had in current inventory) 265,519 tablets. The records indicated that Drate Pharmacy acquired 1606 pints of Promethazine with Codeine yet, dispensed (or had in current inventory) 1611 pints. The overage could be due to multiple factors such as unreported purchases, inaccurate dispensing records, or inaccurate billing of prescriptions.

121. The investigation revealed that from about December 15, 2011, until about January 30, 2014, Drate Pharmacy did not have an address readily retrievable in the pharmacy for patient KM. who received 4 prescriptions for controlled substances at Drate pharmacy. Furthermore, there were a total of 174 prescription transaction records for 32 patients (including KM.) whose

addresses were not readily retrievable in the dispensing report provided to the Board by Drate Pharmacy.

TWENTY-SEVENTH CAUSE FOR DISCIPLINE

(Dishonesty)

122. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301, subsection (f) and/or (g) of the Code, in that Drate Pharmacy directly or indirectly committed acts of dishonesty, fraud, deceit or corruption. On or about January 30, 2014, Respondent Okwuegbe stated that Drate Pharmacy's ordering privileges were never suspended or restricted by any vendor/wholesaler. This was not true as described in paragraph 111, above.

TWENTY-EIGHTH CAUSE FOR DISCIPLINE

(Failure to Exercise Corresponding Responsibility)

123. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under Code section 4301, subsections (f) and/or (o), in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Health and Safety Code section 11153, subsection (a), and/or California Code of Regulations title 16, section 1761, subsections (a) and (b), by failing to properly exercise corresponding responsibility in dispensing controlled substances, as described in paragraphs 108-119, above. Drate Pharmacy dispensed numerous prescriptions for controlled substances without determining whether the prescriptions were written for legitimate medical purposes. The prescriptions filled by Drate Pharmacy were not all for legitimate medical purposes.

TWENTY-NINTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct Failure to Exercise Corresponding Responsibility)

124. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under Code section 4301 in conjunction with Code section 4306.5, subsection (b), in that Drate Pharmacy directly or indirectly committed unprofessional conduct by failing to properly exercise corresponding responsibility in dispensing controlled substances, as described in paragraphs 108-119, above. Drate Pharmacy dispensed numerous prescriptions for controlled substances without

determining whether the prescriptions were written for legitimate medical purposes. The prescriptions filled by Drate Pharmacy were not all for legitimate medical purposes.

THIRTIETH CAUSE FOR DISCIPLINE

(Inaccurate Records)

125. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Code section 4081, subdivision (a), and/or section 4105, subsection (a), by failing to keep records that accurately accounted for the of acquisition, disposition, and current inventory of dangerous drugs. Drate Pharmacy did not have an accurate and complete record of all acquisition, receipt, shipment, or disposition of dangerous drugs. Drate Pharmacy had an overage of 1,319 tablets of hydrocodone/APAP 10/325mg and 5 pints of Promethazine with Codeine syrup as, determined by an audit conducted by a Board inspector. The circumstances are further described in paragraph 120, above.

THIRTY-FIRST CAUSE FOR DISCIPLINE

(CURES Reporting)

126. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301, subsections (f) and/or (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Health and Safety Code section 11165, subsection (d), in that from about December 15, 2011 until about January 30, 2014, Drate Pharmacy failed to report prescription information for controlled substances in Schedules II through IV to the Department of Justice CURES system within 7 days of dispensing those controlled substances. The circumstances are further described in paragraph 112, above.

THIRTY-SECOND CAUSE FOR DISCIPLINE

(Information on Prescriptions)

127. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301, subsection (o), of the Code in in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Health and Safety Code sections 11164, subsection (a)(2), and/or 11206 and/or California Code of Regulations Title 16, section 1707.1 subsection (a)(1)(A),

subsection (a). Drate Pharmacy did not have an address readily retrievable in the pharmacy for patient KM. who received four prescriptions for controlled substances. Furthermore, there were a total of 174 prescription transaction records for 32 patients (including KM.) whose addresses were not readily retrievable by Drate Pharmacy. The circumstances are further described in paragraph 121, above.

THIRTY-THIRD CAUSE FOR DISCIPLINE

(Dishonesty)

128. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (f) and/or(g), in that Respondent Okwuegbe committed acts of dishonesty, fraud, deceit or corruption. On or about January 30, 2014, Respondent Okwuegbe stated that Drate Pharmacy's ordering privileges were never suspended or restricted by any vendor/wholesaler. This was not true as described in paragraph 111, above.

THIRTY-FOURTH CAUSE FOR DISCIPLINE

(Failure to Exercise Corresponding Responsibility)

129. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsections (f) and/or (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Health and Safety Code section 11153, subsection (a), and/or California Code of Regulations title 16, section 1761, subsections (a) and (b), by failing to properly exercise corresponding responsibility in dispensing controlled substances, as described in paragraphs 108-119, above. Drate Pharmacy dispensed numerous prescriptions for controlled substances and/or dangerous drugs without determining whether the prescriptions were written for legitimate medical purposes. The prescriptions filled by Drate Pharmacy were not all for legitimate medical purposes. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

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THIRTY-FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct Failure to Exercise Corresponding Responsibility)

130. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301 in conjunctions with Code section 4306.5, subsection(b), in that Drate Pharmacy committed unprofessional conduct by failing to properly exercise corresponding responsibility in dispensing controlled substances, as described in paragraphs 108-119, above. Drate Pharmacy dispensed numerous prescriptions for controlled substances without determining whether the prescriptions were written for legitimate medical purposes. The prescriptions filled by Drate Pharmacy were not all for legitimate medical purposes. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

THIRTY-SIXTH CAUSE FOR DISCIPLINE

(Inaccurate Records)

131. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Code, section 4081, subdivision (a), and/or section 4105 by failing to keep records that accurately accounted for the acquisition, disposition and current inventory of dangerous drugs. Drate Pharmacy did not have an accurate and complete record of all acquisition, receipt, shipment, or disposition of dangerous drugs. Drate Pharmacy had an overage of 1,319 tablets of hydrocodone/APAP 10/325mg and 5 Pints of promethazine with Codeine syrup as determined by an audit conducted by a Board inspector. The circumstances are further described in paragraph 120, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

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THIRTY-SEVENTH CAUSE FOR DISCIPLINE

(CURES Reporting)

132. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsections (f) and/or (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Health and Safety Code section 11165, subsection (d), in that from about December, 15, 2011 until about January 30, 2014, Drate Pharmacy failed to report prescription information for controlled substances in Scheduls II through IV to the Department of Justice CURES system within 7 days of dispensing those controlled substances. The circumstances are further described in paragraph 112, above. Respondent Okwuegbe either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

THIRTY-EIGHTH CAUSE FOR DISCIPLINE

(Information on Prescriptions)

133. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Health and Safety Code sections 11164, subsection (a)(2), and/or 11206, subsection (a). Drate Pharmacy did not have an address readily retrievable in the pharmacy for patient KM. who received four prescriptions for controlled substances. Furthermore, there were a total of 174 prescription transaction records for 32 patients (including KM.) whose addresses were not readily retrievable by Drate Pharmacy. The circumstances are further described in paragraphs 121, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

THIRTY-NINTH CAUSE FOR DISCIPLINE

(Misuse of Education)

134. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301 of the Code in conjunction with section 4306.5, subsection (a), of the Code in that

Respondent Okwuegbe was involved in acts or omissions that involved, in whole or in part, the inappropriate exercise of his or her education, training, or experience as a pharmacist. The circumstances are described in paragraphs 108-121, above.

ROCKFORTH PHARMACY INVESTIGATION/INSPECTION

135. Respondent Okwuegbe is/was the owner and Pharmacist-in-Charge of Rockforth Pharmacy, Original Pharmacy Permit No. PHY 51512. Rockforth Pharmacy was located at 10500A International Blvd., in Oakland California. During the investigation of Drate Pharmacy an additional investigation of Rockforth Pharmacy was opened. That investigation revealed additional violations by both Drate Pharmacy and Rockforth Pharmacy.

136. The Rockforth investigation revealed that Drate Pharmacy was filling prescriptions and billing insurance companies for prescriptions that were dispensed at Rockforth Pharmacy. However, neither Rockforth nor Drate pharmacy had accurate patient profiles for some of the patients receiving these prescriptions. During a January 28, 2014 inspection of Rockforth Pharmacy, a Board inspector found filled prescription bottles with Drate Pharmacy labels that were ready for dispensing at Rockforth Pharmacy. However, when Drate Pharmacy patient profile records were reviewed for accuracy, the same prescriptions (or refills of those prescriptions) were not on the patient profiles. The following filled prescriptions were missing from Drate Pharmacy's patient profiles:

a. Patient AS's profile was missing Rx 47297 (Omeprazole 20mg dispensed 1/25/14)

b Patient SB's profile was missing Rx 48189 (Amlodipine 10mg dispensed 1/25/14)

c. Patient OE's profile was missing Rx 33305 (ProAir inhaler dispensed 1/27/14)

d. Patient OE's profile was missing Rx 50328 (Glipizide 5mg dispensed 1/27/14)

e. Patient DF's profile was missing Rx 48567 (ASA 81mg dispensed 1/17/14)

f. Patient SP's profile was missing Rx 48535 (Docusate 250mg dispensed 1/6/14)

g. Patient SW's profile was missing Rx 47301 (Omeprazo1e 20mg dispensed 12/3/13)

h Patient SW's profile was missing Rx 50227 (Hydrocodone/APAP 10-325 dispensed 1/21/14)

i. Patient DP's profile was missing Rx 47868 (Carvedilol 25mg dispensed 1/20/14)

j. Patient DP's profile was missing Rx 47869 (Hetz 25mg dispensed 1/2/14)

k. Patient NP's profile was missing Rx 50376 (Xopenex HFA dispensed 1/23/14)

l. Patient LT's profile was missing Rx 39327 (ProAirHFA dispensed 12/21/13)

m. Patient LT's profile was missing Rx 38097 (QVar 80mcg dispensed 12/21/13)

n. Patient DJ's profile was missing Rx 49002 (Atenolol 100mg dispensed 1/22/14)

137. During a January 28, 2014 inspection, Rockforth Pharmacy had no records of acquisition or disposition of the specific prescriptions that were labeled with Drate labels, yet were being dispensed by Rockforth. Rockforth had no records of the following prescriptions:

RX Number:	Date dispensed	Drug	Patient:
47297	1/25/14	Omeprazole 20mg	AS
48189	1/25/14	Amlodipine 10mg	SB
33305	1/27/14	ProAir inhaler	OE
50328	1/27/15	Glipizide 5mg	OE
48567	1/17/14	ASA 81mg	DF
48535	1/6/14	Docusate 250mg	SP
47301	12/3/13	Omeprazole 20mg	SW
50227	1/21/14	Hydrocodone/apap 10-325	SW
47868	1/20/14	Carvedilol 25mg	DP
47869	1/2/14	HCTZ 25mg	DP
50376	1/23/14	Xopenex HFA	NP
39327	12/21/13	ProAir HFA	LT
38097	12/21/13	QVar 80mcg	LT
49002	1/22/14	Atenolol 100mg	DJ
500646	12/ 11/13	Fluocinonide ointment	BL
501011	12/20/13	Aspirin 8lmg	LJ
500691	12/12/13	Prenatal tablets	TM
500692	12/12/13	Ferrous sulfate	TM
39327	12/21/13	Proair	LT

38097	12/21/13	QVar 80mcg	LT

138. Rockforth Pharmacy did not maintain complete patient profiles that were readily retrievable. On January 28, 2014, several prescriptions could not be found on Rockforth's patient profiles:

a. Prescription No. 500646, dated December 11, 2013, could not be found on Patient BL's medication profile.

b. Prescription No. 501011, dated December 20, 2013, could not be found on Patient LJ's medication profile.

c. Prescription No. 500691, dated December 12, 2013, could not be found on Patient TM's medication profile.

d. Prescription No. 500692, dated December 12, 2013, could not be found on Patient TM's medication profile.

139. On January 28, 2014, Rockforth Pharmacy had no medication profile for patient LT. However, Board inspectors found two prescriptions, RX39327 and RX38097, for patient LT at Rockforth pharmacy. Both prescriptions had Drate labels and were dated December 21, 2013.

140. Respondent Okwuegbe gave the following written statement concerning prescriptions with Drate Label found at Rockforth Pharmacy: "Statement of medications with Drate Pharmacy label found at Rockforth Pharmacy. The below referenced prescriptions/medications. . .were filled and labeled at Drate Pharmacy and not at Rockforth Pharmacy. The said medications were enroute for delivery to the various patients who live around Rockforth Pharmacy and some in Hayward. We normally go out for delivery at the end of business and I did not want to leave the medications in the car in the sun before delivery hence they were brought into Rockforth Pharmacy from Drate Pharmacy." This statement was false.

141. The prescriptions referenced in the statement by Respondent Okwuegbe were dated December 13, through January 27, 2014. All of these prescriptions were in will-call on January 28, 2014 at Rockforth, not in any container labeled for delivery. Two separate patients picked up the prescriptions on January 28, 2014, at Rockforth which were labeled with Drate labels. In

addition, consumer DJ lived in Stockton, California- approximately 75 miles from Rockforth Pharmacy.

142. The Rockforth investigation revealed that on or about December 12, 2013, Rockforth Pharmacy received prescription number 50113 for tramadol upon a transfer from Apothecary Drug. This prescription contained no refills. However, on or about January 20, 2014, Drate Pharmacy filled and dispensed a refill of prescription number 50113 without receiving prior authorization from the prescriber to do so.

143. On January 28, 2013, Rockforth Pharmacy failed to maintain its facilities, space, fixtures, and equipment so that dangerous drugs were safely and properly prepared, maintained, secured and distributed. Rockforth Pharmacy failed to store controlled substances listed in Schedules II, III, IV, and V in a securely locked, substantially constructed cabinet. Rockforth Pharmacy stored Schedule II controlled substances in an easily movable lightweight file cabinet.

144. During the January 28, 2014 inspection, Rockforth Pharmacy did not have many required policies and procedures available for inspection. Rockforth Pharmacy could not produce policies and procedures addressing impairment and theft. Rockforth Pharmacy could not produce a job description or policies and procedures for pharmacy technicians. Rockforth Pharmacy could not produce any policies and procedures for the pharmacy's quality assurance program for medication errors.

145. On January 28, 2014, Rockforth Pharmacy and Respondent Okwuegbe refused to unlock a door in and on Rockforth pharmacy's premises, thereby preventing the board inspectors access to a room where dangerous drugs were stored. The room contained visible bottles of hydrocodone, a controlled substance. The inspectors asked Rockforth not to open the door and enter the room without an inspector present. When the Board inspectors were given access to the room on January 29, 2014, the contents of the room had been disturbed. Respondent Okwuegbe made a following statement with regards to the room "I…did not enter the room. I am not aware of authorized anybody to enter the room"

146. On about January 28, 2014, a board inspector found invoices at Rockforth Pharmacy dated January 13, 2014, January 17, 2014, and January 20, 2014 with a pharmacy technician's

signature for delivery. The deliveries contained dangerous drugs and/or controlled substances. In addition, there were no signatures of receipt of controlled substances by a pharmacist that corresponded with two DEA 222 forms that were dated December 12, 2013 and November 11, 2013.

FORTIETH CAUSE FOR DISCIPLINE

(Incomplete Patient Profiles)

147. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301, subsection (o), of the Code in in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1707. l (a) in that Drate Pharmacy did not maintain complete patient profiles that were readily retrievable. Many patient profiles did not include prescriptions filed and billed by Drate Pharmacy. The circumstances are described in paragraph 136, above.

FORTY-FIRST CAUSE FOR DISCIPLINE

(Refill Without Authorization)

148. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Section 4063 of the Code and/or California Code of Regulations, title 16, section 1761 in that Drate Pharmacy dispensed a prescription without prescriber authorization or that contained a significant omission or uncertainty. The circumstances are described in paragraph 142, above.

FORTY-SECOND CAUSE FOR DISCIPLINE

(Incomplete Patient Profiles)

149. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1707. l (a) in that Drate Pharmacy did not maintain complete patient profiles that were readily retrievable. Many patient profiles did not include prescriptions filled and billed by Drate Pharmacy. The circumstances are described in paragraph 136, above. Respondent Okwuegbe, either through his

own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

FORTY-THIRD CAUSE FOR DISCIPLINE

(Refill Without Authorization)

150. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Section 4063 of the Code and/or California Code of Regulations, title 16, section 1761 in that Drate Pharmacy dispensed a prescription without prescriber authorization or that contained a significant omission or uncertainty. The circumstances are described in paragraph 142, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

FORTY -FORTH CAUSE FOR DISCIPLINE

(Refusal to Access Pharmacy/Subversion of Investigation)

151. Rockforth Pharmacy's Original Pharmacy Permit is subject to disciplinary action under section 4301, subsections (o) and or (q), and /or section 4080 of the code in that Rockforth Pharmacy directly or indirectly engaged in conduct that subverted or attempted to subvert an investigation of the board by refusing to allow board inspectors access to an area in the pharmacy that contained dangerous drugs and or controlled substances. The circumstances are described in paragraph 145, above.

FORTY-FIFTH CAUSE FOR DISCIPLINE

(False/Untrue Statements)

152. Rockforth Pharmacy's Original Pharmacy Permit is subject to disciplinary action under section 4301, subsections (f) and/or (g), in that Rockforth Pharmacy directly or indirectly committed acts of dishonesty, fraud, deceit or corruption and created documents that falsely

represented the existence or nonexistence of a state of facts. The circumstances are described in paragraph 140-141, above.

FORTY-SIXTH CAUSE FOR DISCIPLINE

(Records of Drug Acquisition and Disposition)

153. Rockforth Pharmacy's Original Pharmacy Permit is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Code section 4081, subdivision (a), and/or section 4105, subsection (a), by failing to keep records that accurately accounted for the acquisition, disposition of dangerous drugs in readily retrievable form. The circumstances are described in paragraph 137, above.

FORTY-SEVENTH CAUSE FOR DISCIPLINE

(Security and Storage of Dangerous Drugs/Controlled Substances)

154. Rockforth Pharmacy's Original Pharmacy Permit is subject to disciplinary action under section 4301, subsection (o), of the Code in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1714, subsection (b), and Code of Federal Regulations title 21, section 1301.75, subsection (b) by failing to adequately secure controlled substances. The circumstances are described in paragraph 143, above.

FORTY-EIGHTH CAUSE FOR DISCIPLINE

(Controlled Substance Biennial Inventory)

155. Rockforth Pharmacy's Original Pharmacy Permit is subject to disciplinary action under section 4301, subsection (o), of the Code in in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1718, and/or Code of Federal Regulations, title 21, section 1304.11, subsections (a) and/or (b) by failing to complete an initial inventory of controlled substances and/or dangerous drugs. By January 28, 2014, Rockforth Pharmacy had still not completed its initial inventory despite being licensed on July 30, 2013.

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FORTY-NINTH CAUSE FOR DISCIPLINE

(Separation of Invoices)

156. Rockforth Pharmacy's Original Pharmacy Permit is subject to disciplinary action under section 4301, subsection (o), of the Code in in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Code of Federal Regulations, title 21, section 1304.04, subsection (f), by failing to separate recording concerning Schedule II controlled substances from all other records. On or about January 28, 2014, Rockforth Pharmacy mixed Schedule II controlled substance records in a box with other pharmacy invoice records instead of separating them from other records.

FIFTIETH CAUSE FOR DISCIPLINE

(Signature Requirements)

157. Rockforth Pharmacy's Original Pharmacy Permit is subject to disciplinary action under section 4301, subsections (j) and/or (o), of the Code in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of section 4059.5, subdivision (a), of the Code, a state law governing pharmacy, controlled substances, and/or dangerous drugs. Rockforth directly or indirectly violated, or assisted in or abetted a violation section 4059.5, subdivision (a), by having a pharmacy technician, and not a pharmacist, sign for and receive dangerous drugs/controlled substances. The circumstances are further described in paragraph 146, above.

FIFTY-FIRST CAUSE FOR DISCIPLINE

(Self-Assessment of Pharmacist-in-Charge)

158. Rockforth Pharmacy's Original Pharmacy Permit is subject to disciplinary action under section 4301, subsection (o), of the Code in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1715, subsection (a), (b), and/or (d). On or about January 28, 2014, Rockforth Pharmacy did not have a timely Self-Assessment of Pharmacist-in-Charge available for review.

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FIFTY-SECOND CAUSE FOR DISCIPLINE

(False or Misleading Label on a Prescription)

159. Rockforth Pharmacy's Original Pharmacy Permit is subject to disciplinary action under section 4301, subsection (o), of the Code in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Code sections 4076, subsection (a), 4077, subsection (a), and/or 4078, subsection (a)(1). Prescription No. 501986, dated January 27, 2014, stated the manufacturer was Accord when in fact the manufacturer was Qualitest. Prescription No. 500194, dated January 17, 2014, stated the manufacturer was Roxanne when in fact the manufacturer was MGP.

FIFTY-THIRD CAUSE FOR DISCIPLINE

(Patient Profiles)

160. Rockforth Pharmacy's Original Pharmacy Permit is subject to disciplinary action under section 4301, subsection (o), of the Code in in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1707. l (a) in that Rockforth Pharmacy did not maintain complete patient profiles that were readily retrievable. Several prescriptions could not be found of Rockforth's patient profiles. The circumstances are further described in paragraph 138, above.

FIFTY-FOURTH CAUSE FOR DISCIPLINE

(Policies and Procedures)

161. Rockforth Pharmacy's Original Pharmacy Permit is subject to disciplinary action under section 4301, subsection (o), of the Code in in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Code Section 4104 (a) and/or Code of Regulations, title 16, section 1711(c)(l). Rockforth Pharmacy did not have required policies and procedures in an immediately retrievable form during an inspection on or about January 28, 2014. The circumstances are further described in paragraph 144, above.

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FIFTY-FIFTH CAUSE FOR DISCIPLINE

(Refusal to Access Pharmacy/Subversion of Investigation)

162. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsections (o) and or (q), and /or section 4080 of the code in that Rockforth Pharmacy directly or indirectly engaged in conduct that subverted or attempted to subvert an investigation of the board by refusing to allow board inspectors access to an area in the pharmacy that contained dangerous drugs and or controlled substances. The circumstances are described in paragraph 145, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Rockforth Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

FIFTY-SIXTH CAUSE FOR DISCIPLINE

(False/Untrue Statements)

163. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsections (f) and/or (g), in that Rockforth Pharmacy directly or indirectly committed acts of dishonesty, fraud, deceit or corruption and created documents that falsely represented the existence or nonexistence of a state of facts. The circumstances are described in paragraph 140-141, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Rockforth Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

FIFTY-SEVENTH CAUSE FOR DISCIPLINE

(Records of Drug Acquisition and Disposition)

164. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Code section 4081, subdivision (a), and/or section 4105, subsection (a), by failing to keep records that accurately accounted for the acquisition, disposition of dangerous drugs in readily retrievable form. The circumstances are described in paragraph 137, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as

an owner of Rockforth Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

FIFTY-EIGHTH CAUSE FOR DISCIPLINE

(Security and Storage of Dangerous Drugs/Controlled Substances)

165. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1714, subsection (b), and Code of Federal Regulations title 21, section 1301.75, subsection (b) by failing to adequately secure controlled substances. The circumstances are described in paragraph 143, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Rockforth Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

FIFTY-NINTH CAUSE FOR DISCIPLINE

(Controlled Substance Biennial Inventory)

166. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1718, and/or Code of Federal Regulations, title 21, section 1304.11, subsections (a) and/or (b) by failing to complete an initial inventory of controlled substances and/or dangerous drugs. By January 28, 2014, Rockforth Pharmacy had still not completed its initial inventory despite being licensed on July 30, 2013. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Rockforth Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

SIXTIETH CAUSE FOR DISCIPLINE

(Separation of Invoices)

167. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Code of Federal Regulations, title 21, section

1304.04, subsections (f) by failing to separate recording concerning Schedule II controlled substances from all other records. On or about January 28, 2014, Rockforth Pharmacy mixed Schedule II controlled substance records in a box with other pharmacy invoice records instead of separating them from other records. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Rockforth Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

SIXTY-FIRST CAUSE FOR DISCIPLINE

(Signature Requirements)

168. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsections (j) and/or (o), of the Code in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of section 4059.5, subdivision (a), of the Code, a state law governing pharmacy, controlled substances, and/or dangerous drugs. Rockforth directly or indirectly violated, or assisted in or abetted a violation section 4059.5, subdivision (a), by having a pharmacy technician, and not a pharmacist, sign for and receive dangerous drugs/controlled substances. The circumstances are further described in paragraph 146, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Rockforth Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

SIXTY-SECOND CAUSE FOR DISCIPLINE

(Self-Assessment of Pharmacist-in-Charge)

169. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1715, subsection (a), (b), and/or (d). On or about January 28, 2014, Rockforth Pharmacy did not have a timely Self-Assessment of Pharmacist-in-Charge available for review. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Rockforth Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

SIXTY-THIRD CAUSE FOR DISCIPLINE

(False or Misleading Label on a Prescription)

170. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Code sections 4076, subsection (a), 4077, subsection (a), and/or 4078, subsection (a)(1). Prescription No. 501986, dated January 27, 2014, stated the manufacturer was Accord when in fact the manufacturer was Qualitest. Prescription No. 500194, dated January 17, 2014, stated the manufacturer was Roxanne when in fact the manufacturer was MGP. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Rockforth Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

SIXTY-FOURTH CAUSE FOR DISCIPLINE

(Patient Profiles)

171. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations, title 16, section 1707. l (a) in that Rockforth Pharmacy did not maintain complete patient profiles that were readily retrievable. Several prescriptions could not be found of Rockforth's patient profiles. The circumstances are further described in paragraph 138, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Rockforth Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

SIXTY-FIFTH FOR DISCIPLINE

(Policies and Procedures)

172. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Code Section 4104 (a) and/or Code of

Regulations, title 16, section 1711(c)(l). Rockforth Pharmacy did not have required policies and procedures in an immediately retrievable form during an inspection on or about January 28, 2014. The circumstances are further described in paragraph 144, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Rockforth Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

CORRESPONDING RESPONSIBILITY/CONTROLLED SUBSTANCES INVESTIGATION OF ROCKFORTH PHARMACY

173. As a result of the above violations, the Board initiated an investigation into Rockforth Pharmacy's handling and dispensing of controlled substances, specifically Hydrocodone/APAP 10/325mg and Promethazine with Codeine.

174. Despite beginning operation in November 2013, Rockforth Pharmacy failed to transmit its dispensing of controlled substance information to CURES until February 3, 2014. Rockforth only began transmission of this data after being told to do so by Board inspectors in late January 2014. Rockforth dispensed numerous controlled substances in this time period. Rockforth Pharmacy subsequently provided the data to CURES.

175. During this investigation, a Board inspector performed an acquisition and disposition audit of Hydrocodone/APAP 10/325mg and Promethazine with Codeine from Rockforth Pharmacy's opening until January 30, 2014. According to Rockforth Pharmacy's records, Rockforth acquired 13,500 tablets of Hydrocodone/APAP 10/325mg yet dispensed 15,078 tablets. There was a discrepancy (overage) of 1,578 Hydrocodone/APAP 10/325mg tablets. According to Rockforth Pharmacy's records, Rockforth acquired 97.5 pints of Promethazine with Codeine yet dispensed 119.6 pints. There was a discrepancy (overage) of 22.4 pints of Promethazine with Codeine.

176. A board inspector reviewed Rockforth's CURES data for controlled substances dispensed between July 30, 2013 and December 1, 2014.

177. The CURES data revealed that Hydrocodone/APAP 10-325mg tablets accounted for over 40% of the total controlled substances dispensed by Rockforth.

178. Dr. Hai Nguyen was the top prescriber at Rockforth Pharmacy with 130 prescriptions (29.35%) before the Board inspection on January 28, 2013, and 308 (20%) after the inspection. Some of Dr. Nguyen's prescriptions were from patients from well outside of Rockforth's normal service area and included patients from Pittsburg, Folsom, Antioch, and Stockton. Over 95% of the prescriptions written by Dr. Nguyen were for Hydrocodone/APAP 10-325mg, a highly abused drug.

179. A Board inspector reviewed Rockforth's dispensing records for controlled substances dispensed between November 16, 2013 (the first day Rockforth dispensed controlled substance) and January 30, 2014.

180. Rockforth's records revealed 249 (34.53%) of the 721 prescriptions filled by Rockforth were for hydrocodone/APAP 10-325mg tablets. It was the most dispensed controlled substance. 242 (33.57%) of the 721 prescriptions filled were for promethazine with codeine syrup. It was the second most dispensed controlled substance. The top two controlled substances, both highly abused, accounted for 491 (68.10%) of the 721 prescriptions dispensed.

181. Rockforth's records revealed 331 (45.90%) of the 721 controlled substances prescriptions were paid in "cash" vs. insurance.

182. Rockforth's records revealed 210 (56.9%) of Dr. Nguyen's 369 prescriptions were processed as "cash." Dr. Nguyen was Rockforth Pharmacy's top prescriber, accounting for 369 (51.1 8%) of the 721 total prescriptions written by 84 different providers.

183. Rockforth's records revealed Dr. Nguyen wrote 193 (52.3%) prescriptions for promethazine with codeine and 169 (45.79%) for hydrocodone/ APAP 10/325mg. Both are highly abused drugs.

184. Although a large number of Dr. Nguyen's prescriptions were for patients within the pharmacy's and prescriber's service area, there were still some prescriptions from well outside of the normal service area with patients from cities like Pittsburg, Folsom, Antioch, and Stockton, Sacramento. Several patients traveled over 100 miles round trip between Dr. Nguyen's office, Rockforth Pharmacy and the patient's home to obtain their prescription.

185. Rockforth Pharmacy was filling prescriptions from Dr. Nguyen without concern for his prescribing pattern which included a prescription for promethazine with codeine syrup always in a quantity of 240 ml and hydrocodone/APAP 10/325 mg tablets in small quantities. It is highly unlikely Dr. Nguyen' s patients were all suffering from the same exact symptoms/diagnosis warranting prescriptions for the same combination of controlled substances.

186. A Board inspector also compared Rockforth Pharmacy's dispensing patterns with those of several nearby pharmacies. The number of prescriptions dispensed by Rockforth Pharmacy for promethazine with codeine syrup was significantly higher than expected for a new pharmacy when compared to an established neighboring pharmacies. A neighboring CVS pharmacy reported to CURES that it dispensed 56 prescriptions for promethazine with codeine syrup between November 16, 2013 and January 30, 2014. Rockforth Pharmacy dispensed 242 prescriptions in the same time period.

187. The number of prescriptions dispensed by Rockforth Pharmacy for hydrocodone/APAP 10/325 mg was significantly higher than expected for a new pharmacy when compared to established neighboring pharmacies. Rockforth Pharmacy dispensed more prescriptions of hydrocodone/ APAP 10/325mg per hour than three of the four neighboring pharmacies. Medical Arts Pharmacy had a slightly higher prescription rate, but it was also located right next to a hospital emergency department and inside a medical clinic.

188. Rockforth Pharmacy dispensed a significantly higher percentage of prescriptions paid in cash than its neighboring pharmacies.

189. Rockforth Pharmacy filled 369 prescriptions from Dr. Nguyen. The neighboring pharmacies dispensed zero prescriptions from this provider.

190. The analysis of Rockforth Pharmacy's controlled substances dispensing history clearly demonstrates Rockforth Pharmacy and Respondent Okwuegbe aided in filling medically illegitimate prescriptions. Rockforth Pharmacy and Respondent Okwuegbe also failed to fulfill their corresponding responsibility when they indiscriminately dispensed controlled substance prescriptions received from Dr. Nguyen without verifying if they were written for a legitimate medical purpose. Rockforth Pharmacy and Respondent Okwuegbe ignored "red flags" (described

in paragraphs 113, and 173-189, above) when filling prescriptions and failed to verify whether prescriptions were issued for legitimate medical purposes.

SIXTY-SIXTH CAUSE FOR DISCIPLINE

(Failure to Exercise Corresponding Responsibility)

191. Rockforth Pharmacy's Original Pharmacy Permit is subject to disciplinary action under Code section 4301, subsections (f) and/or (o), in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Health and Safety Code section 11153, subsection (a), and/or California Code of Regulations title 16, section 1761, subsections (a) and (b), by failing to properly exercise corresponding responsibility in dispensing controlled substances, as described in paragraphs 173-190, above. Rockforth Pharmacy dispensed numerous prescriptions for controlled substances without determining whether the prescriptions were written for legitimate medical purposes. The prescriptions filled by Rockforth Pharmacy were not all for legitimate medical purposes.

SIXTY-EIGHTH CAUSE FOR DISCIPLINE

(Inaccurate Records)

192. Rockforth Pharmacy's Original Pharmacy Permit is subject to disciplinary action under section 4301, subsection (o), of the Code in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Code section 4081, subdivision (a), and/or section 4105, subsection (a), by failing to keep records that accurately accounted for the acquisition, disposition, and current inventory of dangerous drugs/controlled substances. Rockforth Pharmacy did not have an accurate and complete record of all acquisition, receipt, shipment, or disposition of dangerous drugs/controlled substances. Rockforth Pharmacy had an overage of 1,578 tablets of hydrocodone/APAP 10/325mg and 22.4 pints of Promethazine with Codeine syrup as, determined by an audit conducted by a Board inspector. The circumstances are further described in paragraph 175, above.

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SIXTY-NINTH CAUSE FOR DISCIPLINE

(CURES Reporting)

193. Rockforth Pharmacy's Original Pharmacy Permit is subject to disciplinary action under section 4301, subsections (f) and/or (o), of the Code in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Health and Safety Code section 11165, subsection (d), in that from about November 16, 2013 until about February 3, 2014, Rockforth Pharmacy failed to report prescription information for controlled substances in Schedules II through IV to the Department of Justice CURES system within 7 days of dispensing those controlled substances. The circumstances are further described in paragraph 174, above.

SEVENTIETH CAUSE FOR DISCIPLINE

(Failure to Exercise Corresponding Responsibility)

194. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under Code section 4301, subsections (f) and/or (o), in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Health and Safety Code section 11153, subsection (a), and/or California Code of Regulations title 16, section 1761, subsections (a) and (b), by failing to properly exercise corresponding responsibility in dispensing controlled substances, as described in paragraphs 173-190, above. Rockforth Pharmacy dispensed numerous prescriptions for controlled substances without determining whether the prescriptions were written for legitimate medical purposes. The prescriptions filled by Rockforth Pharmacy were not all for legitimate medical purposes. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Rockforth Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

SEVENTY-FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct Failure to Exercise Corresponding Responsibility)

195. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under Code section 4301 in conjunction with Code section 4306.5, subsection (b), in that Rockforth Pharmacy directly or indirectly committed unprofessional conduct by failing to properly exercise corresponding responsibility in dispensing controlled substances, as described in paragraphs 173-

190, above. Rockforth Pharmacy dispensed numerous prescriptions for controlled substances without determining whether the prescriptions were written for legitimate medical purposes. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Rockforth Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

SEVENTY-SECOND CAUSE FOR DISCIPLINE

(Inaccurate Records)

196. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsection (o), of the Code in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Code section 4081, subdivision (a), and/or section 4105, subsection (a), by failing to keep records that accurately accounted for the acquisition, disposition, and current inventory of dangerous drugs/controlled substances. Rockforth Pharmacy did not have an accurate and complete record of all acquisition, receipt, shipment, or disposition of dangerous drugs/controlled substances. Rockforth Pharmacy had an overage of 1,578 tablets of hydrocodone/APAP 10/325mg and 22.4 pints of Promethazine with Codeine syrup as, determined by an audit conducted by a Board inspector. The circumstances are further described in paragraph 175, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Rockforth Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

SEVENTY-THIRD CAUSE FOR DISCIPLINE

(CURES Reporting)

197. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301, subsections (f) and/or (o), of the Code in that Rockforth Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Health and Safety Code section 11165, subsection (d), in that from about November 16, 2013 until about February 3, 2014, Rockforth Pharmacy failed to report prescription information for controlled substances in Schedules II through IV to the Department of Justice CURES system within 7 days of dispensing those controlled substances. The circumstances are further described in paragraph 174, above.

Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Rockforth Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

SEVENTY-FOURTH CAUSE FOR DISCIPLINE

(Misuse of Education)

198. Respondent Okwuegbe's pharmacist license is subject to disciplinary action under section 4301 of the Code in conjunction with section 4306.5, subsection (a), of the Code in that Respondent Okwuegbe was involved in acts or omissions that involved, in whole or in part, the inappropriate exercise of his education, training, or experience as a pharmacist. The circumstances are described in paragraphs 173-190, above.

JULY 25, 2017 INSPECTION

199. As the result of a consumer complaint, a Board inspector conducted an inspection of Drate Pharmacy located at 3219 Adeline Street in Berkeley, CA, on or about July 25, 2017.

200. The inspector found approximately 50 expired medications. Some of the medications expired in 2015.

201. The inspector opened a refrigerator and found the temperature to be out of the appropriate range at 48°F. The inspector could not find a temperature log for the refrigerator. The inspector was informed by Drate Pharmacy staff that Drate Pharmacy did not keep a log.

202. The inspector found totes full of prescriptions for delivery. The inspector looked for but could not find any notices to give to patients upon delivery stating the patient had the right to a consultation by a pharmacist. The inspector was informed by Drate Pharmacy staff that the delivery driver told the patients they could call the pharmacy if they had questions.

203. The inspector requested and received Drate pharmacy's policies and procedures. There was a policy and procedure for prescription delivery that stated, "some pt. 's might have questions." There was no indication a notice of the right to a consultation was provided to patients upon delivery.

204. The policy for impairment of a pharmacy employee indicated the pharmacy must notify the Board within 30 days of an incident.

205. The inspector conducted an audit of hydrocodone/acetaminophen 10-325mg tablets and oxycodone 30mg tablets and found the number of tablets in stock did not match the perpetual inventory logs.

SEVENTY-FIFTH CAUSE FOR DISCIPLINE

(Operational Standards)

206. Drate Pharmacy's Original Pharmacy Permit is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations 1714, subsection (b), by failing to maintain its facilities, space, fixtures, and equipment so that drugs are safely and properly prepared, maintained, secured and distributed. The refrigerator was found to be warm at 48°F and there were no temperature logs indicating staff checked the temperature daily. The circumstances are further described in paragraph 201, above.

SEVENTY-SIXTH CAUSE FOR DISCIPLINE

(Staff Impairment Policies)

207. Drate Pharmacy's Original Pharmacy Permit is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of code section 4101, subsection (a) and/or (c), by maintaining an illegal policy for notifying the Board regarding impaired employees. Drate Pharmacy had a policy and procedure in place for notifying the Board of staff impairment. That policy and procedure stated that Drate Pharmacy and its staff would notify the Board of an incident (of staff impairment) within 30 days rather than 14 days as required.

SEVENTY-SEVENTH CAUSE FOR DISCIPLINE

(Expired Medication)

208. Drate Pharmacy's Original Pharmacy Permit is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of code section 4342, subsection (a), Health and Safety Code section 111295 and/or Health and Safety Code section 111285 by having approximately 50

expired medications in its active inventory. The circumstances are further described in paragraph 200, above.

SEVENTY-EIGHTH CAUSE FOR DISCIPLINE

(Consultation)

209. Drate Pharmacy's Original Pharmacy Permit is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations 1707.2, subsections (a) and/or (b)(2) by not providing a written notice for delivered prescriptions informing patients they had the right to a consultation by a pharmacist. The circumstances are further described in paragraphs 202-203, above.

SEVENTY-NINTH CAUSE FOR DISCIPLINE

(Inaccurate Records)

210. Drate Pharmacy's Original Pharmacy Permits are subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Code section 4081, subdivision (a), and/or section 4105, subsection (a), by failing to keep records that accurately accounted for the of acquisition, disposition, and current inventory of dangerous drugs. Drate Pharmacy did not have an accurate and complete record of all acquisition, receipt, shipment, or disposition of dangerous drugs. An audit of hydrocodone/acetaminophen 10-325mg tablets and oxycodone 30mg tablets from April 28, 2015 to June 24, 2017 and from June 24, 2017 to July 24, 2017 revealed a shortage of ten tablets of hydrocodone/acetaminophen between June 24, 2017 and July 24, 2017 and 99 tablets between April 28, 2015 to June 24, 2017. The audit also revealed a surplus of 140 tablets of oxycodone 30mg tablets between April 28, 2015 and June 24, 2017.

EIGHTIETH CAUSE FOR DISCIPLINE

(Operational Standards)

211. Respondent Okwegbe's Pharmacist License is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations 1714, subsection (b), by

failing to maintain its facilities, space, fixtures, and equipment so that drugs are safely and properly prepared, maintained, secured and distributed. The refrigerator was found to be warm at 48°F and there were no temperature logs indicating staff checked the temperature daily. The circumstances are further described in paragraph 201, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

EIGHTY-FIRST CAUSE FOR DISCIPLINE

(Staff Impairment Policies)

212. Respondent Okwegbe's Pharmacist License is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of code section 4101, subsection (a) and/or (c), by maintaining an illegal policy for notifying the Board regarding impaired employees. Drate Pharmacy had a policy and procedure in place for notifying the Board of staff impairment. That policy and procedure stated that Drate Pharmacy and its staff would notify the Board of an incident (of staff impairment) within 30 days rather than 14 days as required. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

EIGHTY-SECOND CAUSE FOR DISCIPLINE

(Expired Medication)

213. Respondent Okwegbe's Pharmacist License is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of code section 4342, subsection (a), Health and Safety Code section 111295 and/or Health and Safety Code section 111285 by having approximately 50 expired medications in its active inventory. The circumstances are further described in paragraph 200, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as

an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

EIGHT-THIRD CAUSE FOR DISCIPLINE

(Consultation)

214. Respondent Okwegbe's Pharmacist License is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of California Code of Regulations 1707.2, subsections (a) and/or (b)(2) by not providing a written notice for delivered prescriptions informing patients they had the right to a consultation by a pharmacist. The circumstances are further described in paragraph 202-203, above. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

EIGHT-FOURTH CAUSE FOR DISCIPLINE

(Inaccurate Records)

215. Respondent Okwegbe's Pharmacist License is subject to disciplinary action under section 4301, subsection (o), of the Code in that Drate Pharmacy directly or indirectly violated, or assisted in or abetted a violation of Code section 4081, subdivision (a), and/or section 4105, subsection (a), by failing to keep records that accurately accounted for the of acquisition, disposition, and current inventory of dangerous drugs. Drate Pharmacy did not have an accurate and complete record of all acquisition, receipt, shipment, or disposition of dangerous drugs. An audit of hydrocodone/acetaminophen 10-325mg tablets and oxycodone 30mg tablets from April 28, 2015 to June 24, 2017 and from June 24, 2017 to July 24, 2017 revealed a shortage of ten tablets of hydrocodone/acetaminophen between June 24, 2017 and July 24, 2017 and 99 tablets between April 28, 2015 to June 24, 2017. The audit also revealed a surplus of 140 tablets of oxycodone 30mg tablets between April 28, 2015 and June 24, 2017. Respondent Okwuegbe, either through his own conduct or inaction, or derivatively as an owner of Drate Pharmacy, or as the Pharmacist-in-Charge under Code section 4113(c) and/or 4036.5, is responsible for the violations in this paragraph.

OTHER MATTERS

216. Pursuant to Code section 4307, if discipline is imposed on Original Pharmacist License No. RPH 59510 issued to Kenneth Etumudon Okwuegbe, Kenneth Etumudon Okwuegbe shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Original Pharmacist License No. RPH 59510 is placed on probation, or until Original Pharmacist License No. RPH 59510 is reinstated if it is revoked.

217. Pursuant to Code section 4307, if discipline is imposed on Pharmacy License No. PHY 50789 issued to Drate Pharmacy, and Kenneth Etumudon Okwuegbe had knowledge of or knowingly participated in any of the conduct for which Pharmacy License No. PHY 50789 is disciplined, Kenneth Etumudon Okwuegbe shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy License No. PHY 50789 is placed on probation, or until Pharmacy License No. PHY 50789 is reinstated if it is revoked.

218. Pursuant to Code section 4307, if discipline is imposed on Pharmacy License No. PHY 53329 issued to Drate Pharmacy, and Kenneth Etumudon Okwuegbe had knowledge of or knowingly participated in any of the conduct for which Pharmacy License No. PHY 53329 is disciplined, Kenneth Etumudon Okwuegbe shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy License No. PHY 53329 is placed on probation, or until Pharmacy License No. PHY 53329 is reinstated if it is revoked.

219. Pursuant to Code section 4307, if discipline is imposed on Pharmacy License No. PHY 51512 issued to Rockforth Pharmacy, and Kenneth Etumudon Okwuegbe had knowledge of or knowingly participated in any of the conduct for which Pharmacy License No. PHY 51512 is disciplined, Kenneth Etumudon Okwuegbe shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy License No. PHY 51512 is placed on probation, or until Pharmacy License No. PHY 51512 is reinstated if it is revoked.

PRAYER

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

1. Revoking or suspending Pharmacist License Number RPH 59510, issued to Kenneth Etumudon Okwuegbe;

2. Revoking or suspending Original Permit Number PHY 53329, issued to Drate Pharmacy, Kenneth Etumudon Okwuegbe, Sole owner;

3. Revoking or suspending Original Permit Number PHY 50789, issued to Drate Pharmacy, Kenneth Etumudon Okwuegbe, Sole owner;

4. Revoking or suspending Original Permit Number PHY 51512, issued to Rockforth Pharmacy, Kenneth Etumudon Okwuegbe, Sole owner;

5. Prohibiting Kenneth Etumudon Okwuegbe from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Original Pharmacist License No. RPH 59510 is placed on probation, or until Original Pharmacist License No. RPH 59510 is reinstated if it is revoked;

6. Prohibiting Kenneth Etumudon Okwuegbe from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy License No. PHY 53329 is placed on probation, or until Pharmacy License No. PHY 53329 is reinstated if it is revoked;

7. Prohibiting Kenneth Etumudon Okwuegbe from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy License No. PHY 50789 is placed on probation, or until Pharmacy License No. PHY 50789 is reinstated if it is revoked;

8. Prohibiting Kenneth Etumudon Okwuegbe from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy License No. PHY 51512 is placed on probation, or until Pharmacy License No. PHY 51512 is reinstated if it is revoked;

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

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

DATED: 9/8/18

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