

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

In the Matter of the Accusation Against:

**WEST COAST PHARMACY, INC.,
dba WEST COAST PHARMACY
LOAN MONG LE, PRES./SECY.
KIM NGUYEN
aka KIM KHANH NGUYEN, PIC
5731 Watt Avenue
North Highlands, CA 95660
Pharmacy Permit No. PHY 50531**

**KIM KHANH NGUYEN
9642 McKenna Drive
Elk grove, CA 95757
Pharmacist License No. RPH 54305**

and

**LOAN MONG LE
3760 Monteverde Drive
Lincoln, CA 95648
Pharmacist License No. RPH 50209**

Respondents.

Case No. 5610

OAH No. 2016051143

**STIPULATED SURRENDER OF
LICENSE AND ORDER AS TO
RESPONDENT WEST COAST
PHARMACY, INC., dba WEST COAST
PHARMACY ONLY**

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 January 11, 2017.

It is so ORDERED on December 12, 2016.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA



By

Amy Gutierrez, Pharm.D.
Board President

1 KAMALA D. HARRIS
Attorney General of California
2 JANICE K. LACHMAN
Supervising Deputy Attorney General
3 MALISSA N. SIEMANTEL
Deputy Attorney General
4 State Bar No. 240157
1300 I Street, Suite 125
5 P.O. Box 944255
Sacramento, CA 94244-2550
6 Telephone: (916) 327-7855
Facsimile: (916) 324-5567
7 *Attorneys for Complainant*

8 **BEFORE THE**
BOARD OF PHARMACY
9 **DEPARTMENT OF CONSUMER AFFAIRS**
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

12 **WEST COAST PHARMACY, INC.,**
13 **dba WEST COAST PHARMACY**
LOAN MONG LE, PRES./SECY.
14 **KIM NGUYEN,**
aka KIM KHANH NGUYEN, PIC
15 **5731 Watt Avenue**
North Highlands, CA 95660

16 **Pharmacy Permit No. PHY 50531,**

17 **KIM KHANH NGUYEN**
18 **9642 McKenna Drive**
Elk Grove, CA 95757

19 **Pharmacist License No. RPH 54305,**

20 **and**

21 **LOAN MONG LE**
22 **3760 Monteverde Drive**
Lincoln, CA 95648

23 **Pharmacist License No. RPH 50209**

24 Respondents.

Case No. 5610 .

OAH No. 2016051143

STIPULATED SURRENDER OF
LICENSE AND ORDER AS TO
RESPONDENT WEST COAST
PHARMACY, INC., dba WEST COAST
PHARMACY ONLY

26 ///
27 ///
28 ///

1 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
2 entitled proceedings, as specified below, that the following matters are true:

3 PARTIES

4 1. Virginia Herold ("Complainant") is the Executive Officer of the Board of Pharmacy
5 ("Board"). She brought this action solely in her official capacity and is represented in this matter
6 by Kamala D. Harris, Attorney General of the State of California, by Malissa N. Siemantel,
7 Deputy Attorney General.

8 2. Respondent West Coast Pharmacy, Inc., doing business as West Coast Pharmacy
9 ("Respondent West Coast Pharmacy") is represented in this proceeding by attorney Paul Chan,
10 whose address is: 2311 Capitol Avenue, Sacramento, CA 95816.

11 3. On or about January 19, 2011, the Board issued Pharmacy Permit No. PHY 50531 to
12 Respondent West Coast Pharmacy with Loan Mong Le ("Respondent Le") as president and
13 secretary. On or about July 7, 2014, Kim Nguyen, also known as Kim Khanh Nguyen
14 ("Respondent Nguyen"), became the pharmacist-in-charge. Respondent West Coast Pharmacy
15 filed a discontinuance of business that became effective on November 16, 2015. The pharmacy
16 permit was cancelled on December 16, 2015. The pharmacy permit was in full force and effect at
17 all times relevant to the charges brought herein.

18 JURISDICTION

19 4. Accusation No. 5610 was filed before the Board, and is currently pending against
20 Respondents. The Accusation and all other statutorily required documents were properly served
21 on Respondent on February 19, 2016. Respondents timely filed their Notice of Defense
22 contesting the Accusation. A copy of Accusation No. 5610 is attached as exhibit A and
23 incorporated by reference.

24 ADVISEMENT AND WAIVERS

25 5. Respondent West Coast Pharmacy has carefully read, fully discussed with counsel,
26 and understands the charges and allegations in Accusation No. 5610. Respondent West Coast
27 Pharmacy also has carefully read, fully discussed with counsel, and understands the effects of this
28 Stipulated Surrender of License and Order.

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

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

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

12 **ORDER**

13 IT IS HEREBY ORDERED that Pharmacy Permit No. PHY 50531, issued to Respondent
14 West Coast Pharmacy, Inc., doing business as West Coast Pharmacy, is surrendered and accepted
15 by the Board of Pharmacy.

16 1. The surrender of Respondent West Coast Pharmacy's Pharmacy Permit and the
17 acceptance of the surrendered license by the Board shall constitute the imposition of discipline
18 against Respondent West Coast Pharmacy. This stipulation constitutes a record of the discipline
19 and shall become a part of Respondent West Coast Pharmacy's license history with the Board of
20 Pharmacy.

21 2. Respondent West Coast Pharmacy shall lose all rights and privileges as a pharmacy in
22 California as of the effective date of the Board's Decision and Order.

23 3. Respondent West Coast Pharmacy shall cause to be delivered to the Board its pocket
24 license and, if one was issued, its wall certificate on or before the effective date of the Decision
25 and Order.

26 4. Prior to the issuance of a new or reinstated license to Respondent West Coast
27 Pharmacy, Respondent West Coast Pharmacy shall pay to the Board costs of investigation and

28 ///

1 enforcement in the amount of \$9,000.00. Respondent West Coast shall be jointly and severally
2 liable with Respondent Le for payment of those costs.

3 5. If Respondent West Coast Pharmacy ever applies for licensure or petitions for
4 reinstatement in the State of California, the Board shall treat it as a new application for licensure.
5 Respondent West Coast Pharmacy must comply with all the laws, regulations and procedures for
6 licensure in effect at the time the application or petition is filed, and all of the charges and
7 allegations contained in Accusation No. 5610 shall be deemed to be true, correct and admitted by
8 Respondent West Coast Pharmacy when the Board determines whether to grant or deny the
9 application or petition.

10 6. If Respondent West Coast Pharmacy should ever apply or reapply for a new license
11 or certification, or petition for reinstatement of a license, by any other health care licensing
12 agency in the State of California, all of the charges and allegations contained in Accusation, No.
13 5610 shall be deemed to be true, correct, and admitted by Respondent West Coast Pharmacy for
14 the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict
15 licensure.

16 7. Respondent West Coast Pharmacy shall not apply for licensure or petition for
17 reinstatement for three (3) years from the effective date of the Decision and Order.

18 ACCEPTANCE

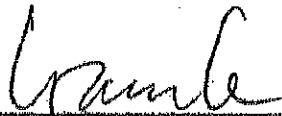
19 I, Loan Mong Le, as president and secretary of West Coast Pharmacy, doing business as
20 West Coast Pharmacy, have carefully read the above Stipulated Surrender of License and Order
21 and have fully discussed it with my attorney, Paul Chan. I, on behalf of West Coast Pharmacy,
22 doing business as West Coast Pharmacy, understand the stipulation and the effect it will have on
23 the Pharmacy Permit. I am authorized to enter into this Stipulated Surrender of License and
24 Order on behalf of West Coast Pharmacy, doing business as West Coast Pharmacy. West Coast
25 Pharmacy, doing business as West Coast Pharmacy enters into this Stipulated Surrender of
26 License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the

27 ///

28 ///

1 Decision and Order of the Board of Pharmacy.

2 DATED: 10/30/16



3 WEST COAST PHARMACY, INC., DBA WEST
4 COAST PHARMACY,
5 LOAN MONG LE, PRES./SECY.
6 Respondent

7 I have read and fully discussed with Loan Mong Le as an authorized representative of West
8 Coast Pharmacy, Inc., doing business as West Coast Pharmacy the terms and conditions and other
9 matters contained in this Stipulated Surrender of License and Order. I approve its form and
10 content.

11 DATED: 10/30/16



12 PAUL CHAN
13 Attorney for Respondent West Coast Pharmacy,
14 Inc., dba West Coast Pharmacy

15 ENDORSEMENT

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

18 Dated:

19 Respectfully submitted,

20 KAMALA D. HARRIS
21 Attorney General of California
22 JANICE K. LACHMAN
23 Supervising Deputy Attorney General

24 MALISSA N. SIEMANTEL
25 Deputy Attorney General
26 Attorneys for Complainant

27 SA2015104991
28 12482454.doc

1 Decision and Order of the Board of Pharmacy.

2 DATED: _____

WEST COAST PHARMACY, INC., DBA WEST
COAST PHARMACY,
LOAN MONG LE, PRES./SECY.
Respondent

3
4
5 I have read and fully discussed with Loan Mong Le as an authorized representative of West
6 Coast Pharmacy, Inc., doing business as West Coast Pharmacy the terms and conditions and other
7 matters contained in this Stipulated Surrender of License and Order. I approve its form and
8 content.

9
10 DATED: _____

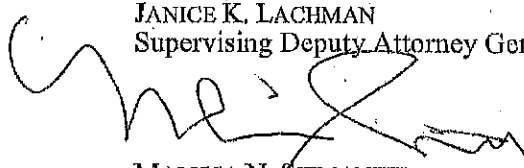
PAUL CHAN
*Attorney for Respondent West Coast Pharmacy,
Inc., dba West Coast Pharmacy*

11
12
13 ENDORSEMENT

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

16
17 Dated: 10/31/10

Respectfully submitted,
KAMALA D. HARRIS
Attorney General of California
JANICE K. LACHMAN
Supervising Deputy Attorney General



MALISSA N. SIBMANTEL
Deputy Attorney General
Attorneys for Complainant

18
19
20
21
22
23
24
25 SA2015104991
12482454.doc

Exhibit A

Accusation No. 5610

1 KAMALA D. HARRIS
Attorney General of California
2 JANICE K. LACHMAN
Supervising Deputy Attorney General
3 MALISSA N. SIEMANTEL
Deputy Attorney General
4 State Bar No. 240157
1300 I Street, Suite 125
5 P.O. Box 944255
Sacramento, CA 94244-2550
6 Telephone: (916) 327-7855
Facsimile: (916) 324-5567
7 *Attorneys for Complainant*

8 **BEFORE THE**
BOARD OF PHARMACY
9 **DEPARTMENT OF CONSUMER AFFAIRS**
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. 5610

12 **WEST COAST PHARMACY, INC.,**
dba **WEST COAST PHARMACY**
13 **LOAN MONG LE, PRES./SECY.**
KIM NGUYEN,
14 **aka KIM KHANH NGUYEN, PIC**
5731 Watt Avenue
15 North Highlands, CA 95660

ACCUSATION

16 Pharmacy Permit No. PHY 50531,

17 **KIM KHANH NGUYEN**
9642 McKenna Drive
18 Elk Grove, CA 95757

19 Pharmacist License No. RPH 54305,

20 and

21 **LOAN MONG LE**
3760 Monteverde Drive
22 Lincoln, CA 95648

23 Pharmacist License No. RPH 50209

24 Respondents.

25
26 ///

27 ///

28 ///

1 Complainant alleges:

2 PARTIES

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

5 2. On or about January 19, 2011, the Board issued Pharmacy Permit Number PHY
6 50531 to West Coast Pharmacy, Inc., doing business as West Coast Pharmacy ("Respondent West
7 Coast Pharmacy"), with Loan Mong Le ("Respondent Le") as president and secretary. On or
8 about July 7, 2014, Kim Nguyen, also known as Kim Khanh Nguyen ("Respondent Nguyen"),
9 became the pharmacist-in-charge. Respondent West Coast Pharmacy filed a discontinuance of
10 business that became effective on November 16, 2015. The pharmacy permit was cancelled on
11 December 16, 2015. The pharmacy permit was in full force and effect at all times relevant to the
12 charges brought herein.

13 3. On or about April 15, 2003, the Board issued Pharmacist License Number RPH
14 54305 to Respondent Nguyen. The pharmacist license was in full force and effect at all times
15 relevant to the charges brought herein and will expire on January 31, 2017, unless renewed.

16 4. On or about August 18, 1998, the Board issued Pharmacist License Number RPH
17 50209 to Respondent Le. The pharmacist license was in full force and effect at all times relevant
18 to the charges brought herein and will expire on January 31, 2018, unless renewed.

19 JURISDICTION

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

22 6. Section 4300 states, in pertinent part:

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

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

26 (1) Suspending judgment.

27 (2) Placing him or her upon probation.

28 ///

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

2 (4) Revoking his or her license.

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

5 7. Section 4300.1 states:

6 The expiration, cancellation, forfeiture, or suspension of a board-issued
7 license by operation of law or by order or decision of the board or a court of law, the
8 placement of a license on a retired status, or the voluntary surrender of a license by a
9 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.

10 STATUTORY AND REGULATORY PROVISIONS

11 8. Section 4301 states, in pertinent part:

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

15
16 (b) Incompetence.

17 (c) Gross negligence.
18

19 (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.
20

21 (o) Violating or attempting to violate, directly or indirectly, or assisting in
22 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
23 pharmacy, including regulations established by the board or by any other state or
federal regulatory agency

24 9. Section 4081 states, in pertinent part:

25 (a) All records of manufacture and of sale, acquisition, or disposition of
26 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
27 three years from the date of making. A current inventory shall be kept by every
28 manufacturer, wholesaler, pharmacy, veterinary food-animal drug retailer, physician,
dentist, podiatrist, veterinarian, laboratory, clinic, hospital, institution, or
establishment holding a currently valid and unrevoked certificate, license, permit,

1 registration, or exemption under Division 2 (commencing with Section 1200) of the
2 Health and Safety Code or under Part 4 (commencing with Section 16000) of
3 Division 9 of the Welfare and Institutions Code who maintains a stock of dangerous
4 drugs or dangerous devices.

5 (b) The owner, officer, and partner of any pharmacy, wholesaler, or
6 veterinary food-animal drug retailer shall be jointly responsible, with the
7 pharmacist-in-charge or representative-in-charge, for maintaining the records and
8 inventory described in this section . . .

9 10. Section 4105, subdivision (a), states:

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

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

17 12. Section 4115 states, in pertinent part:

18 (a) A pharmacy technician may perform packaging, manipulative,
19 repetitive, or other nondiscretionary tasks, only while assisting, and while under the
20 direct supervision and control of a pharmacist. The pharmacist shall be responsible
21 for the duties performed under his or her supervision by a technician.

22
23 (d) The board shall adopt regulations to specify tasks pursuant to
24 subdivision (a) that a pharmacy technician may perform under the supervision of a
25 pharmacist. Any pharmacy that employs a pharmacy technician shall do so in
26 conformity with the regulations adopted by the board.

27
28 (f)(1) A pharmacy with only one pharmacist shall have no more than one
pharmacy technician performing the tasks specified in subdivision (a). The ratio of
pharmacy technicians performing the tasks specified in subdivision (a) to any
additional pharmacist shall not exceed 2:1, except that this ratio shall not apply to
personnel performing clerical functions pursuant to Section 4116 or 4117. This ratio
is applicable to all practice settings, except for an inpatient of a licensed health
facility, a patient of a licensed home health agency, as specified in paragraph (2), an
inmate of a correctional facility of the Department of Corrections and Rehabilitation,
and for a person receiving treatment in a facility operated by the State Department of
State Hospitals, the State Department of Developmental Services, or the Department
of Veterans Affairs.

(2) The board may adopt regulations establishing the ratio of pharmacy
technicians performing the tasks specified in subdivision (a) to pharmacists applicable
to the filling of prescriptions of an inpatient of a licensed health facility and for a
patient of a licensed home health agency. Any ratio established by the board pursuant
to this subdivision shall allow, at a minimum, at least one pharmacy technician for a

1 single pharmacist in a pharmacy and two pharmacy technicians for each additional
2 pharmacist, except that this ratio shall not apply to personnel performing clerical
3 functions pursuant to Section 4116 or 4117 . . .

4 13. Section 4156 states:

5 A pharmacy corporation shall not do, or fail to do, any act where doing
6 or failing to do the act would constitute unprofessional conduct under any statute or
7 regulation. In the conduct of its practice, a pharmacy corporation shall observe and
8 be bound by the laws and regulations that apply to a person licensed under this
9 chapter

10 14. Section 4306.5 states, in pertinent part:

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

13

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

18 15. Section 4342, subdivision (a), states:

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

26 16. Health and Safety Code section 11153, subdivision (a), states:

27 A prescription for a controlled substance shall only be issued for a
28 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.

17. Health and Safety Code section 111295 states that "[i]t is unlawful for any person to
manufacture, sell, deliver, hold, or offer for sale any drug or device that is adulterated."

///

1 18. Title 21, Code of Federal Regulations ("CFR"), section 1301.75, subdivision (b),
2 states that "[c]ontrolled substances listed in Schedules II, III, IV, and V shall be stored in a
3 securely locked, substantially constructed cabinet. However, pharmacies and institutional
4 practitioners may disperse such substances throughout the stock of noncontrolled substances in
5 such a manner as to obstruct the theft or diversion of the controlled substances."

6 19. Title 16, California Code of Regulations ("CCR"), section 1707.2 states, in pertinent
7 part:

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

10 (1) upon request; or

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

12 (b)(1) In addition to the obligation to consult set forth in subsection (a), a
13 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:

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

16 (B) whenever a prescription drug not previously dispensed to a patient in
17 the same dosage form, strength or with the same written directions, is dispensed by
the pharmacy . . .

18 20. Title 16, CCR, section 1711 states, in pertinent part:

19 (a) Each pharmacy shall establish or participate in an established quality
20 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
21 pharmacy service and prevent errors.

22 (b) For purposes of this section, "medication error" means any variation
23 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
24 variation that is corrected prior to furnishing the drug to the patient or patient's agent
or any variation allowed by law.

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

27 (2) When a pharmacist determines that a medication error has occurred, a
28 pharmacist shall as soon as possible:

///

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

(A) Communicate to the patient or the patient's agent the fact that a medication error has occurred and the steps required to avoid injury or mitigate the error.

(B) Communicate to the prescriber the fact that a medication error has occurred.

....

(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.

(f) The record of the quality assurance review, as provided in subdivision (e) shall be immediately retrievable in the pharmacy for at least one year from the date the record was created . . .

21: Title 16, CCR, 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.

....

1 (d) Each pharmacist while on duty shall be responsible for the security of
2 the prescription department, including provisions for effective control against theft or
3 diversion of dangerous drugs and devices, and records for such drugs and devices . . .

4 22. Title 16, CCR, section 1715.6 states that "[t]he owner shall report to the Board within
5 thirty (30) days of discovery of any loss of the controlled substances, including their amounts and
6 strengths."

7 23. Title 16, CCR, section 1735.2 states, in pertinent part:

8 (g) All chemicals, bulk drug substances, drug products, and other
9 components used for drug compounding shall be stored and used according to
10 compendial and other applicable requirements to maintain their integrity, potency,
11 quality, and labeled strength.

12 (h) Every compounded drug product shall be given an expiration date
13 representing the date beyond which, in the professional judgment of the pharmacist
14 performing or supervising the compounding, it should not be used. This "beyond use
15 date" of the compounded drug product shall not exceed 180 days from preparation or
16 the shortest expiration date of any component in the compounded drug product,
17 unless a longer date is supported by stability studies of finished drugs or compounded
18 drug products using the same components and packaging. Shorter dating than set
19 forth in this subsection may be used if it is deemed appropriate in the professional
20 judgment of the responsible pharmacist.

21 (j) Prior to allowing any drug product to be compounded in a pharmacy,
22 the pharmacist-in-charge shall complete a self-assessment for compounding
23 pharmacies developed by the board. (Incorporated by reference is "Community
24 Pharmacy & Hospital Outpatient Pharmacy Compounding Self-Assessment" Form
25 17M-39 Rev. 02/12.) That form contains a first section applicable to all
26 compounding, and a second section applicable to sterile injectable compounding. The
27 first section must be completed by the pharmacist-in-charge before any compounding
28 is performed in the pharmacy. The second section must be completed by the
pharmacist-in-charge before any sterile injectable compounding is performed in the
pharmacy. The applicable sections of the self-assessment shall subsequently be
completed before July 1 of each odd-numbered year, within 30 days of the start of a
new pharmacist-in-charge, and within 30 days of the issuance of a new pharmacy
license. The primary purpose of the self-assessment is to promote compliance through
self-examination and education.

24 24. Title 16, CCR, section 1761 states:

25 (a) No pharmacist shall compound or dispense any prescription which
26 contains any significant error, omission, irregularity, uncertainty, ambiguity or
27 alteration. Upon receipt of any such prescription, the pharmacist shall contact the
28 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

1 knows or has objective reason to know that said prescription was not issued for a
2 legitimate medical purpose.

3 25. Title 16, CCR, section 1793.2 states, in pertinent part:

4 "Nondiscretionary tasks" as used in Business and Professions Code
5 section 4115, include:

6 (a) removing the drug or drugs from stock . . .

7 COST RECOVERY

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

12 DRUG CLASSIFICATIONS

13 27. "Guaifenesin with codeine syrup" is a Schedule V controlled substance as designated
14 by Health and Safety Code section 11058, subdivision (c)(1), and is used to treat cough.

15 28. "Percolone/Roxicodone" are brand names for oxycodone. Oxycodone is a Schedule
16 II controlled substance as designated by Health and Safety Code section 11055, subdivision
17 (b)(1)(M). Oxycodone is used to treat pain.

18 29. "Phenergan" is a brand name for promethazine. Promethazine with codeine syrup is a
19 Schedule V controlled substance as designated by Health and Safety Code section 11058,
20 subdivision (c)(1), and is used to treat cough.

21 30. "Norco" is a brand name for hydrocodone bitartrate and acetaminophen and is used to
22 treat pain. Norco is a Schedule II controlled substance pursuant to Title 21, CFR, section
23 1308.12.

24 31. "Xanax," a brand name for alprazolam, is a Schedule IV controlled substance as
25 designated by Health and Safety Code section 11057, subdivision (d)(1). Xanax is used to treat
26 anxiety.

27 32. "Dolophine", a brand name for methadone, is a Schedule II controlled substance as
28 designated by Health and Safety Code section 11055, subdivision (c)(14). Dolophine is used to
treat pain.

1 33. "Soma", a brand name for carisoprodol, is a Schedule IV Controlled Substance as
2 designated by Title 21, CFR, section 1308.14, subdivision (c)(6), and is used to treat muscle
3 spasms.

4 34. All of the above controlled substances are dangerous drugs pursuant to section 4022.

5 **STATEMENT OF FACTS**

6 35. On or about June 2, 2015, a Board inspector went to West Coast Pharmacy to conduct
7 an inspection. There were several employees working in the pharmacy at that time, including
8 pharmacy technicians, TCH K., TCH O.G., TCH S., and TCH J.G. Respondent Nguyen was the
9 only pharmacist on duty.

10 36. The inspector observed two large safes located near the south side counter. The left
11 safe contained Schedule III to V controlled substances and certain expensive non-controlled
12 medications; the right safe contained Schedule II controlled substances. The doors to both safes
13 were unlocked during the entire inspection. The inspector observed TCH K. remove controlled
14 substances from the safes, take them to the front filling counter, and replace drugs in the safes
15 throughout the inspection. The safes were not visible from the front filling counter where
16 Respondent Nguyen was working. Respondent Nguyen admitted that the safes were unlocked
17 while she was in the pharmacy and that the technicians had access to them. On two occasions,
18 the inspector observed delivery drivers enter the pharmacy (the drivers collected prescriptions for
19 delivery) and visit with pharmacy employees. One of the drivers walked past the drug safes and
20 entered the bathroom.

21 37. The inspector asked Respondent Nguyen if there were ever any prescription errors
22 made in the pharmacy. Respondent Nguyen admitted that some prescription errors had occurred
23 within the last year, that the most recent error had occurred within the last month, and that she did
24 not document the error.

25 38. TCH S. was working next to the cash register and handled almost all of the
26 transactions. The inspector observed TCH S. repeatedly ask patients who were picking up
27 medications whether they had any questions for the pharmacist. TCH S. told the inspector later
28 that she was trained to ask the question on new prescriptions, which had an "N" on the receipt.

1 After each transaction, TCH S. put a portion of the receipt in the trash. The inspector retrieved 15
2 receipts, 14 of which were marked with an "N", indicating that they were new prescriptions. The
3 inspector did not see Respondent Nguyen consult any patients during the entire inspection.

4 39. TCH K. was working at the front counter, filling prescriptions and placing the baskets
5 to her left or on the floor for Respondent Nguyen to verify. On multiple occasions, the inspector
6 observed TCH O.G. pull drugs from the drug shelves or the drug order delivery totes and place
7 them in prescription baskets. TCH O.G. would then take the baskets to the front filling counter
8 and place them on the counter or on the floor between Respondent Nguyen and TCH K.

9 40. The inspector reviewed various prescription documents on file at the pharmacy,
10 including prescription number 228880, dated May 26, 2015, which had been written for 100
11 tablets of oxycodone 30 mg. Respondent Nguyen told the inspector that she filled the
12 prescription and that it was dispensed to the patient. Respondent Nguyen stated that she did not
13 fill all controlled substance prescriptions. Respondent Nguyen retrieved a copy of a prescription
14 dated May 7, 2015, that she refused to fill after calling the prescriber and determining that it had
15 been forged. The forged prescription matched prescription number 228880 in several respects.
16 Respondent Nguyen admitted that she should have verified the prescription.

17 41. The inspector examined the compounding area and found that there was no
18 compounding self assessment in the pharmacy. There were also expired drugs and drug products
19 above and below the compounding counter, which the inspector later determined had been used in
20 the preparation of certain compounded prescriptions and dispensed to patients. Several expired
21 drugs were labeled with a retest date.¹ The inspector asked Respondent Nguyen if any of the
22 drugs which were past their retest date had been tested. Respondent Nguyen admitted that they
23 had not been tested.

24 42. When the pharmacy was closed, the inspector had Respondent Nguyen complete a
25 count of the stock on hand of four drugs, methadone 10 mg, hydrocodone/APAP 10/325 mg,
26 oxycodone 30 mg and alprazolam 2 mg. Respondent Nguyen counted the pharmacy's inventory

27 ¹ Drugs which are labeled with a retest date must be tested for stability before the retest
28 date is reached. Without a stability test, the drugs are not assured to be of suitable integrity.

1 of the drugs and noted them on a form provided by the inspector. Respondent Nguyen gave the
2 inspector a controlled substance inventory dated May 29, 2014. The inspector requested the
3 pharmacy's disposition records for the period from May 29, 2014 to June 2, 2015.

4 43. On or about June 3, 2015, the inspector called Respondent Nguyen and requested
5 copies of two completed Report of Theft or Loss of Controlled Substances (DEA 106) forms
6 which he found during the inspection. Respondent Nguyen faxed the inspector copies of both
7 forms, one dated September 4, 2014, and the other dated October 9, 2014. The forms indicated
8 that the pharmacy had been broken into at night and that certain controlled substances,
9 guaifenesin/codeine syrup, promethazine/codeine syrup, carisoprodol 350 mg, and alprazolam (in
10 various doses), had been stolen. Respondent Nguyen told the inspector she completed the DEA
11 forms and estimated the total loss on each form. Respondent Nguyen admitted that she did not
12 conduct a subsequent inventory to determine the exact amount of the losses or report the thefts to
13 the Board. That same day, Respondent Nguyen provided the inspector with the pharmacy's
14 disposition records, an invoice for controlled substances received on June 3, 2015, a drug
15 inventory conducted by Respondent Nguyen on June 3, 2015, and a dispensing record for June 3,
16 2015. Respondent Nguyen admitted the thefts were not reported to the Board.

17 44. In or about June 2015, the inspector requested and obtained sales and credit
18 information from three of the pharmacy's wholesalers.

19 45. On or about July 27, 2015, the inspector received an email from Respondent Nguyen,
20 admitting that minor errors had occurred in the pharmacy, such as miscounts, "wrong NDC's" or
21 wrong sizes, and that she had not completed incident reports of the errors.

22 46. The inspector determined based on the dispensing records, the records provided by
23 the wholesalers, the drug inventories, the DEA 106 forms, and the June 3, 2015 invoice that the
24 pharmacy had significant shortages of 5 of 12 controlled substances and notable overages of 5 of
25 the 12 drugs for the audit period from May 29, 2014 to June 3, 2015, as set forth below in
26 paragraph 49, subparagraph (b).

27 ///

28 ///

1 FIRST CAUSE FOR DISCIPLINE

2 (Failure to Maintain Pharmacy, Fixtures, and Equipment
3 so that Drugs Were Safely and Properly Secured)

4 47. Respondents West Coast Pharmacy, Nguyen and Le are subject to disciplinary action
5 pursuant to section 4301, subdivisions (o) and (j), for unprofessional conduct, in that Respondents
6 failed to maintain the pharmacy and its facilities, space, fixtures and/or equipment so that drugs
7 were safely and properly secured, in violation of Title 16, CCR, section 1714, subdivision (b),
8 and failed to store Schedule II, III, IV, and V Controlled Substances in securely locked,
9 substantially constructed cabinets, in violation of Title 21, CFR, section 1301.75, subdivision (b),
10 as follows:

11 a. On or about September 4, 2014, Respondent Nguyen completed a DEA 106 form,
12 indicating that the pharmacy had been broken into at night and that 2,365 milliliters (ml) of
13 guaifenesin/codeine syrup and 6,622 ml of promethazine/codeine syrup had been taken. Further,
14 Respondents failed to safely and properly secure the pharmacy to prevent additional thefts of
15 controlled substances, as follows: On or about October 9, 2014, Respondent Nguyen completed a
16 DEA 106 form, indicating that the pharmacy had once again been broken into at night and that
17 500 tablets of alprazolam 0.25 mg, 500 tablets of alprazolam 0.5 mg, 2,000 tablets of alprazolam
18 1 mg, 500 tablets of alprazolam 2 mg, 1,000 tablets of carisoprodol 350 mg, and 1,892 ml of
19 guaifenesin/codeine syrup had been taken.

20 b. Respondents stored their complete inventory of controlled substances in two safes
21 which were unlocked, as set forth in paragraph 35 above, and placed the safes in a location or
22 position, enabling pharmacy technicians to access the controlled substances without being
23 observed and supervised by a pharmacist. Further, on two occasions during the inspection of
24 June 2, 2015, delivery drivers entered the pharmacy and had access to the drug stock area and
25 safes without supervision by the pharmacist.

26 c. On and between May 29, 2014 and June 3, 2015, Respondents failed to maintain their
27 premises so that drugs were secured from theft or other types of losses, resulting in significant
28 shortages of the following controlled substances:

Drug	Units	Shortage
alprazolam 0.25 mg	Tablets	-258
alprazolam 0.5 mg	Tablets	-1,537
alprazolam 2 mg	Tablets	-855
oxycodone 30 mg	Tablets	-30
	Total	- 2,680
promethazine/codeine liquid	ml	-10,381
	Total	-10,381

SECOND CAUSE FOR DISCIPLINE

(Failure to Report Loss of Controlled Substances)

48. Respondents West Coast Pharmacy, Nguyen and Le are subject to disciplinary action pursuant to section 4301, subdivision (o), for unprofessional conduct, in that Respondents violated Title 16, CCR, section 1715.6 by failing to report to the Board the thefts or losses of the controlled substances guaifenesin/codeine syrup, promethazine/codeine syrup, carisoprodol 350 mg, and alprazolam (various doses), as documented on the DEA 106 forms, within thirty (30) days of discovery of the losses.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain a Current Inventory of All Dangerous Drugs)

49. Respondents West Coast Pharmacy, Nguyen and Le are subject to disciplinary action pursuant to section 4301, subdivision (o), for unprofessional conduct, in that Respondents violated sections 4081, subdivision (a), and 4105, subdivision (o), by failing to maintain an accurate or current inventory of all dangerous drugs in the pharmacy, as follows:

a. Respondents failed to conduct an inventory of their drug stock following the thefts of the controlled substances documented on the DEA 106 forms, as set forth in paragraph 43 above.

b. On and between May 29, 2014 and June 3, 2015, Respondents failed to maintain an accurate or current inventory of all dangerous drugs in the pharmacy, resulting in significant shortages and overages of the following controlled substances:

///

///

///

///

Drug	Shortage or Overage
alprazolam 0.25 mg	-258 tablets
alprazolam 0.5 mg	-1,537 tablets
alprazolam 1 mg	261 tablets
alprazolam 2 mg	-855 tablets
guaifenesin/codeine liquid	2,636 ml
hydrocodone/APAP 10/325 mg	441 tablets
hydrocodone/APAP 5/325 mg	755 tablets
methadone 10 mg	120 tablets
oxycodone 30 mg	-30 tablets
promethazine/codeine liquid	-10,381 ml

FOURTH CAUSE FOR DISCIPLINE

(Failure to Provide Oral Consultation to Patients)

50. Respondents West Coast Pharmacy, Nguyen and Le are subject to disciplinary action pursuant to section 4301, subdivision (o), for unprofessional conduct, in that Respondents violated Title 16, CCR, section 1707.2, subdivisions (a)(1) and (2) and (b)(1)(A) and (B), as follows: On or about June 2, 2015, during the inspection of West Coast Pharmacy, Respondent Nguyen failed to provide any oral consultations to patients despite the fact that at least 14 patients had picked up prescriptions which had been marked as new, as set forth in paragraph 38 above. Further, TCH S. was observed screening patients with new prescriptions by asking if they had any questions for the pharmacist.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Comply with Quality Assurance Program)

51. Respondents West Coast Pharmacy, Nguyen and Le are subject to disciplinary action pursuant to section 4301, subdivision (o), for unprofessional conduct, in that Respondents violated Title 16, CCR, section 1711, as follows: Respondents failed to complete or have available at the pharmacy any records pertaining to medication errors, quality assurance reports or quality assurance reviews despite the fact that prescription errors had occurred in the pharmacy during the year prior to June 2, 2015, including miscounts, "wrong NDC's" or wrong sizes.

///

///

///

1 SIXTH CAUSE FOR DISCIPLINE

2 (Violation of the Pharmacy Law/Pharmacy Technician to Pharmacist Ratio)

3 52. Respondents West Coast Pharmacy, Nguyen and Le are subject to disciplinary action
4 pursuant to section 4301, subdivision (o), for unprofessional conduct, in that Respondents
5 violated section 4115, subdivisions (d) and (f)(1), as follows: On or about June 2, 2015, during
6 the inspection of West Coast Pharmacy, Respondents authorized or allowed TCH K. and TCH
7 O.G. to perform pharmacy technician duties at the same time (TCH K. was observed filling
8 prescriptions while TCH O.G. was removing dangerous drugs from the drug stock to be used for
9 filling prescriptions) when, in fact, Respondent Nguyen was the only pharmacist on duty.

10 SEVENTH CAUSE FOR DISCIPLINE

11 (Failure to Exercise Corresponding Responsibility with Regard to
12 the Dispensing or Furnishing of Controlled Substances)

13 53. Respondents West Coast Pharmacy, Nguyen and Le are subject to disciplinary action
14 pursuant to sections 4301 and 4306.5 for unprofessional conduct in that Respondents failed to
15 exercise or implement their best professional judgment or corresponding responsibility with
16 regard to the dispensing or furnishing of controlled substances and dangerous drugs, as follows:
17 On or about May 26, 2015, Respondents dispensed prescription number 228880 for 100 tablets of
18 oxycodone for a patient without verifying the legitimacy of the prescription or ensuring that it
19 was issued for a legitimate medical purpose despite irregularities in the prescription, including the
20 distance from the prescriber and the patient to the pharmacy and the similarity between the
21 prescription and the forged prescription dated May 7, 2015, identified in paragraph 40 above.
22 The two prescriptions had the same pre-printed prescriber information, general format,
23 prescription pad identifying number, drug, quantity, strength, and general directions. Further, the
24 handwriting and signatures appeared the same.

25 EIGHTH CAUSE FOR DISCIPLINE

26 (Dispensing a Prescription Containing Significant Error, Omission, Irregularity, etc.)

27 54. Respondents West Coast Pharmacy, Nguyen and Le are subject to disciplinary action
28 pursuant to section 4301, subdivision (o), for unprofessional conduct, in that Respondents

1 violated Title 16, CCR, section 1761, subdivision (a), as follows: Respondents dispensed a
2 prescription containing significant irregularities without contacting the prescriber to obtain the
3 information needed to validate the prescription, as set forth in paragraph 53 above.

4 **NINTH CAUSE FOR DISCIPLINE**

5 **(Failure to Complete Compounding Self-Assessment)**

6 55. Respondents West Coast Pharmacy, Nguyen and Le are subject to disciplinary action
7 pursuant to section 4301, subdivision (o), for unprofessional conduct, in that Respondents
8 violated Title 16, CCR, section 1735.2, subdivision (j), as follows: Respondents failed to
9 complete or have available at the pharmacy a compounding self assessment, as set forth in
10 paragraph 41 above.

11 **TENTH CAUSE FOR DISCIPLINE**

12 **(Compounding Prescription Drug Preparations Using Expired Drugs)**

13 56. Respondents West Coast Pharmacy, Nguyen and Le are subject to disciplinary action
14 pursuant to section 4301, subdivision (o), for unprofessional conduct, in that Respondents
15 violated Health and Safety Code section 111295 and Title 16, CCR, section 1735.2, subdivision
16 (h), as follows:

17 a. Respondents and/or their pharmacy technicians compounded the following
18 prescription drug preparations using drugs that were beyond their expiration date. Consequently,
19 the drugs were adulterated and unsafe for patient use. Further, Respondents failed to test the
20 expired drugs for stability, dispensed the prescriptions to patients, and gave the drugs a longer
21 beyond use date than the expired components used in the drug preparations.

22

Date	Ingredient	Lot No.	Documented expiration date	Beyond use date given for prescription
03/27/2015	estriol powder	11151225	11/23/2014	09/27/2015
03/27/2015	testosterone powder	1302190904	06/08/2014	09/27/2015
04/23/2015	testosterone cypionate powder	1210010079	06/19/2014	None documented
05/08/2015	testosterone powder	1302190904	06/08/2014	11/08/2015
05/15/2015	estriol powder	11151225	11/23/2014	10/2015
05/15/2015	testosterone powder	1302190904	06/08/2014	10/2015
05/18/2015	testosterone cypionate powder	1210010079	06/19/2014	10/2015

23
24
25
26
27
28

1 b. Respondents and/or their pharmacy technicians prepared 13 compounded prescription
2 preparations and stored them for future use in jars that were labeled for individual patients, some
3 of which were dated as far back as June 22, 2011 (the beyond use dates on the prescription labels
4 were handwritten). Further, some of these labeled compounded prescriptions had the date
5 changed several times with progressively longer dates, and five of the products were expired past
6 the last handwritten date. In addition, Respondents failed to conduct any stability studies to
7 extend the beyond use dates of these compounded drug products.

8 **ELEVENTH CAUSE FOR DISCIPLINE**

9 **(Failure to Store Drugs/Components Used in Compounding in a Manner**
10 **to Maintain their Integrity, Potency, Quality, and Labeled Strength)**

11 57. Respondents West Coast Pharmacy, Nguyen and Le are subject to disciplinary action
12 pursuant to section 4301, subdivision (o), for unprofessional conduct, in that Respondents
13 violated section 4342, subdivision (a), Health and Safety Code section 111295, and Title 16,
14 CCR, section 1735.2, subdivision (g), as follows:

15 a. Respondents stored the following expired drugs, commonly used in compounding
16 prescription preparations, on the drug stock shelves intermingled with non-expired drugs.
17 Further, Respondents failed to test any drugs for stability in order to extend the manufacturer's
18 labeled expiration dates.

19

Drug	Package Size	Expiration or retest date
cyclobenzaprine HCL	25 grams	Exp. 08/2014
testosterone cypionate	25 grams	Retest 06/19/2014
testosterone micronized	100 grams	Retest 06/08/2014
7-keto DHEA micronized	25 grams	Retest 06/05/2014
lidocaine HCL	100 grams	Retest 12/27/2014
liothyronine sodium	250 milligrams	Retest 05/31/2014
nifedipine	5 grams	Retest 03/30/2014
methyltestosterone	5 grams	Exp. 12/2014
amitriptyline HCL	25 grams	Retest 03/2015

20
21
22
23
24
25

26 b. Respondents and/or their employees prepared 13 compounded prescription
27 preparations and stored them for future use in jars that were labeled for individual patients, some
28 of which were dated as far back as June 22, 2011. Further, five of the products were expired past

1 the last handwritten date on the prescription label.

2 c. Respondents stored a 30 gram size jar in the compounding area that was labeled
3 "Biest" without any indication on the label as to the active ingredients, manufacturer, lot number
4 or expiration date of the prescription drugs it contained. Further, on or about May 18, 2015,
5 Respondents' employee, TCH J.G., used the "Biest" to compound a prescription preparation.

6 **TWELFTH CAUSE FOR DISCIPLINE**

7 **(Incompetence)**

8 58. Respondents West Coast Pharmacy, Nguyen and Le are subject to disciplinary action
9 pursuant to section 4301, subdivision (b), for unprofessional conduct, in that Respondents
10 committed acts or omissions constituting incompetence, as set forth in paragraphs 47 to 57 above.

11 **THIRTEENTH CAUSE FOR DISCIPLINE**

12 **(Gross Negligence)**

13 59. Respondents West Coast Pharmacy, Nguyen and Le are subject to disciplinary action
14 pursuant to section 4301, subdivision (c), for unprofessional conduct, in that Respondents
15 committed acts or omissions constituting gross negligence, as set forth in paragraphs 47 to 57
16 above.

17 **PRAYER**

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

20 1. Revoking or suspending Pharmacy Permit Number PHY 50531, issued to West Coast
21 Pharmacy, Inc., doing business as West Coast Pharmacy;

22 2. Revoking or suspending Pharmacist License Number RPH 54305, issued to Kim
23 Nguyen, also known as Kim Khanh Nguyen;

24 3. Revoking or suspending Pharmacist License Number RPH 50209, issued to Loan
25 Mong Le;

26 4. Ordering West Coast Pharmacy, Inc., doing business as West Coast Pharmacy, Kim
27 Nguyen, also known as Kim Khanh Nguyen, and Loan Mong Le to pay the Board of Pharmacy

28 ///

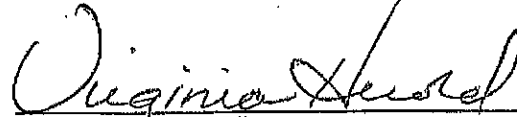
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

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

DATED:

2/5/16



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

SA2015104991
12100681.doc