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

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| In the Matter of the Accusation Against:<br><br>FERRY'S PHARMACY INC., dba FERRY'S PHARMACY, DANIEL OWEN FERRY AND DOROTHY ANN FERRY, OWNERS<br><br>Pharmacy Permit No. PHY 19913<br><br>and<br><br>DANIEL OWEN FERRY<br><br>Pharmacist License No. RPH 24741<br><br>Respondents. | Case No. 5964<br><br>OAH No. 2017120416 |

**DECISION AND ORDER**

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Pharmacy, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective at 5:00 p.m. on May 15, 2019.

It is so ORDERED on April 15, 2019.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By

Victor Law, R.Ph.
Board President

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**PROPOSED DECISION**

Heather M. Rowan, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on June 13, October 18 and 19, 2018, and January 29 and 30, 2019, in Sacramento, California.

Jeffrey Phillips, Deputy Attorney General, represented Virginia Herold (complainant), Executive Officer, Board of Pharmacy (Board), Department of Consumer Affairs, State of California.

Gregory Matzen, Attorney at Law, represented Ferry's Pharmacy, Inc. and Daniel Owen Ferry (respondent Ferry). Respondent Ferry was present throughout the hearing. At hearing, the parties stipulated that Dorothy Ann Ferry is no longer an owner of Ferry's Pharmacy. She was not present.

Evidence was received on June 13, October 18 and 19, 2018, and January 29 and 30, 2019; the record was closed and the matter was submitted for decision on January 30, 2019.

## FACTUAL FINDINGS

1. On, August 12, 1966, the Board issued Pharmacist License Number RPH 24741 (license) to respondent Ferry. The license was in full force and effect at all times relevant to the Accusation. Said license expired on September 30, 2018. No evidence of renewal was presented at hearing. On January 17, 1978, the Board issued Original Permit Number PHY 19913 (permit) to Ferry's Pharmacy, Incorporated, to do business as Ferry's Pharmacy (Pharmacy) in Anderson, California. Respondent Ferry has been the pharmacist-in-charge (PIC) since January 17, 1978. The permit was in full force and effect at all times relevant to the Accusation. The permit expired on November 1, 2018, with no evidence of license renewal.[1] Respondents have no other history of discipline.

2. Complainant, acting solely in her official capacity, signed the Accusation on September 16, 2017. The Accusation seeks to discipline respondent Ferry's license and the Pharmacy's permit based on numerous violations of federal and state laws and regulations governing pharmacy. Respondents timely filed a Notice of Defense. The matter was set for an evidentiary hearing before an Administrative Law Judge of the Office of Administrative Hearings, an independent adjudicative agency of the State of California, pursuant to Government Code section 11500, et seq.

*The Board's Investigation*

3. Patricia Peterson has been an inspector with the Board since October 2012. She graduated from St. Louis College of Pharmacy in 1981, and began working as a pharmacist in California in 1984. She was a PIC for approximately 20 years in various retail pharmacies. She explained that the duties of a PIC include ensuring pharmacy staff comply with federal and state laws and regulations, supervise pharmacists and other staff, set procedures and policies, and maintain oversight of the pharmacy.

4. Inspector Peterson was assigned to investigate the Pharmacy following a complaint by a former employee alleging that respondent Ferry was selling cannabis from the Pharmacy's parking lot, pills in prescription bottles did not match what was on the labels, respondent Ferry dispensed the wrong medication to a patient, expiration dates on prescription bottles were incorrect, and controlled substance drawers were left unlocked during business hours. Inspector Peterson visited the Pharmacy on September 8, 2014. She spoke with respondent Ferry and pharmacist James Visco, as well as other staff, and requested to view certain documents. She also surveyed the prescriptions in "will call," observed the pharmacy's workings, and investigated the Pharmacy's automatic pill-dispensing machine, made by a company called Parata.[2] Inspector Peterson submitted a written report following investigation, dated June 9, 2016, and testified at hearing.

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[1] The License History Certifications the Board provided for both the license and permit were dated June 11, 2018.

[2] This automated machine is referred to simply as Parata herein.

5. Steven Kyle has been an inspector with the Board for approximately five years. He received his Doctorate of Pharmacy (PharmD.) in 1996 and is a licensed pharmacist in California. He worked as a pharmacist for 18 years for numerous pharmacies, and as a PIC for 10 years. Inspector Kyle has inspected more than 100 pharmacies. He is assigned to the prescription drug abuse team and his duties include investigating and inspecting pharmacies and licensees regarding their compliance with pharmacy laws and regulations.

6. Inspector Kyle was assigned to investigate the Pharmacy regarding a discrepancy in ordered and sold controlled substances. The Pharmacy also reported a drug loss. He visited the Pharmacy on March 23, 2016. Inspector Kyle's primary purpose was to investigate the Pharmacy's selling and reporting controlled substances. He was also aware of the prior investigation and violations, and intended to determine whether the prior violations had been corrected. Inspector Kyle submitted his written report following investigation, dated August 1, 2016, and testified at hearing.

7. Inspector Peterson was unable to substantiate all of the complaint's contentions, including the allegation regarding illegal cannabis sales, but through her investigation, she substantiated some of the complaint's allegations as well as other violations of the Pharmacy Law. Inspector Kyle's investigation also resulted in several confirmed violations.

INVALID EXPIRATION DATES

8. Inspector Peterson determined that the Pharmacy had misbranded drugs because an invalid expiration date was listed on the prescription bottles. The Pharmacy uses a Parata to dispense its high-use prescription drugs. The Parata automatically counts tablets and prints a label, depending on the information pharmacy employees input into the machine. The Pharmacy purchased the Parata about a year and a half prior to Inspector Peterson's inspection. Two or three months before the inspection, a pharmacy technician who was knowledgeable in operating the Parata and had worked at the Pharmacy for 20 years quit her job, but did not provide Parata training to the remaining staff before she left. Consequently, the established settings in the machine remained unchanged after she left.

9. Inspector Peterson discovered that every prescription label printed on a certain day had an expiration date one year from the date it was printed. This was true whether the actual expiration date on the "stock bottle" from where the pills came was, for example, six months or 18 months from the print-date. In many cases, the expiration date may not have been incorrect. A pharmacy can print an expiration date on a label that is one year from the print-date, but only if the actually expiration date from the stock bottle was longer than one year from that date. Best practice is to print the actual expiration date from the stock bottle on the label.

10. Inspector Kyle also reviewed the prescription bottles the Parata dispensed. He compared the labels that had an expiration date of one year from the dispensed date with the

stock bottles. He found that in several cases, the one-year expiration date printed on the prescription bottles postdated the manufacturer's expiration on the stock bottles. He explained that expired drugs can be dangerous to patients because they can lose potency, experience bacteria growth and a change in chemical composition, or become more concentrated.

MISBRANDED DRUGS: DRUG MANUFACTURER AND DESCRIPTION

11. Inspector Peterson identified prescription bottles that had either the wrong manufacturer or no manufacturer name listed on the label. She also found many labels that had no description, or had a description of a pill on the label that did not match the actual pill inside the bottle. Inspector Peterson explained that if a pill description differs from the actual pill, a patient might think she received the wrong pill and not take the prescription as directed by her doctor. There is also the possibility that bottle contains the wrong drug.

12. Inspector Peterson pulled several bottles at random from the Pharmacy's "will call" area, and inspected the markings on the pills contained in each bottle to determine that the pills were indeed the prescribed drugs. Inspector Peterson learned that the Parata was not updated if a drug manufacturer changed, which meant that labels were printed for one manufacturer's pill, while the actual pill was from another manufacturer. This caused disparities, as each manufacturers' pills look different and have a different National Drug Code (NDC). Inspector Peterson also opened prescription bottles that contained one medication, but the pills came from two different manufacturers and looked different from one another.

13. The Pharmacy apparently attempted to identify misbranded bottles by having an employee place green stickers on each of the bottles that were misbranded because the pill description was wrong. Inspector Peterson was informed that the green sticker indicated a change in the pill, and that the pharmacist would need to consult with the patient, or be informed of the change.

FAILURE TO SECURE CONTROLLED SUBSTANCES

14. Controlled substances must be in a secured cabinet during business hours. Alternately, a pharmacy may disperse the controlled substances throughout its stock of non-controlled substances. Locking controlled substances helps prevent theft and confusion. Inspector Peterson watched the employees at the Pharmacy for some time during her inspection. For the entire time she was observing, she saw a lock on the top of a drawer. She learned that this drawer contained controlled substances. Respondent Ferry informed her that the PIC unlocked the drawer in the morning and re-locked it at closing. He asserted that the PIC is generally standing beside the cabinet, and it is protected in this way.

15. Inspector Kyle testified that by the time of his visit in March 2016, the Pharmacy had dispersed its controlled substances throughout the inventory. In June 2015, the Pharmacy reported that over 3,000 pills of oxycodone were missing due to employee

theft. In addition, 1,629 pills of other controlled substances were unaccounted for. Inspector Kyle opined that the drugs should have been in a locked cabinet, and that the large amount of missing pills suggests the Pharmacy was not monitoring its stock.

LAPSE IN CURES REPORTING

16. Inspector Kyle investigated a lapse in the Pharmacy's Controlled Substance Utilization Review and Evaluation System (CURES) reporting. He explained that the CURES report shows all Schedule II, III, and IV controlled substance prescriptions a pharmacy dispenses for a given time period. The reports must be made within seven days of dispensing. In 2013, the reports showed a 113-day gap in reporting, as well as several shorter non-reporting periods, and several non-reporting periods in 2014. Inspector Kyle inferred from this lapse that the Pharmacy was not consistently reporting its controlled substance dispensing as required.

17. Inspector Kyle spoke with the staff who were present as well as respondent Ferry. He inquired as to whether the Pharmacy was dispensing controlled substances during the gaps in reporting, and was told that it was. Respondent Ferry explained that the Pharmacy had software issues that caused the lapse in reporting. The Pharmacy submitted the reports, but due to an error between the format the Pharmacy used and the format Atlantic Associates[3] could read, the reports were not accepted. Inspector Kyle explained that a PIC must correct any rejected reports, and there was no evidence available at the time of the inspection that all of the rejected reports had been corrected.

PARTIALLY-FILLED PRESCRIPTIONS

18. Inspector Peterson explained that a pharmacy is permitted to partially fill a prescription if a drug is not fully stocked, by giving the patient a lesser amount of pills than prescribed, but the remaining pills must be filled within 72 hours. If this is not possible, the pharmacist must contact the doctor for a new prescription. If the pharmacy partially fills a prescription, the pharmacist must write the date the prescription was partially filled and the date it was completed on the front of the prescription.

19. Inspector Peterson reviewed the Pharmacy's partial-fill log. Initially, she observed that the notes regarding when the prescriptions were filled were written on the back of the prescriptions instead of the front. She also identified prescriptions with inconsistent hand-written notes; for example, one prescription that the doctor dated June 11, 2014, had a corresponding hand-written note stating it was written on July 25, 2014, and was linked to incorrect prescription numbers in the log book. Inspector Peterson reviewed a sample of the log for partially-filled prescriptions, and identified several prescriptions that were completed anywhere from four to 15 days after the partial fill. She also encountered gaps in the logs, incorrect invoices, and partial fills that were not properly completed. Respondent Ferry

[3] Atlantic Associates is a service that facilitates CURES reporting.

informed her that he orders the drugs when they run out, and stated he cannot control how long it takes for the newly-ordered drugs to arrive.

20. Inspector Peterson was told that the Pharmacy filled an average of 350 prescriptions per day. She was not clear about how many prescriptions she reviewed, but stated that from her random selection of prescriptions, she identified five partial-fills: one in September 2014, and four in July 2014. She opined that the number of partially filled prescriptions was "unusual." She also stated that in her experience as an inspector, it is unusual that a pharmacy would partially fill a prescription for a controlled substance.

CONTROLLED SUBSTANCES INVENTORY

21. State and federal law require pharmacies to perform a biennial inventory of controlled substances in the pharmacy. The report must identify all Schedule II through V drugs and the date the inventory was completed. The report must also indicate whether the inventory was completed before opening or after closing the pharmacy to ensure there were no pending prescription transactions. Finally, inventory reports must be maintained by the pharmacy for at least three years. The inventory must be completed when the pharmacy opens and every two years after. All Schedule II drugs must be accurately counted, and Schedules III and IV must be accurately counted unless the stock contains more than 1,000 pills, in which case the amount can be estimated.

22. During her investigation, Inspector Peterson requested copies of the Pharmacy's controlled substances inventory and was given the inventory from the previous year. The front page of the form was blank, except that "12/28/13" was written at the top of the page. The front page of the form should have stated when the inventory started and ended to show the point in time the inventory was conducted. The inventory contained several dates. Respondent Ferry informed Inspector Peterson that the inventory was started on November 20, 2013, and continued over several days through December 28, 2013, when it was completed. He told her he was not aware it needed to be completed in one day. Additionally, several sections of the inventory report were incomplete.

23. On September 9, 2014, the day after the inspection, respondent Ferry sent Inspector Peterson a completed controlled substances inventory. The inventory was done in one day, outside business hours, and all sections were complete. The inventory complied with Pharmacy Law requirements.

REPORTING LOSS OF CONTROLLED SUBSTANCES

24. On July 13, 2012, the Pharmacy was robbed at gunpoint and controlled substances were stolen. Respondent Ferry did not report the theft, including the type of drug, quantity, and date of loss to the Board. Inspector Peterson recalled that respondent Ferry told her that he called the Board and learned he needed to fill out a Drug Enforcement Administration (DEA) Form 106, which he did, but he forgot to forward the form to the Board.

EXPIRED DRUGS ON SHELF

25. During Inspector Kyle's investigation, he reviewed parts of the Pharmacy's shelved drug stock. In viewing a sample of the stock, he identified 17 stock bottles that contained expired drugs that were intermingled with valid drugs. The expiration dates varied from one month to one year prior to the inspection. A pharmacy is prohibited from holding drugs that are expired or have no expiration date. As explained above, expired drugs can pose a danger to patients.

26. Dr. Visco was present during the inspection, and explained that he did not know if these drugs had recently been dispensed. He also asserted that the Pharmacy had a practice of pulling expired drugs from the shelves and placing them in a box. The drugs were then sent to a "reverse distributor."[4] Inspector Kyle advised Dr. Visco to remove all expired drugs from the shelf and send him a list of the drugs to be returned to the reverse distributor. On April 4, 2016, Inspector Kyle received a list of 102 expired drugs that the Pharmacy pulled from the shelves.

SELF-ASSESSMENT REQUIREMENT

27. Pharmacy Law requires the PIC to conduct a self-assessment of the pharmacy's compliance with federal and state pharmacy law. The self-assessment must be completed by July 1 of every odd year. Inspector Peterson found that respondent Ferry did not complete the self-assessment as required based on his former employee's allegation that she filled out the assessment, and respondent Ferry only signed it. Inspector Peterson's report alleges respondent Ferry told her he only signed the self-assessment, but denied such a statement at hearing.

DISPENSING ERRONEOUS OR UNCERTAIN PRESCRIPTION

28. A pharmacy is permitted to dispense a generic drug to a patient unless a prescriber checks and initials the "do not substitute" box on the face of the prescription. Inspector Peterson explained that the requirement that the prescriber initial the box this way prevents the patient from making changes to the prescription. Inspector Peterson reviewed several bundles of paper prescriptions that the Pharmacy had dispensed. One prescription for Ritalin 20mg was filled out by a doctor, the "do not substitute" box was checked but not initialed, and the doctor wrote "white tab only" on the face of the prescription. Dr. Visco filled the prescription with a generic substitute for Ritalin, which was contrary to the prescriber's intent. Because the box was checked but not initialed, Dr. Visco should have called the prescriber to clarify.

29. When a prescription for controlled substances raises "red flags" regarding its legitimacy, the pharmacist has a corresponding responsibility to verify the prescription was

[4] A reverse distributor collects expired drugs for return to the manufacturer. Pharmacies are sometimes reimbursed for the partial cost of these drugs.

issued for a legitimate medical purpose and was by a physician in the normal course of his or her professional practice. The pharmacist can cross-check the prescription with the patient's CURES report or the CURES records of the prescribing physician to see if the prescription appears legitimate. He may also call the prescribing physician to resolve any irregularities with the prescription. If, after making reasonable attempts to verify its legitimacy, the pharmacist continues to doubt the legitimacy of a prescription, he is obligated to reject the prescription and not fill it.

30. Additionally, California prescriptions require a wet signature and a hand-written date. The limit for refills on controlled substances in California is four. A pharmacy can accept a prescription for a controlled substance via fax, but the pharmacist must confirm the order with the prescriber.

Inspector Kyle also reviewed several prescription bundles at random. He identified at least 10 that were missing a hand-written date by the prescriber, which would require rejecting the prescription or contacting the prescriber. More than one was accepted via fax, with no evidence that the prescriber was consulted. Inspector Kyle reviewed two additional prescriptions, written by out of state prescribers, that were lacking in components the California Pharmacy Law requires. One prescription was from a prescriber in Oregon who prescribed Norco to a patient who lived in Red Bluff, California and the other was from a prescriber in Maryland, also for a Red Bluff patient. Both prescriptions did not comply with California Pharmacy Law, which requires that if a prescriber is out of state, a California pharmacy can fill the prescription for a California patient only after confirming it with the prescriber. The pharmacist on duty should have called the prescribers to verify the prescriptions, but no evidence was presented that any calls were made. Inspector Kyle opined that these prescriptions should have "raised red flags" for the Pharmacy.

FAILURE TO PROVIDE INTERPRETATIVE SERVICES

31. A pharmacy is required to offer interpretive services to any patient who is not proficient in English. Inspector Peterson inquired as to an available interpretive service and was told none was available. Following the inspection, respondent Ferry informed Inspector Peterson that he had engaged a service.

FAILURE TO COMPLY WITH QUALITY ASSURANCE PROGRAM REQUIREMENTS

32. Pharmacy Law requires each pharmacy to establish or participate in a Quality Assurance Program to document medication errors and assess an appropriate response to prevent future errors. The pharmacist must document all prescription errors, determine how they occurred, and assess what course of action is appropriate, including contacting the patient and the prescriber.

33. Inspector Kyle reviewed the Quality Assurance binder that the Pharmacy kept. The error report forms were incomplete. In some cases, there was no evidence that an internal investigation was initiated, a review was performed, or that the PIC identified how

the error would be remedied and prevented. The forms did not indicate whether the pharmacy contacted the patients and prescribers about the errors. Additionally, the forms did not provide adequate detail regarding the identified errors.

*Respondent's Evidence*

DR. JAMES VISCO, PHARMD.

34. Dr. Visco is 75 years old and has been a Doctor of Pharmacy since 1967. He has worked in hospital settings, community pharmacies, and retail pharmacies. He has been a staff pharmacist and PIC and has owned his own pharmacies. He has worked at the Pharmacy since 2000. Since 2012, he has worked part-time, alternating weeks with respondent Ferry.

35. Dr. Visco is also on the Shasta County Osteoporosis Awareness Committee, writes articles for health-related magazines, and participates in a radio show regarding health topics. Through the Pharmacy, Dr. Visco participates in cancer prevention outreach.

36. Dr. Visco was at the Pharmacy the day the prescription for Ritalin 20mg came in. The patient had been ordering prescriptions at the pharmacy for several years. He looked at the prescription, and saw the "do not substitute" box was not initialed, and that the prescriber had written "White tab only" on the face of the prescription. Dr. Visco was aware that the name brand name Ritalin 20mg was a yellow pill, but the generic form was white. He reviewed the record of prescriptions for the patient, and saw that the doctor's habit was not to check the "do not substitute" box. Dr. Visco determined that the generic form was intended, and discussed the matter with the patient when the prescription was picked up. Based on the totality of the circumstances, he did not view the prescription as being unclear or uncertain, which would have prompted a call to the prescriber.

The Pharmacy did not have the 120 pills of Ritalin 20mg, available, as prescribed in generic, so an order was submitted to the distributor. The distributor sent a different manufacturer's generic version of Ritalin, and the pills were yellow, instead of white. The last 15 of the 120 prescribed were yellow, and though he could not remember the exact circumstances, Dr. Visco stated that his practice is to consult with patients whenever such changes are made.

37. Dr. Visco agreed that the Parata machine dated all labels with a default one-year expiration date. He noted that some of the expiration dates were entered into the Parata incorrectly. He reviewed all of the drugs that were listed in the Accusation, and researched their actual expiration dates. He determined that even though the expiration dates were not correct, if the patients took the medication as directed, the drugs would have been consumed before the actual expiration date.

38. Dr. Visco asserted that the Pharmacy filled about 300 to 350 prescriptions per day. The partially filled prescriptions that were fulfilled more than 72 hours later represented

a minute amount of the total. Additionally, the Pharmacy orders stock bottles in certain amounts, and depending on the orders filled, odd numbers of pills may be left. The Pharmacy orders many drugs from the distributor only as needed due to expense.

39. Dr. Visco has been serving the Anderson community for many years, and attempts to do what is best for the patients. In one instance, for example, Dr. Visco recalled a partial fill that he personally filled. The foster mother of a child who had prescriptions filled at the Pharmacy previously, brought in two prescriptions for Focalin, a Schedule II drug that is prescribed to treat attention deficit hyperactivity disorder. One prescription was to be filled on July 26, 2014, and the next on August 26. The child was leaving for Bible camp, and needed more pills than were in the first prescription. Dr. Visco decided that in the best interest of the child he would fill the first prescription on July 26, and on August 20, before the child went to camp, he would borrow seven pills from the second prescription so the child would have the amount of pills required. The rest of the second prescription was filled on August 28. Though this "looked like" a partial fill beyond 72 hours, Dr. Visco did not consider it a partial fill.

40. Another circumstance that Dr. Visco recalled involved a partial fill for morphine for a "very ill woman." The first part was filled on July 25, and the order was fulfilled on July 30. She was a long-time customer and Dr. Visco fulfilled the prescription without consulting the prescriber.

41. Dr. Visco asserted that the will-call shelf consistently holds over 600 medications. Some of the medications had green tags on them, which signifies to the employees that the pills might look different than the customer is used to. In these cases, it is always Dr. Visco's practice to consult with the patient.

DR. OWEN FERRY, PHARMD.

42. Dr. Ferry is 76 years old and has been a licensed pharmacist in California since 1966. He was a pharmacist at "Jolly's Pharmacy" from 1966 to 1975 when he purchased the pharmacy and changed the name to "Ferry's Pharmacy." He has been the PIC at the Pharmacy since 1975.

43. Dr. Ferry has been involved in the Anderson community for many years. He has lived there since 1947 and raised his family there. He taught grade school one day per week in the early 1980's. He also taught a course on retail pharmacy at Enterprise High School. The Pharmacy is involved in "Think Pink" cancer awareness activities through the American Cancer Society. He also ensures that the Pharmacy focuses on health education, including cancer prevention. He hosts an annual fundraiser for veterans, participates in school fundraisers, the local chamber of commerce, and city council committees. Shasta County awarded him the "Health Care Hero" award in 2016.. Respondent Ferry also volunteers at his church.

44. Dr. Ferry stated that after the investigators explained to him the errors in the Pharmacy's procedures, he took many steps to correct them. He acknowledged that he relied too heavily on the pharmacy technician who worked for him for 20 years and then abruptly quit. He also admitted that he could have acted more quickly to ensure her duties were fulfilled following her departure.

45. In 2012, the Pharmacy purchased the Parata to ensure the frequently-filled prescriptions were more efficiently filled. His former technician understood how to use the Parata and handled operating and programming it. He was not informed of all of the Parata's functionalities, including programming specific expiration dates and NDCs, until after the Board's investigations. He acknowledged that the labels might have been incorrect, but he asserted that the drugs he dispensed were not expired.

Following Inspector Kyle's visit, respondent Ferry called the company to request help, and a Parata technician went to the Pharmacy to reprogram the machine on March 25, 2016. The Pharmacy now programs the exact expiration date and NDC from the stock bottle into the Parata.

46. Previously, the Pharmacy staff placed a green sticker on any prescription that contained pills that looked different than the patient's prior prescription, even though the drug was the same. Some of the prescription bottles might have also had two different versions of the same generic drug. The sticker indicated that a consultation with a pharmacist was necessary. The Pharmacy no longer uses the green stickers and no longer has two different pills in one bottle, even if the drug is the same.

47. The Pharmacy fills a large quantity of prescriptions, and the partial fills accounted for one percent of the total. Given the cost of some drugs, the Pharmacy does not keep large amounts of inventory. Respondent Ferry acknowledged that the Pharmacy's partial fill policy did not previously comport with the Board's requirements. He explained that prior to the investigations, he believed that the 72-hour period referred to business hours. If a prescription was filled on a Friday afternoon, for example, respondent Ferry believed that it could be filled on Tuesday and still comply. Since the investigations, respondent Ferry has instructed staff not to fill prescriptions if the entire amount is not in stock, or to confirm with the manufacturer that the drug can be obtained within 72 hours.

48. Respondent Ferry previously misunderstood the controlled substances inventory requirement. He did not understand the import of conducting the inventory outside of business hours and within one day. The day after Inspector Peterson conducted her investigation, respondent Ferry took a controlled substances inventory. He obtained a standard inventory form from the Board's website, and took the inventory at the close of business on September 9, 2014. This inventory was more detailed than the Board requires, but respondent Ferry wanted to ensure he was aware of the complete inventory.

Prior to opening on June 22, 2015, respondent Ferry conducted another controlled substances inventory. He again used the Board's standard form. The Pharmacy conducted

another controlled-substances count on April 25, 2017. The Board's form caused some confusion during the inventory counts due to the reclassification of certain drugs, but the confusion has since resolved. The Pharmacy now conducts controlled substances inventories annually, though they are only required every other year.

49. Respondent Ferry operated the Pharmacy for 37 years before he had a significant loss of controlled substances. On July 13, 2012, he was robbed at gunpoint. A masked man came into the pharmacy, held a gun to respondent Ferry's head, and demanded controlled substances. Respondent Ferry complied. He then called the Board to ask what he was required to do following such an event. The Board employee informed him that he needed to fill out a DEA form 106 and send it to the DEA. The employee did not tell respondent Ferry that he should also send the form to the Board. The Pharmacy reported a loss of 103 tablets of methadone, 270 tablets of oxycodone 20 mg, 90 tablets of oxycodone 40 mg, 199 tablets of oxycodone 60 mg, and 197 tablets of oxycodone 80 mg.

50. Inspector Peterson informed respondent Ferry that all controlled substances must either be kept in a locked, substantially built cabinet, or distributed throughout the stock. His practice had been to station the pharmacist on duty next to the cabinet, and unlock the cabinet when it was first needed in the day. The pharmacist then locked it at closing.[5] Respondent Ferry asserted that he did not understand how dispersing the drugs throughout the rest of the stock would be more safe than his current practice, but he opted to try this method.

51. Respondent Ferry has been conducting random drug-tests of his employees for more than 10 years. On June 10, 2015, respondent Ferry learned that one of his employees was under the influence of a substance. He requested that the employee take a drug test, and the employee refused. Respondent immediately fired the employee and took an inventory. He discovered a loss of 3,279 pills of oxycodone 30 mg, which he reported to the Board on DEA form 106 on June 25, 2015.

52. Respondent Ferry takes several steps in an attempt to prevent drug loss. The Pharmacy has a security system that includes cameras and a hidden alarm button for staff to push should a robbery occur. Respondent Ferry continues to drug test all employees. The controlled substances are dispersed throughout the pharmacy and a perpetual inventory is maintained.

53. After decades of experience in Anderson, respondent Ferry was aware that the primary language spoken other than English was Spanish. He made a point of having a bilingual employee in case any patient required assistance. In his experience, however, most patients brought a relative to the Pharmacy if they required translation. The day following Inspector Peterson's investigation, respondent Ferry engaged Language Scientific, Inc., as

[5] Inspector Peterson testified that locking the cabinet would have prevented the loss of controlled substances due to the robbery. This argument unreasonably implies that a reasonable person would refuse to unlock the cabinet with a gun pointed at his head.

the Pharmacy's telephonic interpreter, and later placed a poster in the Pharmacy that informed all non-English-speaking customers that translation services were available.

54. Respondent Ferry admitted that he had trouble submitting timely CURES reports, especially after his former employee left the Pharmacy. He attempted several times to submit the reports by disc, but Atlantic Associates was unable to read them. Since Inspector Peterson's inspection, respondent Ferry has purchased an entirely new computer system. This system keeps a "perpetual inventory," and submits CURES reports every two days. Very few submissions have been rejected, and respondent Ferry ensures any rejections are corrected.

55. Respondent Ferry was surprised by the number of expired drugs that Inspector Kyle found on the shelves. For many years, respondent Ferry paid a reverse distributor to come to the Pharmacy every six months and remove all expired drugs. Without notifying the Pharmacy, the service stopped coming. It was not until Inspector Kyle pointed out the amount of expired drugs that respondent Ferry realized the reverse distributor had not pulled expired drugs for over one year. Since the inspections, respondent Ferry has instructed a pharmacy technician to check the shelves monthly. He has also engaged Inmar, a reverse distributor, to come every three months to remove expired drugs. Respondent Ferry is confident that no expired drugs were dispensed to patients, because before using a stock bottle, the staff checks the labels.

56. The Pharmacy has a Quality Assurance binder that contains documentation of any pharmacy error and the investigation that followed. Respondent Ferry admitted that the binder was lacking prior to these inspections, but he has since updated his policy. Any time there is an incident at the Pharmacy, the pharmacist who identified the issue prepares a report. Respondent Ferry meets with any employee who was involved and discusses ways to prevent similar errors. The patients are consulted if necessary. The discussions and plan are documented.

57. Respondent Ferry disputed that he instructed his former employee to fill out the required self-assessment and then signed it without reading it. His employee filled out the form at his direction with his input. She was not able to answer many of the questions, and could not have independently completed it. He believes that the self-assessments are completed properly, and are meant to ensure that the Pharmacy has the correct policies and procedures in place, even if he or his staff make mistakes in practice.

58. On April 3, 2017, another Board inspector, Scott Huhn visited the Pharmacy. Inspector Huhn reviewed each of the prior areas that Inspectors Peterson and Kyle identified as being noncompliant. The only comments Inspector Huhn made in his report were that respondent Ferry should submit change of ownership paperwork to the Board, raw chemicals should be secured,[6] and some cleaning was necessary. He approved of all the changes that

[6] Respondent Ferry explained that he had some vintage, decorative bottles sitting atop display cabinets that contained chemicals. The bottles were removed.

respondent Ferry put into place following the previous inspections, and found no repeated violations.

LETTERS OF SUPPORT

59. Respondent Ferry submitted several letters of support:

a. Nirmal S. Mehton, M.D., is a family medicine practitioner in Anderson. He has known respondent Ferry since 1995. He described respondent Ferry as professional and courteous, and is not aware of any unprofessional activities or behavior. Dr. Mehton believes respondent Ferry provides good pharmacy service for the area.

b. Frank P. LiVolsi, M.D., is an obstetrician and gynecologist in Anderson. He described respondent Ferry as being honest, frank, and upright. In his experience, respondent Ferry has served Dr. LiVolsi's patients and family well and with great care.

c. Susan R. Ault, Family Nurse Practitioner, has worked with respondent Ferry as a colleague and as her personal pharmacist. She described him as being "honest, open, above board, moral and ethical" within his practice. She does not believe that respondent Ferry would intentionally violate the law or otherwise sully his "long-established business or his impeccable reputation."

d. Patricia A. Clarke is a retired Shasta County Supervisor. She has lived in Shasta County since 1977, owned a business in Anderson, and was involved in the local Chamber of Commerce. She also served on the city council. She worked closely with respondent Ferry while he was the Chamber of Commerce president. She described him as being "involved with the city, supportive of the community and its activities," a dependable employer, and a respected member of the community.

e. Keith Webster and his family have been customers at the Pharmacy for over 40 years. He is a long-time customer of the Pharmacy. He has seen respondent Ferry's dedication to the community, his generosity, and his reputation as a businessman. He believes respondent Ferry is a good man.

f. Ralph and Theresa Reyes have been customers at the Pharmacy for over 20 years. They trust respondent Ferry and his staff, and believe they are partners in their overall medical care. They asserted that respondent Ferry has an excellent reputation in the community and the Pharmacy is a valued community resource. They hold respondent Ferry in high regard.

g. Kim Chamberlain is a past board member of the Northern California Cemetery Support Board and the Anderson Chamber of Commerce. She owned a beauty salon in Anderson for 33 years. She has known respondent Ferry for many decades as a friend, colleague, and pharmacist.

She described his generosity, commitment to the community, and professionalism.

h. Sandy Brinton is a pharmacy technician and has worked at the Pharmacy since 2013. She was born and raised in Anderson, and has been a customer at the Pharmacy "as long as [she] can remember." She described respondent Ferry's generosity, his commitment to and compassion for his patients and the community, and the community's dependence on and appreciation for the Pharmacy.

i. Ruth McDonald-Boyd has been a customer at the Pharmacy for 25 years. She described the service she receives, the kindness the pharmacists and employees display, and the importance of the local, independent business.

j. Mark Griffith is an insurance broker who has known respondent Ferry through the business community since 1982. He and his wife are also customers at the Pharmacy. He trusts respondent Ferry because he has "knowledge, integrity, and a commitment and dedication to patient privacy." He wrote that the Pharmacy employs over 10 local people and provides personal and dedicated service.

k. Lynn Kenny has been a customer at the Pharmacy for more than eight years. When she moved to Anderson, she chose the Pharmacy because respondent Ferry was professional, local, and employed people who seemed to be happy at their jobs. She described respondent Ferry as "one of the kindest, open-hearted persons" she knows, who is generous, professional, moral, and ethical.

l. Marshall Burbank has been a customer at the Pharmacy for over 20 years. He described respondent Ferry as a caring, honest person who is a pillar in the community. Mr. Burbank asserted that respondent Ferry saved his life on more than one occasion, and has been a great support.

*Discussion*

60. The evidence established respondent Ferry and the Pharmacy violated Pharmacy Law by: (1) dispensing drugs with an invalid expiration date, drugs with the wrong or no manufacturer listed, and invalid physical description of the medication; (2) failing to properly secure Schedule II controlled substances in a securely locked cabinet; (3) improperly completing the required biennial inventory; (4) failing to complete partially filled prescriptions within 72 hours; (5) failing to report loss by theft of controlled substances; (6) failing to provide interpretive services; (7) failing to report prescription information to CURES; (8) failing to promptly document medication errors and to adhere to its Quality Assurance Program policy; (9) failing to maintain a current inventory of dangerous drugs; (10) dispensing medications based on prescriptions that did not comply with California law; and dispensing a prescription that was uncertain or erroneous.

61. The evidence did not establish, however, that respondent Ferry failed to complete a self-assessment as required, or that between September 2014 and March 2016, respondents failed to secure controlled substances to prevent theft.

62. Respondent Ferry admitted that he made mistakes by not fully understanding the Parata, how to report a drug loss, securing controlled substances, and the required reporting and self-assessments. He could have acted more quickly to ensure the Pharmacy was running properly after his long-time employee quit. His arguments that patients were not *actually* harmed by, for example, the wrong expiration dates, the wrong pill description or manufacturing, and mixing different generic versions of a drug in one bottle, were misplaced. It is not actual harm, but the fact that, by his own misunderstanding, he put his patients in harm's way that is most concerning.

63. Respondent Ferry testified that he called the Board following the robbery to ask what steps he was required to take. A Board employee told him to fill out the DEA form 106, which he did. This was respondent Ferry's first experience with a robbery. He took the proactive step of calling the Board for instructions, and filled out the correct form. His testimony that he was given incomplete information was credible. When he next experienced a loss of controlled substances, he learned from his past mistake, and submitted the proper form to the DEA and the Board.

64. The Pharmacy's control over and dispensing of controlled substances also raises concern. The Pharmacy and respondent Ferry owed a corresponding duty to verify that the controlled substance prescriptions presented by patients were written for a legitimate medical purpose and by a physician in the normal course of his or her professional practice. Given the current epidemic of overusing and overdosing on prescription medications, it is incumbent upon PICs to exercise professional judgment in assessing the legitimacy of each prescription presented. By accepting prescriptions that were not signed and dated by the prescriber, or that were from out-of-state and raised red flags as to their validity, the Pharmacy and respondent Ferry not only violated Pharmacy Law, but their duty to the public.

65. Additionally, respondent Ferry's history with his patients and knowledge of their prescriptions should not take the place of the prescriber's judgment. In the face of uncertainty, the prescriber must be consulted.

66. The majority of the errors that led to the Accusation were the result of a lack of attention to detail, a failure by respondent Ferry to understand his own equipment, and a lack of understanding of the Pharmacy Law. Some of respondents' mistakes were simple error and readily corrected. Respondent Ferry has implemented many procedures to ensure compliance with the Pharmacy Law, and even exceeding the requirements. His dedication to his pharmacy and community, as well as his sincere desire to follow the law were apparent. The changes he has made are commendable.

67. Respondent Ferry's evidence of the importance of a local pharmacy in the small town of Anderson was credible, as was the evidence that respondent Ferry is dedicated

to his community and his patients. His decisions in the Pharmacy are patient-centered and are often based on his years of experience with any particular patient, their doctor's prescribing habits, and the patient's medical history. In the 44 years since he purchased the Pharmacy, respondent Ferry has made efforts to evolve as Pharmacy Law did. His efforts were apparent in April 2017 when Inspector Huhn reviewed all of the past violations, and found that the Pharmacy's policies and procedures complied with the law.

68. The Board has adopted disciplinary guidelines (Guidelines) to consider when determining the appropriate discipline to impose for violating the Pharmacy Law. (Cal. Code Regs., tit. 16, § 1760.) The Guidelines categorize different violations into one of four categories, and recommends a range of discipline for each. Each of the violations committed by respondents fall under Category I or II. The recommended discipline for the Category I ranges from revocation stayed, one year's probation, all standard terms and conditions, and all appropriate optional terms and conditions, to outright revocation. The recommended discipline for Category II ranges from revocation stayed, three years' probation, all standard terms and conditions, and all appropriate optional terms and conditions, to outright revocation.

69. The Guidelines also provide criteria for consideration when determining the specific discipline imposed for the particular category violated. Relevant criteria include: (1) actual or potential harm to the public or any consumer; (2) prior disciplinary record or warnings; (3) number or variety of current violations; (4) nature and severity of the acts or crimes under consideration; (5) evidence of aggravation, mitigation, or rehabilitation; (6) time passed since the act or offense; (7) whether the conduct was intentional or negligent, or demonstrated incompetence; and (8) whether respondent financially benefitted from the misconduct. Mitigating evidence, such as recent letters of support, may also be considered.

70. The allegations in the Accusation are many and could have resulted in harm to consumers. Respondent Ferry has been a licensed pharmacist for more than 50 years. Other than minor citations and fines, he has had no other Board discipline. Although he continued to place blame on his former employee for others, respondent Ferry took responsibility for several Pharmacy Law violations. (*Seide v. Committee of Bar Examiners of the State Bar of California* (1989) 49 Cal.3d 933, 940-941 [acknowledging the wrongfulness of one's past conduct is an essential element of rehabilitation].) The violations occurred between three and five years ago, and no evidence was presented that any of the violations were intentional or that respondent Ferry financially benefitted.

71. The purpose of license discipline is not to punish the licensee, but to protect the public. (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 784-786; *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d 1471, 1476.) Respondent Ferry has taken the allegations seriously, and corrected his practices to comply with the Pharmacy Law. For example, he hired an interpreter service and a new reverse distributor, his staff checks the shelves monthly for expired drugs, a Parata technician reprogrammed his machine and instructed staff regarding its proper use, and he replaced his computer system so that inventory is perpetual and CURES reports are submitted every

second day. Additionally, many members of the community, patients, colleagues, and friends submitted letters in support of respondent Ferry's generosity, professionalism, and impact on the community of Anderson.

The Pharmacy is a reliable business on which the community depends. Respondent Ferry's corrections and safeguard demonstrate his commitment to protecting the public. To revoke his license would unduly punish him following five decades as a revered pharmacist.

72. Respondent Ferry's violations of Pharmacy Law primarily relate to running the pharmacist as a business, keeping abreast of changing requirements, and complying with required reporting. For this reason, while it would not be contrary to the public interest to allow respondent Ferry to maintain his pharmacist license on a restricted basis, his ability to own and operate the business has waned. Therefore, the Pharmacy's permit should be revoked.

*Costs*

73. Complainant has requested that respondents be ordered to pay investigation and enforcement costs in the total amount of $40,347.50 pursuant to Business and Professions Code section 125.3. This amount consists of costs incurred directly by the Board ($23,597.50) as well as costs incurred by the Office of the Attorney General and billed to the Board ($16,750). At hearing, complainant introduced a signed Certification of Costs of Investigation by Agency Executive Officer as well as supporting declarations by Inspectors Peterson and Kyle. Complainant also introduced a Certification of Prosecution Costs: Declaration of Jeffrey Phillips. The declaration attached a computer printout of the tasks the Attorney General's office performed, the amount of time spent performing these tasks, and the amounts charged. Respondent did not object to any of complainant's evidence of costs, and did not introduce any evidence of his inability to pay them.

74. Complainant established that the requested costs are reasonable in light of the allegations and issues in this matter. Complainant's request for costs is further addressed in the Legal Conclusions below.

## LEGAL CONCLUSIONS

1. Complainant bears the burden of proving each of the grounds for discipline alleged in the Accusation by clear and convincing evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) Clear and convincing evidence requires proof that is so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

*Applicable Law*

DUTIES OF A PHARMACIST-IN-CHARGE

2. "'Pharmacist-in-charge' means a pharmacist proposed by a pharmacy and approved by the board as the supervisor or manager responsible for ensuring the pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy." (Bus. & Prof. Code, § 4036.5.) Business and Professions Code section 4113, subdivision (c), provides: "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."

*Cause for Discipline*

3. Pursuant to Business and Professions Code section 4301, the Board is authorized to discipline a permit or license if the permit holder or licensee is guilty of unprofessional conduct, which includes:

> [¶] . . . [¶]
>
> (j) The violation of any of the statutes of this state, of any other state, or of the United States regulating controlled substances and dangerous drugs.
>
> [¶] . . . [¶]
>
> (o) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any provision or term of this chapter or of the applicable federal and state laws and regulations governing pharmacy, including regulations established by the board or by any other state or federal regulatory agency.

MISBRANDED DRUGS AND INCORRECT LABELS

4. Business and Professions Code section 4342 allows the Board to take action against a licensee to "prevent the sale of . . . drugs that do not conform to the standard and tests as to quality and strength" as provided under pharmacy law.

5. Health and Safety Code section 111330 provides that a drug is "misbranded" if its labeling is false or misleading in any particular. Health and Safety Code section 111480 requires the following to be included on a prescription bottle label:

(a) Except where the prescriber 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.

[¶] . . . [¶]

(i) The expiration date of the effectiveness of the drug or device if the information is included on the original label of the manufacturer of the drug or device.

6. Business and Professions Code section 4077, subdivision (a) prohibits dispensing dangerous drugs except in a correctly labeled container, pursuant to Business and Professions Code section 4076. Pursuant to Business and Professions Code section 4076, subdivision (a), a pharmacist may not dispense a prescription in a container that is not labeled with the following:

(1) . . . [E]ither the manufacturer's trade name of the drug or the generic name and the name of the manufacturer.

[¶] . . . [¶]

(9) The expiration date of the effectiveness of the drug dispensed.

[¶] . . . [¶]

(11)(A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsule. . . .

7. Pursuant to Factual Findings 8 through 13, complainant established cause for discipline against respondent Ferry and the Pharmacy based on incorrect expiration dates and incorrect or missing manufacturer names or pill descriptions in 2013/2014 and 2014 through 2016, which constitutes unprofessional conduct under Business and Professions Code section 4301, subdivisions (o) and (j). Specifically, complainant established cause for discipline pursuant to Business and Professions Code sections 4342, 4076, and 4077, and Health and Safety Code sections 111330 and 111480.

//

CONTROLLED SUBSTANCES CABINET

8. California Code of Regulations, title 16, section 1714 requires:

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

Similarly, Code of Federal Regulations, title 21, section 1301.75, subdivision (b), requires Schedule II through V controlled substances to be stored in a "a securely locked, substantially constructed cabinet. Pharmacies may, however, disperse such substances throughout the stock of noncontrolled substances in such a manner as to obstruct the theft or diversion of the controlled substances."

9. Pursuant to Factual Findings 14 and 50, complainant established cause for discipline against respondent Ferry and the Pharmacy under Business and Professions Code section 4301, subdivisions (o) and (j), in that, in 2014, the Pharmacy's controlled substances were not kept locked in a substantially built cabinet during business hours as required by California Code of Regulations, title 16, section 1714, subdivision (b) and Code of Federal Regulations, title 21, section 1301.75, subdivision (b).

10. Pursuant to Factual Findings 15 and 50 through 52, complainant did not establish cause for discipline under California Code of Regulations, title 16, section 1714, subdivision (b) and (d) based on the Pharmacy's 2015 loss of controlled substances. The controlled substances were dispersed throughout the stock, as is permitted under the federal regulations, and respondent Ferry took additional steps to prevent theft, such as employee drug testing, security cameras, an alarm system, and an emergency button.

CONTROLLED SUBSTANCE INVENTORY

11. Code of Federal Regulations, title 21, section 1304.11 requires that inventories have a complete and accurate record of controlled substances on hand. The requirements for taking the inventory include:

[¶] . . . [¶]

(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.

California Code of Regulations, title 16, section 1718, requires that the inventory log be available for inspection on request for three years.

12. Pursuant to Factual Findings 21, 22, and 48, complainant established cause for discipline against respondent Ferry and the Pharmacy under Business and Professions Code section 4301, subdivisions (o) and (j), in that respondents did not complete an accurate biennial inventory up to 2014. Respondent Ferry and the Pharmacy violated Code of Federal Regulations, title 21, section 1304.11.

PARTIAL FILLS

13. California Code of Regulations, title 16, section 1745, subdivision (d) provides:

A pharmacist may partially fill a prescription for a controlled substance listed in Schedule II, if the pharmacist is unable to supply the full quantity ordered by the prescriber. The pharmacist shall make a notation of the quantity supplied on the face of the written prescription. The remaining portion of the prescription may be filled within 72 hours of the first partial filling. If the remaining portion is not filled within the 72-hour period, the pharmacist shall notify the prescriber. The pharmacist may not supply the drug after 72-hour period has expired without a new prescription.

As set forth in Factual Findings 18, 19, 39, and 47, complainant established cause for discipline against respondent Ferry and the Pharmacy under Business and Professions Code

section 4301, subdivisions (o) and (j), in that respondents violated California Code of Regulations, title 16, section 1745, subdivision (d).

SELF-ASSESSMENT BY PIC

14. California Code of Regulations, title 16, section 1745, subdivision (d) requires: "the pharmacist-in-charge of each pharmacy . . . 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." Each self-assessment shall be kept on file in the pharmacy for three years after it is performed.

As set forth in Findings 27, 57, and 61, complainant did not establish cause for discipline against respondent Ferry and the Pharmacy under California Code of Regulations, title 16, section 1745, subdivision (d) for failure to complete a self-assessment.

FAILURE TO REPORT LOSS

15. California Code of Regulations, title 16, section 1715.6, requires a pharmacy owner to report to the Board within 30 days of discovery of any loss of controlled substances. As set forth in Factual Finding 24 and 50, complainant established cause for discipline against respondent Ferry and the Pharmacy under Business and Professions Code section 4301, subdivisions (o) and (j), in that respondents failed to notify the Board of a drug loss as required by California Code of Regulations, title 16, section 1715.6.

DISPENSING ERRONEOUS PRESCRIPTIONS

16. California Code of Regulations, title 16, section 1761, prohibits a pharmacist from dispensing a prescription that contains "any significant error, omission, irregularity, uncertainty, ambiguity or alteration. Upon receipt of any such prescription, the pharmacist shall contact the prescriber to obtain the information needed to validate the prescription." As set forth in Factual Findings 28 and 36, complainant established cause for discipline against the Pharmacy under Business and Professions Code section 4301, subdivision (o), in that the Pharmacy dispensed a prescription that was uncertain, in violation of California Code of Regulations, title 16, section 1761, subdivision (a).

INTERPRETIVE SERVICES

17. California Code of Regulations, title 16, section 1707.5, subdivision (d), requires a pharmacy to provide interpretive services for non-English speakers. As set forth in Factual Findings 31 and 53, complainant established cause for discipline against respondent Ferry and the Pharmacy under Business and Professions Code section 4301, subdivision (o), in that respondents failed to provide interpretive services, in violation of California Code of Regulations, title 16, section 1761, subdivision (a).

CURES REPORTING

18. Health and Safety Code section 11165, subdivision (d) requires:

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

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

(2) The prescriber's category of licensure, license number, national provider identifier (NPI) number, 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, if provided.

(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.

(11) The serial number for the corresponding prescription form, if applicable.

19. As set forth in Factual Findings 16, 17, and 54, complainant established cause for discipline against respondent Ferry and the Pharmacy under Business and Professions Code section 4301, subdivision (j), in that respondents failed to submit CURES reports over several periods of time in 2013 and 2014, in violation of Health and Safety Code section 11165, subdivision (d).

FAILURE TO PARTICIPATE IN QUALITY ASSURANCE PROGRAM

20. Every 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 services and prevent errors." (Cal. Code Regs., tit. 16, § 1711, subd. (a).) "Each quality assurance program shall be managed in accordance with written policies and procedures maintained in the pharmacy in an immediately retrievable form." (Cal. Code Regs., tit. 16, § 1711, subd. (c)(1).) Each medication error shall be investigated as soon as reasonably possible, but no later than two business days from the date of discovery. All medication errors are subject to a quality assurance review, the record of which should contain: the date, location, and participants in the review; the pertinent data and other information relating to the medication error; the findings and determinations generated by the review; and any recommended charges to pharmacy policies, procedures, and processes. (Cal. Code Regs., tit. 16, § 1711, subds. (d) and (e).)

21. As set forth in Factual Findings 33 and 56, complainant established cause for discipline against respondent Ferry and the Pharmacy under Business and Professions Code section 4301, subdivision (o), in that respondents failed to fully and accurately participate in a quality assurance program, which violated California Code of Regulations, title 16, section 1711.

BIENNIAL INVENTORY AND RECORD REQUIREMENTS

22. Pharmacies must maintain a current inventory[7] of all dangerous drugs it maintains. (Bus. & Prof. Code, § 4081, subd. (a).) Pharmacies are required to maintain all documentation regarding acquiring and dispensing dangerous drugs for three years, and the record must be readily available. (Bus. & Prof. Code, § 4105, subds. (a) – (c).)

[7] "Current inventory," as used in Business and Professions Code sections 4081 and 4332, includes "complete accountability for all dangerous drugs handled by every licensee enumerated" therein. (Cal. Code Regs., tit. 16, § 1718.)

23. Pursuant to Factual Findings 15, 47, and 48, complainant established caused for discipline against respondent Ferry and the Pharmacy under Business and Professions Code section 4301, subdivision (o), in that respondents failed to maintain an accurate or current inventory between 2014 and 2016, in violation of Business and Professions Code sections 4081 and 4150, and California Code of Regulations, title 16, section 1718.

CONTROLLED SUBSTANCES PRESCRIPTIONS

24. No person may dispense a controlled substance unless the prescription complies with Health and Safety Code section 11162.1, subdivision (a). That section requires a prescription form to include, in part:

> (1) A latent, repetitive "void" pattern shall be printed across the entire front of the prescription blank; if a prescription is scanned or photocopied, the word "void" shall appear in a pattern across the entire front of the prescription.
>
> (2) A watermark shall be printed on the backside of the prescription blank; the watermark shall consist of the words "California Security Prescription."
>
> (3) A chemical void protection that prevents alteration by chemical washing.
>
> (4) A feature printed in thermochromic ink.
>
> (5) An area of opaque writing so that the writing disappears if the prescription is lightened.
>
> (6) A description of the security features included on each prescription form.
>
> (7) Six quantity check off boxes shall be printed on the form so that the prescriber may indicate the quantity by checking the applicable box . . .
>
> (8) Prescription blanks shall contain a statement printed on the bottom of the prescription blank that the "Prescription is void if the number of drugs prescribed is not noted."
>
> (9) A check box indicating the prescriber's order not to substitute.
>
> (10) An identifying number assigned to the approved security printer by the Department of Justice.

25. Pursuant to Factual Findings 29 and 30, complainant established cause for discipline against respondent Ferry and the Pharmacy under Business and Professions Code section 4301, subdivision (o), in that respondent Ferry and the Pharmacy accepted

prescriptions and dispensed controlled substances for prescriptions that did not satisfy California Pharmacy Law, in violation of Health and Safety Code sections 11164 and 11162.1.

*Appropriate Discipline*

26. When all the evidence is considered, and for the reasons set forth in Findings 60 through 71, the Pharmacy's permit shall be revoked. Respondent Ferry's license shall be revoked, the revocation shall be stayed, and the license placed on probation for a period of three years, subject to the terms and conditions set forth below.

*Costs*

27. Pursuant to *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, various factors must be considered in determining the amount of costs to be assessed. The Board must not assess the full costs of investigation and prosecution when to do so will unfairly penalize a licensee who has committed some misconduct, but who has used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed. The Board must consider the licensee's subjective good faith belief in the merits of his or her position, as well as whether the licensee has raised a colorable challenge to the proposed discipline. The Board must determine that the licensee will be financially able to make later payments. Finally, the Board may not assess the full costs of investigation and prosecution when it has conducted a disproportionately large investigation to prove that a licensee engaged in relatively innocuous misconduct.

28. As discussed in Findings 72 and 73, complainant's request that respondent reimburse the Board $40,347.50 for its costs to investigate and enforce this matter is reasonable. Respondents provided no evidence of any basis to reduce these costs, for which they are jointly and severally liable. Respondents shall be ordered to pay the Board's costs in the total amount of $40,347.50, pursuant to a payment plan approved by the Board.

## ORDER

1. Pharmacy Permit Number 19913 issued to respondent Ferry's Pharmacy, Inc. doing business as Ferry's Pharmacy, listing Daniel Owen Ferry as president and pharmacist-in-charge, is hereby REVOKED.

Respondent owner shall, by the effective date of this decision, arrange for the destruction of, the transfer to, sale of, or storage in a facility licensed by the board of all controlled substances and dangerous drugs and devices. Respondent owner shall provide written proof of such disposition, submit a completed Discontinuance of Business form and return the wall and renewal license to the board within five days of disposition.

Respondent owner shall also, by the effective date of this decision, arrange for the continuation of care for ongoing patients of the pharmacy by, at minimum, providing a written notice to ongoing patients that specifies the anticipated closing date of the pharmacy and that identifies one or more area pharmacies capable of taking up the patients' care, and by cooperating as may be necessary in the transfer of records or prescriptions for ongoing patients. Within five days of its provision to the pharmacy's ongoing patients, Respondent owner shall provide a copy of the written notice to the board. For the purposes of this provision, "ongoing patients" means those patients for whom the pharmacy has on file a prescription with one or more refills outstanding, or for whom the pharmacy has filled a prescription within the preceding 60 days.

2. Pharmacist License No. RPH 24741 issued to Daniel Owen Ferry is REVOKED; however, the revocation is stayed and respondent is placed on probation for three years upon the following terms and conditions:

(1) **Obey All Laws**: Respondent shall obey all state and federal laws and regulations. Respondent shall report any of the following occurrences to the board, in writing, within 72 hours of such occurrence:

- an arrest or issuance of a criminal complaint for violation of any provision of the Pharmacy Law, state and federal food and drug laws, or state and federal controlled substances laws
- a plea of guilty or nolo contendere in any state or federal criminal proceeding to any criminal complaint, information or indictment
- a conviction of any crime
- discipline, citation, or other administrative action filed by any state or federal agency which involves respondent's license or which is related to the practice of pharmacy or the manufacturing, obtaining, handling, distributing, billing, or charging for any drug, device or controlled substance.

Failure to timely report such occurrence shall be considered a violation of probation.

(2) **Report to the Board:** Respondent shall report to the board quarterly, on a schedule as directed by the board or its designee. The report shall be made either in person or in writing, as directed. Among other requirements, respondent shall state in each report under penalty of perjury whether there has been compliance with all the terms and conditions of probation. Failure to submit timely reports in a form as directed shall be considered a violation of probation. Any period(s) of delinquency in submission of reports as directed may be added to the total period of probation. Moreover, if the final probation report is not made as directed, probation shall be automatically extended until such time as the final report is made and accepted by the board.

(3) **Interview with the Board:** Upon receipt of reasonable prior notice, respondent shall appear in person for interviews with the board or its designee, at such intervals and locations as are determined by the board or its designee. Failure to appear for any scheduled interview without prior notification to board staff, or failure to appear for two (2) or more scheduled interviews with the board or its designee during the period of probation, shall be considered a violation of probation.

(4) **Cooperate with Board Staff:** Respondent shall cooperate with the board's inspection program and with the board's monitoring and investigation of respondent's compliance with the terms and conditions of his probation. Failure to cooperate shall be considered a violation of probation.

(5) **Continuing Education:** Respondent shall provide evidence of efforts to maintain skill and knowledge as a pharmacist as directed by the board or its designee.

(6) **Reporting of Employment and Notice to Employers:** During the period of probation, respondent shall notify all present and prospective employers of the decision in case number 5964 and the terms, conditions and restrictions imposed on respondent by the decision, as follows:

Within 30 days of the effective date of this decision, and within 15 days of respondent undertaking any new employment, respondent shall cause his direct supervisor, pharmacist-in-charge (including each new pharmacist-in-charge employed during respondent's tenure of employment) and owner to report to the board in writing acknowledging that the listed individual(s) has/have read the decision in case number 5964, and terms and conditions imposed thereby. It shall be respondent's responsibility to ensure that his employer(s) and/or supervisor(s) submit timely acknowledgment(s) to the board.

If respondent works for or is employed by or through a pharmacy employment service, respondent must notify his direct supervisor, pharmacist-in-charge, and owner at every entity licensed by the board of the terms and conditions of the decision in case number 5964 in advance of the respondent commencing work at each licensed entity. A record of this notification must be provided to the board upon request.

Furthermore, within 30 days of the effective date of this decision, and within 15 days of respondent undertaking any new employment by or through a pharmacy employment service, respondent shall cause his direct supervisor with the pharmacy employment service to report to the board in writing acknowledging that he has read the decision in case number 5964 and the terms and conditions imposed thereby. It shall be respondent's responsibility to ensure that his employer(s) and/or supervisor(s) submit timely acknowledgment(s) to the board.

Failure to timely notify present or prospective employer(s) or to cause that/those employer(s) to submit timely acknowledgments to the board shall be considered a violation of probation.

"Employment" within the meaning of this provision shall include any full-time, part-time, temporary, relief or pharmacy management service as a pharmacist or any position for which a pharmacist license is a requirement or criterion for employment, whether the respondent is an employee, independent contractor or volunteer.

(7) **Notification of Change in Name, Address, or Phone Number:** Respondent shall further notify the board in writing within ten (10) days of any change in name, residence address, mailing address, e-mail address or phone number.

Failure to timely notify the board of any change in employer, name, address, or phone number shall be considered a violation of probation.

(8) **Restrictions on Supervision and Oversight of Licensed Facilities:** During the period of probation, respondent shall not supervise any intern pharmacist or serve as a consultant to any entity licensed by the board. Respondent may be a pharmacist-in-charge, designated representative-in-charge, responsible manager or other compliance supervisor of any single entity licensed by the board, but only if respondent or that entity retains, at his expense, an independent consultant who shall be responsible for reviewing the operations of the entity on a quarterly basis for compliance by respondent and the entity with state and federal laws and regulations governing the practice of the entity, and compliance by respondent with the obligations of his supervisory position. Respondent may serve in such a position at only one entity licensed by the board, only upon approval by the board or its designee. Any such approval shall be site specific. The consultant shall be a pharmacist licensed by and not on probation with the board, who has been approved by the board or its designee to serve in this position. Respondent shall submit the name of the proposed consultant to the board or its designee for approval within thirty (30) days of the effective date of the decision or prior to assumption of duties allowed in this term. Assumption of any unauthorized supervision responsibilities shall be considered a violation of probation. In addition, failure to timely seek approval for, timely retain, or ensure timely reporting by the consultant shall be considered a violation of probation.

(9) **Reimbursement of Board Costs:** As a condition precedent to successful completion of probation, respondent shall pay to the board its costs of investigation and prosecution in the amount of $40,347.50. Respondent shall make said payments as follows:

There shall be no deviation from this schedule absent prior written approval by the board or its designee. Failure to pay costs by the deadline(s) as directed shall be considered a violation of probation.

Respondent shall be permitted to pay these costs in a payment plan approved by the board or its designee, so long as full payment is completed no later than 120 days prior to the end date of probation

(10) **Probation Monitoring Costs:** Respondent shall pay any costs associated with probation monitoring as determined by the board each and every year of probation.

Such costs shall be payable to the board on a schedule as directed by the board or its designee. Failure to pay such costs by the deadline(s) as directed shall be considered a violation of probation.

(11) **Status of License:** Respondent shall, at all times while on probation, maintain an active, current license with the board, including any period during which suspension or probation is tolled. Failure to maintain an active, current license shall be considered a violation of probation.

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

(12) **License Surrender While on Probation/Suspension:** Following the effective date of this decision, should respondent cease practice due to retirement or health, or be otherwise unable to satisfy the terms and conditions of probation, respondent may tender his license to the board for surrender. The board or its designee shall have the discretion whether to grant the request for surrender or take any other action it deems appropriate and reasonable. Upon formal acceptance of the surrender of the license, respondent will no longer be subject to the terms and conditions of probation. This surrender constitutes a record of discipline and shall become a part of the respondent's license history with the board.

Upon acceptance of the surrender, respondent shall relinquish his pocket and wall license to the board within 10 days of notification by the board that the surrender is accepted. Respondent may not reapply for any license from the board for three years from the effective date of the surrender. Respondent shall meet all requirements applicable to the license sought as of the date the application for that license is submitted to the board, including any outstanding costs.

(13) **Tolling of Probation:** Except during periods of suspension, respondent shall, at all times while on probation, be employed as a pharmacist in California for a minimum of 40 hours per calendar month. Any month during which this minimum is not met shall toll the period of probation, i.e., the period of probation shall be extended by one month for each month during which this minimum is not met. During any such period of tolling of probation, respondent must nonetheless comply with all terms and conditions of probation.

Should respondent, regardless of residency, for any reason (including vacation) cease practicing as a pharmacist for a minimum of 40 hours per calendar month in California, respondent must notify the board in writing within 10 days of the cessation of practice, and must further notify the board in writing within 10 days of the resumption of practice. Any failure to provide such notification(s) shall be considered a violation of probation.

It is a violation of probation for respondent's probation to remain tolled pursuant to the provisions of this condition for a total period, counting consecutive and non-consecutive months, exceeding 36 months.

"Cessation of practice" means any calendar month during which respondent is not practicing as a pharmacist for at least 40 hours, as defined by Business and Professions Code section 4000 et seq. "Resumption of practice" means any calendar month during which respondent is practicing as a pharmacist for at least 40 hours as a pharmacist as defined by Business and Professions Code section 4000 et seq.

Respondent is required to practice as a pharmacist in a licensed pharmacy setting that dispenses medication for a minimum of one year prior to the completion of probation. After the first year of probation, the board or its designee may consider a modification of this requirement. If respondent fails to comply with this requirement or a subsequent modification thereto, such failure shall be considered a violation of probation.

(14) **Violation of Probation:** If a respondent has not complied with any term or condition of probation, the board shall have continuing jurisdiction over respondent, and probation shall automatically be extended, until all terms and conditions have been satisfied or the board has taken other action as deemed appropriate to treat the failure to comply as a violation of probation, to terminate probation, and to impose the penalty that was stayed.

If respondent violates probation in any respect, the board, after giving respondent notice and an opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. Notice and opportunity to be heard are not required for those provisions stating that a violation thereof may lead to automatic termination of the stay and/or revocation of the license. If a petition to revoke probation or an accusation is filed against respondent during probation, the board shall have continuing jurisdiction and the period of probation shall be automatically extended until the petition to revoke probation or accusation is heard and decided.

(15) **No Ownership of Licensed Premises:** Respondent shall not own, have any legal or beneficial interest in, or serve as a manager, administrator, member, officer, director, trustee, associate, or partner of any business, firm, partnership, or corporation currently or hereinafter licensed by the board. Respondent shall sell or transfer any legal or beneficial interest in any entity licensed by the board within 90 days following the effective date of this decision and shall immediately thereafter provide written proof thereof to the board. Failure to timely divest any legal or beneficial interest(s) or provide documentation thereof shall be considered a violation of probation.

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(16) **Completion of Probation:** Upon written notice by the board or its designee indicating successful completion of probation, respondent's license will be fully restored.

DATED: February 26, 2019

DocuSigned by:
Heather M. Rowan
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HEATHER M. ROWAN
Administrative Law Judge
Office of Administrative Hearings

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

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>**FERRYS PHARMACY INC.,**<br>**dba FERRYS PHARMACY**<br>**DANIEL OWEN FERRY AND**<br>**DOROTHY ANN FERRY, OWNERS**<br>**2940 East Street**<br>**Anderson, CA 96007**<br><br>**Pharmacy Permit No. PHY 19913**<br><br>**and**<br><br>**DANIEL OWEN FERRY**<br>**21316 Gaines Lane**<br>**Anderson, CA 96007**<br><br>**Pharmacist License No. RPH 24741**<br><br>Respondents. | Case No. 5964<br><br>**A C C U S A T I O N** |

Complainant alleges:

**PARTIES**

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

2. On or about January 17, 1978, the Board issued Pharmacy Permit Number PHY 19913 to Ferrys Pharmacy, Inc., doing business as Ferrys Pharmacy ("Respondent Ferrys Pharmacy"), with Daniel Owen Ferry ("Respondent Ferry") as president and pharmacist-in-

charge and Dorothy Ann Ferry as secretary and treasurer. The pharmacy permit was in full force and effect at all times relevant to the charges brought in the Accusation and will expire on November 1, 2017, unless renewed.

3. On or about August 12, 1966, the Board issued Pharmacist License Number RPH 24741 to Respondent Ferry. The pharmacist license was in full force and effect at all times relevant to the charges brought in the Accusation and will expire on September 30, 2018, unless renewed.

## JURISDICTION

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

5. Code section 4300 states, in pertinent part:

> (a) Every license issued may be suspended or revoked.
>
> (b) The board shall discipline the holder of any license issued by the board, whose default has been entered or whose case has been heard by the board and found guilty, by any of the following methods:
>
> (1) Suspending judgment.
>
> (2) Placing him or her upon probation.
>
> (3) Suspending his or her right to practice for a period not exceeding one year.
>
> (4) Revoking his or her license.
>
> (5) Taking any other action in relation to disciplining him or her as the board in its discretion may deem proper . . .

6. Code section 4300.1 states:

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

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## STATUTORY AND REGULATORY PROVISIONS

**(Statutory Provisions)**

7. Code section 4301 states, in pertinent part:

The board shall take action against any holder of a license who is guilty of unprofessional conduct . . . Unprofessional conduct shall include, but is not limited to, any of the following:

. . . .

(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 . . .

8. Code section 4073 states, in pertinent part:

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

(b) In no case shall a selection be made pursuant to this section if the prescriber personally indicates, either orally or in his or her own handwriting, "Do not substitute," or words of similar meaning. Nothing in this subdivision shall prohibit a prescriber from checking a box on a prescription marked "Do not substitute"; provided that the prescriber personally initials the box or checkmark. To indicate that a selection shall not be made pursuant to this section for an electronic data transmission prescription as defined in subdivision (c) of Section 4040, a prescriber may indicate "Do not substitute," or words of similar meaning, in the prescription as transmitted by electronic data, or may check a box marked on the prescription "Do not substitute." In either instance, it shall not be required that the prohibition on substitution be manually initialed by the prescriber . . .

9. Code section 4076 states, in pertinent part:

(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.

. . . .

(9) The expiration date of the effectiveness of the drug dispensed.

. . . .

(11)(A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules . . .

10. Code section 4077, subdivision (a), that "[e]xcept 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."

11. Code section 4078, subdivision (a)(1), states that "[n]o person shall place a false or misleading label on a prescription."

12. Code section 4081, subdivision (a), states:

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

13. Code section 4105 states, in pertinent part:

(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.

(d) Any records that are maintained electronically shall be maintained so that the pharmacist-in-charge, the pharmacist on duty if the pharmacist-in-charge is not on duty, or, in the case of a veterinary food-animal drug retailer or wholesaler, the designated representative on duty, shall, at all times during which the licensed premises are open for business, be able to produce a hard copy and electronic copy of all records of acquisition or disposition or other drug or dispensing-related records maintained electronically . . .

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

15. Code section 4307(a) states:

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, 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 manger, administrator, owner, member, officer, director, associate, partner, or any other person with management or control had knowledge 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 manger, administrator, owner, member, officer, director, associate, partner, or any other person 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.

16. Code section 4342, subdivision (a), states:

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).

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17. Health and Safety Code section 11162.1 states, in pertinent part:

(a) The prescription forms for controlled substances shall be printed with the following features:

(1) A latent, repetitive "void" pattern shall be printed across the entire front of the prescription blank; if a prescription is scanned or photocopied, the word "void" shall appear in a pattern across the entire front of the prescription.

(2) A watermark shall be printed on the backside of the prescription blank; the watermark shall consist of the words "California Security Prescription."

. . . .

(6) A description of the security features included on each prescription form.

(7)(A) Six quantity check off boxes shall be printed on the form so that the prescriber may indicate the quantity by checking the applicable box . . .

. . . .

(8) Prescription blanks shall contain a statement printed on the bottom of the prescription blank that the "Prescription is void if the number of drugs prescribed is not noted.

. . . .

(12) A check box indicating the prescriber's order not to substitute.

(13) An identifying number assigned to the approved security printer by the Department of Justice.

. . . .

(b) Each batch of controlled substance prescription forms shall have the lot number printed on the form and each form within that batch shall be numbered sequentially beginning with the numeral one . . .

18. Health and Safety Code section 11164 states, in pertinent part:

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:

(1) The prescription shall be signed and dated by the prescriber in ink and shall contain the prescriber's address and telephone number; the name 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; refill information, such as the number of refills ordered and whether the prescription is a first-time request or a

refill; and the name, quantity, strength, and directions for use of the controlled substance prescribed . . .

19. Health and Safety Code section 11165, subdivision (d), states:

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

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

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

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

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

(5) Quantity of the controlled substance dispensed.

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

(7) Number of refills ordered.

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

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

20. Health and Safety Code section 111330 states that "[a]ny drug or device is misbranded if its labeling is false or misleading in any particular."

21. Health and Safety Code section 111480 states, in pertinent part:

Any drug or device sold by filling or refilling a written or oral prescription of a practitioner licensed to prescribe the drug or device shall be exempt from the labeling requirements of Sections 111335, 111340, 111350, 111355, 111360, 111365, 111375, 111380, 111385, 111395, 111415, and 111420, if the drug or device bears a label displaying all the following:

(a) Except where the prescriber 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.

. . . .

(i) The expiration date of the effectiveness of the drug or device if the information is included on the original label of the manufacturer of the drug or device . . .

**(Regulatory Provisions)**

22. Title 21, Code of Federal Regulations ("CFR"), section 1301.75, subdivision (b), states:

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.

23. Title 21, CFR, 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 . . . The inventory may be taken either as of opening of business or as of the close of business on the inventory date and it shall be indicated on the inventory.

. . . .

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

24. Title 16, California Code of Regulations ("CCR"), section 1707.5, subdivision (d), states:

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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 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.

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

(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.

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

(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.

. . . .

(3) The communication requirement in paragraph (2) of this subdivision shall only apply to medication errors if the drug was administered to or by the patient, or if the medication error resulted in a clinically significant delay in therapy.

. . . .

(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.

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(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 . . .

26. 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.

. . . .

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

27. Title 16, CCR, section 1715, subdivision (a), states:

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

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

29. Title 16, CCR, section 1718 states, in pertinent part:

> "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 . . .

30. Title 16, CCR, section 1745, subdivision (d), states:

> A pharmacist may partially fill a prescription for a controlled substance listed in Schedule II, if the pharmacist is unable to supply the full quantity ordered by the prescriber. The pharmacist shall make a notation of the quantity supplied on the face of the written prescription. The remaining portion of the prescription may be filled within 72 hours of the first partial filling. If the remaining portion is not filled within the 72-hour period, the pharmacist shall notify the prescriber. The pharmacist may not supply the drug after 72 hour period has expired without a new prescription.

31. Title 16, CCR, section 1761, subdivision (a), states:

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

## COST RECOVERY

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

## DRUG CLASSIFICATIONS

33. Cyclobenzaprine is a dangerous drug pursuant to Code section 4022 and is indicated for use as a muscle relaxant. "Flexeril" is a brand name for cyclobenzaprine.

34. Morphine ER (extended release) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(L), and is used to treat chronic pain. Morphine ER is also a dangerous drug pursuant to Code section 4022. "MS Contin" is a brand name for morphine ER.

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35. Dexmethylphenidate ER is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d)(6), and is used to treat Attention Deficit Hyperactivity Disorder (ADHD). Dexmethylphenidate ER is also a dangerous drug pursuant to Code section 4022. "Focalin XR" is a brand name for dexmethylphenidate ER.

36. Methylphenidate is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d)(6), and is used to ADHD. Methylphenidate is also a dangerous drug pursuant to Code section 4022. "Ritalin" is a brand name for methylphenidate.

37. Levothyroxine is a dangerous drug pursuant to Code section 4022 and is used to treat hypothyroidism. "Synthroid" is a brand name for levothyroxine.

38. Clonazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(7), and is used to treat anxiety and restless legs. Clonazepam is also a dangerous drug pursuant to Code section 4022. "Klonopin" is a brand name for clonazepam.

39. Nabumetone is a dangerous drug pursuant to Code section 4022 and is used to treat inflammation and arthritis. "Relafen" is a brand name for nabumetone.

40. Zolpidem is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(32), and is used to treat insomnia. Zolpidem is also a dangerous drug pursuant to Code section 4022. "Ambien" is a brand name for zolpidem.

41. Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(14), and is used to treat pain. Methadone is also a dangerous drug pursuant to Code section 4022. "Dolophine" is a brand name for methadone.

42. "Norco" is a brand name for a combination drug containing hydrocodone and acetaminophen (APAP). Norco was previously designated as a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), but was reclassified as a Schedule II controlled substance pursuant to Title 21, CFR, section 1308.12, subdivision (b)(1)(vi), effective October 6, 2014. Norco is also a dangerous drug pursuant to Code section 4022 and is used to treat pain.

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43. "Percocet" is a brand name for a combination drug containing oxycodone and APAP. Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M). Oxycodone is also a dangerous drug pursuant to Code section 4022 and is used to treat pain.

44. Oxycodone is a Schedule II controlled substance and a dangerous drug as set forth in paragraph 42 above, and is used to treat pain. "Percolone" and "Roxicodone" are brand names for oxycodone.

45. Pravastatin is a dangerous drug pursuant to Code section 4022 and is used to treat hypercholesterolemia. "Pravachol" is a brand name for pravastatin.

46. "Suboxone" is a brand name for a combination drug containing buprenorphine and naloxone. Suboxone is a Schedule III controlled substance pursuant to Title 21, CFR, section 1308.13, subdivision (e)(2). Suboxone is also a dangerous drug pursuant to Code section 4022 and is used to treat opioid dependence.

47. Buprenorphine is a Schedule V controlled substance pursuant to Health and Safety Code section 11058, subdivision (d), and a Schedule III controlled substance pursuant to Title 21, CFR, section 1308.13, subdivision (e)(2). Buprenorphine is used to treat pain. "Subutex" is a brand name for buprenorphine.

48. Febuxostat is a dangerous drug pursuant to Code section 4022 and is used to treat gout. "Uloric" is a brand name for febuxostat.

49. Alprazolam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(1). Alprazolam is also a dangerous drug pursuant to Code section 4022 and is used to treat anxiety. "Xanax" is a brand name for alprazolam.

**BOARD INSPECTION OF SEPTEMBER 8, 2014, AND INVESTIGATION**

50. On or about September 8, 2014, Board Inspector P. went to Ferrys Pharmacy to conduct an inspection after the Board received a complaint from a confidential informant. The informant alleged that the pharmacist-in-charge, Respondent Ferry ("PIC Ferry"), often made medication errors and dispensed drugs in prescription bottles that were mislabeled.

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51. Staff pharmacist V. ("RPH V.") gave Inspector P. a tour of the pharmacy. Inspector P. noted that they had a Parata Automated Dispensing System (Parata) which counts prescription products, places them in prescription bottles, and affixes a prescription label to the bottles.

52. PIC Ferry arrived at the pharmacy about a half hour after the inspection commenced. Inspector P. obtained a copy of the pharmacy's biennial controlled substance inventory dated December 28, 2013, and noted that it was not in compliance with the law. Inspector P. asked PIC Ferry if he had any recent drug losses. PIC Ferry replied yes. PIC Ferry stated that he filled out a DEA 106 form and sent it to the DEA, but had forgotten to send a copy to the Board. Inspector P. obtained a copy of the DEA 106 form. The pharmacy had reported a loss of 103 tablets of methadone, 270 tablets of Oxycontin 20 mg, 90 tablets of Oxycontin 40 mg, 199 tablets of Oxycontin 60 mg, and 197 tablets of Oxycontin 80 mg tablets due to an armed robbery; the loss occurred on July 13, 2012. Inspector P. confirmed later that the Board had no record of this loss.

53. Inspector P. had PIC Ferry provide her with the pharmacy's Schedule II controlled substance bundles. Inspector P. reviewed the bundles and found several prescriptions that had been partially filled; the remaining portion of the drug was supplied beyond 72 hours without a new prescription issued by the prescriber. Inspector P. asked PIC Ferry about the partial fills. PIC Ferry told Inspector P. that they kept a partial fill binder. Inspector P. obtained a copy of one page in the binder, then requested and received the invoices showing the date each drug was received by the pharmacy. Later, Inspector P. asked RPH V. if he filled prescription number 6689501 for patient SJ. RPH V. replied yes. The prescription was written for Ritalin 20 mg – white tablet only. The partial fill documentation showed that the remaining drug was filled with a light yellow tablet. Inspector P. asked RPH V. if he called the prescriber before he changed the tablets. RPH V. admitted that he had not.

54. Inspector P. reviewed PIC Ferry's self-assessment dated June 1, 2013, and asked him if he had read the form. PIC Ferry admitted that one of his pharmacy technicians had filled out the self-assessment and that PIC Ferry had signed the form without reading it.

55. Inspector P. observed a lock sitting on a counter over a set of drawers. Inspector P. noted that no one re-locked the drawers for over an hour. Inspector P. asked PIC Ferry what was

in the drawers. PIC Ferry pulled open the drawers and showed Inspector P. various Schedule II controlled substances. PIC Ferry stated that he unlocked the drawers in the morning, left them unlocked, and re-locked them at night when the pharmacy closed.

56. Inspector P. reviewed prescriptions located in the will-call area and found 21 prescription bottles that were misbranded. The physical description of the pills on the prescription label did not match the tablets inside the bottles, the wrong drug manufacturer was listed on some of the labels, and some of the labels were missing the physical description of the pill or the drug manufacturer. Inspector P. placed the misbranded prescriptions into a red tote.

57. Inspector P. asked PIC Ferry if he had interpretive services. He admitted that he did not. Later, Inspector P. received documentation showing that the pharmacy obtained interpretive services on September 17, 2014.

58. Inspector P. observed during her inspection that the prescription labels produced by the Parata were defaulted to a one-year expiration date. Inspector P. confirmed with PIC Ferry that every label produced from the Parata on the day of the inspection would show an expiration date of September 8, 2015. At the conclusion of the inspection, Inspector P. asked PIC Ferry to provide her with a print out of the current cell details on the Parata through September 8, 2014.

59. On or about September 9, 2014, Inspector P. received an Inventory by Cell Parata report from the pharmacy which included the expiration date of each drug contained within the Parata. Inspector P. found in reviewing the report that a number of drugs had expiration dates prior to September 9, 2014. Inspector P. sent a fax to PIC Ferry requesting Drug Utilization Reports (DUR) for these medications.

60. On or about September 12, 2014, Inspector P. received various documents from the pharmacy, including a biennial inventory dated August 13, 2012, signed by RPH V. Inspector P. noted that it was not in compliance with the law. Later, Inspector P. spoke with consumer K. O. by phone regarding medications she had received from the pharmacy (K. O. was identified by the informant as one of the consumers who had received incorrect medications from the pharmacy).

61. On or about September 22, 2014, Inspector P. received a package from K. O. containing prescription bottles she had received from the pharmacy. Some of the prescription

labels did not identify the drug manufacturer or had the incorrect manufacturer.

62. On or about March 14, 2016, Inspector P. received copies of DUR's from the pharmacy. Inspector P. found in reviewing the DUR's that the pharmacy had dispensed approximately 843 prescriptions with an invalid expiration date.

**FIRST CAUSE FOR DISCIPLINE**

**(Misbranded Drugs)**

63. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (j) and (o), in that Respondent violated Code section 4342 and Health and Safety Code sections 111330 and 111480, as follows:

a. On and between April 1, 2014 and September 8, 2014, Respondent dispensed approximately 843 prescriptions with an invalid expiration date in that the prescription bottles were labeled with an expiration date of one year from the date the medications were dispensed by the Parata when, in fact, the drugs had an expiration date prior to the stated date on the label. Consequently, the drugs were misbranded.

b. On or about September 8, 2014, Respondent had 21 prescription in their will-call area that were misbranded in that the prescription labels either did not list the drug manufacturer or had the wrong drug manufacturer listed.

c. On and between March 26, 2014 and August 5, 2014, Respondent dispensed four (4) prescriptions to consumer K. O. that were misbranded in that the prescription labels either did not list the drug manufacturer or had the wrong drug manufacturer listed.

**SECOND CAUSE FOR DISCIPLINE**

**(Incorrect Prescription Labels)**

64. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent violated Code sections 4076, subdivisions (a)(1), (9), and (11)(A), and 4077, subdivision (a), as follows:

a. On and between April 1, 2014 and September 8, 2014, Respondent dispensed approximately 843 prescriptions with an invalid expiration date listed on the prescription label, as set forth in subparagraph 62 (a) above.

b. On or about September 8, 2014, Respondent had 21 prescription bottles in their will-call area that were incorrectly labeled in that the prescription labels had an invalid physical description of the dispensed medications, listed the wrong drug manufacturer, and/or did not include the physical description of the medication or the drug manufacturer.

c. On and between March 26, 2014 and August 5, 2014, Respondent dispensed four prescriptions to consumer K. O. that were misbranded in that the prescription labels either did not list the drug manufacturer or had the wrong drug manufacturer listed.

**THIRD CAUSE FOR DISCIPLINE**

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

65. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (o) and (j), in that Respondent failed to maintain the pharmacy and its facilities, space, fixtures and/or equipment so that drugs were safely and properly secured, in violation of Title 16, CCR, section 1714, subdivision (b), and failed to store Schedule II Controlled Substances in securely locked, substantially constructed cabinets, in violation of Title 21, CFR, section 1301.75, subdivision (b), as follows: On or about September 8, 2014, Respondent kept Schedule II controlled substances in an unlocked cabinet and admitted that it was the pharmacy's practice to unlock the cabinet at the beginning of the day, to keep the cabinet unlocked during business hours, and lock the cabinet at the end of the day.

**FOURTH CAUSE FOR DISCIPLINE**

**(Improper Biennial Inventories)**

66. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (o) and (j), in that Respondent violated Title 16, CCR, section 1718, and Title 21, CFR, section 1304.11, by failing to complete proper biennial inventories, as follows:

a. Respondent's biennial inventory dated December 28, 2013, was started on November 20, 2013 and completed on December 28, 2013, rather than being completed in one day. Further, the inventory form was not signed by a pharmacist and did not indicate whether the inventory was

taken at the opening or close of business.

b. Respondent's biennial inventory dated August 13, 2012, was not completed at the opening or close of business, but was conducted throughout the day.

**FIFTH FOR DISCIPLINE**

**(Partial Filling of Schedule II Controlled Substances Not in Compliance with the Law)**

67. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (o) and (j), in that Respondent violated Title 16, CCR, section 1745, subdivision (d), as follows: Respondent partially filled the following prescriptions for Schedule II controlled substances with the remaining portion of the drugs having been supplied beyond 72 hours without a new prescription issued by the prescriber:

| **Rx No. on Rx Blank** | **Drug/patient initials** | **Date filled** | **Partial dated or filled** | **Order for partial received** |
|---|---|---|---|---|
| 2684618 for #90 | morphine ER 60 mg/EJ | #27 on 7/25/14 | #63 on 7/30/14 | 7/31/14 – received after partial fill date |
| 2684672 for #30 | Focalin XR 30 mg/AD | #15 on 7/25/14 | #15 on 7/28/14; pharmacy could not verify receipt of order to fill | 8/25/14 incorrect invoice |
| 2684672 for #30 (should have been 2687989 for #30) | Focalin XR 30 mg/AD | #7 on 7/25/14 or #7 on 8/13/14 | #23 on 8/28/14 | 8/25/14 invoice provided incorrect |
| **Rx No. on Rx Blank** | **Drug/patient initials** | **Date filled** | **Partial dated or filled** | **Order for partial received** |
| 6689501 for #120 | Ritalin 20 mg/SJ | #105 on 9/2/14 | #15 on 9/8/14; per PIC Ferry, no balance date on any document | 9/5/14 |
| 2684682 for #60 | MS ER 60 mg/SJ | #12 on 7/25/14 | #48 on 7/30/14 | 7/28/14 |

68. In addition to dispensing beyond 72 hours, the pharmacist erroneously documented when the partial fill was completed for RX No. 2684618. The partial fill for morphine sulfate ER 60mg was documented as completed on July 30, 2014, however the order to complete the partial fill did not arrive until July 31, 2014.

**SIXTH CAUSE FOR DISCIPLINE**

**(Failure to Report Loss of Controlled Substances)**

69. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (j) and (o), in that Respondent violated Title 16, CCR, section 1715.6, as follows: Respondent failed to report to the Board the burglary or theft of controlled substances from the pharmacy on July 13, 2012, as set forth in paragraph 51 above.

**SEVENTH CAUSE FOR DISCIPLINE**

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

70. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent violated Title 16, CCR, section 1715, by failing to complete a self assessment, as follows: Respondent's pharmacist-in-charge, Respondent Ferry, had a pharmacy technician complete the self-assessment and Respondent Ferry signed the form without reading it, as set forth in paragraph 53 above.

**EIGHTH CAUSE FOR DISCIPLINE**

**(Dispensing Erroneous/Uncertain Prescription)**

71. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent violated Title 16, CCR, section 1761, subdivision (a), by dispensing a prescription containing a significant error, omission, irregularity, uncertainty, ambiguity or alteration, as follows: On and between September 5, 2014 and September 8, 2014, Respondent's employee, RPH V., partially filled prescription number 6689501 for consumer SJ that was written for Ritalin 20 mg – white tablet only, but substituted or dispensed a light yellow tablet by a different manufacturer without contacting the prescriber.

**NINTH CAUSE FOR DISCIPLINE**

**(Failure to Provide Interpretive Services)**

72. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent violated Title 16,

CCR, section 1707.5, subdivision (d), as follows: On or about September 8, 2014, Respondent failed to provide interpretive services to consumers.

**TENTH CAUSE FOR DISCIPLINE**

**(Misbranded Drugs)**

73. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (j) and (o), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated Code section 4342 and Health and Safety Code sections 111330 and 111480, as follows:

a. On and between April 1, 2014 and September 8, 2014, Respondent dispensed approximately 843 prescriptions with an invalid expiration date in that the prescription bottles were labeled with an expiration date of one year from the date the medications were dispensed by the Parata when, in fact, the drugs had an expiration date prior to the stated date on the label. Consequently, the drugs were misbranded.

b. On or about September 8, 2014, Respondent had 21 prescription bottles in their will-call area that were misbranded in that the prescription labels either did not list the drug manufacturer or had the wrong drug manufacturer listed.

c. On and between March 26, 2014 and August 5, 2014, Respondent dispensed four prescriptions to consumer K. O. that were misbranded in that the prescription labels either did not list the drug manufacturer or had the wrong drug manufacturer listed.

**ELEVENTH CAUSE FOR DISCIPLINE**

**(Incorrect Prescription Labels)**

74. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated Code sections 4076, subdivisions (a)(1), (9), and (11)(A), and 4077, subdivision (a), as follows:

a. On and between April 1, 2014 and September 8, 2014, Respondent dispensed approximately 843 prescriptions with an invalid expiration date listed on the prescription label, as set forth in subparagraph 62 (a) above.

b. On or about September 8, 2014, Respondent had 21 prescription bottles in their will-call area that were incorrectly labeled in that the prescription labels had an invalid physical description of the dispensed medications, listed the wrong drug manufacturer, and/or did not include the physical description of the medication or the drug manufacturer.

c. On and between March 26, 2014 and August 5, 2014, Respondent dispensed four prescriptions to consumer K. O. that were misbranded in that the prescription labels either did not list the drug manufacturer or had the wrong drug manufacturer listed.

**TWELFTH CAUSE FOR DISCIPLINE**

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

75. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (o) and (j), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, failed to maintain the pharmacy and its facilities, space, fixtures and/or equipment so that drugs were safely and properly secured, in violation of Title 16, CCR, section 1714, subdivision (b), and failed to store Schedule II Controlled Substances in securely locked, substantially constructed cabinets, in violation of Title 21, CFR, section 1301.75, subdivision (b), as follows: On or about September 8, 2014, Respondent kept Schedule II controlled substances in an unlocked cabinet; admitted that it was his practice to unlock the cabinet at the beginning of the day, keep the cabinet unlocked during business hours, and lock the cabinet at the end of the day.

**THIRTEENTH CAUSE FOR DISCIPLINE**

**(Improper Biennial Inventories)**

76. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (o) and (j), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated Title 16, CCR, section 1718 and Title 21, CFR, section 1304.11, by failing to complete proper biennial inventories, as follows:

a. Respondent's biennial inventory dated December 28, 2013, was started on November 20, 2013 and completed on December 28, 2013, rather than being completed in one day as required. Further, the inventory form was not signed by a pharmacist and did not indicate

whether the inventory was taken at the opening or close of business.

b. Respondent's biennial inventory dated August 13, 2012, was not completed at the opening or close of business, but was conducted throughout the day.

**FOURTEENTH CAUSE FOR DISCIPLINE**

**(Partial Filling of Schedule II Controlled Substances Not in Compliance with the Law)**

77. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (o) and (j), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated Title 16, CCR, section 1745, subdivision (d), as follows: Respondent partially filled the following prescriptions for Schedule II controlled substances with the remaining portion of the drugs having been supplied beyond 72 hours without a new prescription issued by the prescriber:

| **Rx No. on Rx Blank** | **Drug/patient initials** | **Date filled** | **Partial dated or filled** | **Order for partial received** |
|---|---|---|---|---|
| 2684618 for #90 | morphine ER 60 mg/EJ | #27 on 7/25/14 | #63 on 7/30/14 | 7/31/14 – received after partial fill date |
| 2684672 for #30 | Focalin XR 30 mg/AD | #15 on 7/25/14 | #15 on 7/28/14; pharmacy could not verify receipt of order to fill | 8/25/14 incorrect invoice |
| 2684672 for #30 (should have been 2687989 for #30) | Focalin XR 30 mg/AD | #7 on 7/25/14 or #7 on 8/13/14 | #23 on 8/28/14 | 8/25/14 invoice provided incorrect |
| **Rx No. on Rx Blank** | **Drug/patient initials** | **Date filled** | **Partial dated or filled** | **Order for partial received** |
| 6689501 for #120 | Ritalin 20 mg/SJ | #105 on 9/2/14 | #15 on 9/8/14; per PIC Ferry, no balance date on any document | 9/5/14 |
| 2684682 for #60 | MS ER 60 mg/SJ | #12 on 7/25/14 | #48 on 7/30/14 | 7/28/14 |

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**FIFTEENTH CAUSE FOR DISCIPLINE**

**(Failure to Report Loss of Controlled Substances)**

78. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (j) and (o), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated Title 16, CCR, section 1715.6, as follows: Respondent failed to report to the Board the burglary or theft of controlled substances from the pharmacy on July 13, 2012, as set forth in paragraph 51 above.

**SIXTEENTH CAUSE FOR DISCIPLINE**

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

79. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated Title 16, CCR, section 1715, by failing to complete a self assessment, as follows: Respondent had a pharmacy technician complete the self-assessment and Respondent signed the form without reading it, as set forth in paragraph (53) above.

**SEVENTEENTH CAUSE FOR DISCIPLINE**

**(Failure to Provide Interpretive Services)**

80. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated Title 16, CCR, section 1707.5, subdivision (d), as follows: On or before September 8, 2014, Respondent failed to provide interpretive services to consumers.

**BOARD INSPECTION OF MARCH 23, 2016, AND INVESTIGATION**

81. On or about March 23, 2016, Board Inspector K. went to Ferrys Pharmacy to conduct an inspection. RPH V. was present along with other pharmacy personnel and provided certain documents to Inspector K. as requested.

**Cures Reporting**

82. Inspector K. reviewed Ferry Pharmacy's CURES data and found that the pharmacy had not made any reports to CURES between February 28, 2013 and June 21, 2013, November 8, 2013 and November 26, 2013, October 18, 2014 and October 27, 2014, and November 15, 2014

and November 24, 2014. RPH V. told Inspector K. that the pharmacy operated continuously during these time periods actively dispensing prescriptions.

83. On and between May 16, 2016 and May 28, 2016, Inspector K. received various emails containing the pharmacy's dispensing data from September 10, 2014 to March 23, 2016. Inspector K. found, among other things, that between October 20, 2014 and October 25, 2014, and November 17, 2014 and November 22, 2014, the pharmacy dispensed over 170 prescriptions for hydrocodone/APAP 10/325 mg, a total of over 21,000 tablets for the 12 day period, none of which had been reported to CURES.

**Expired Drugs**

84. During the inspection, Inspector K. found 17 packages of prescription drugs that were expired intermingled with non-expired drugs in the pharmacy's drug stock. At the conclusion of his inspection, Inspector K. provided RPH V. with a copy of his inspection report. Inspector K. instructed Ferry's Pharmacy to remove all expired drugs from the drug stock and provide him with a list of drugs that were to be returned to the pharmacy's reverse distributor.

85. On or about April 4, 2016, Ferry's Pharmacy faxed Inspector K. a list of expired drugs (102 packages) that had been pulled from their inventory on March 24, 2016. Some of the drugs on the list had been expired for a year.

**Quality Assurance Program**

86. During the inspection, Inspector K. reviewed a binder containing the pharmacy's Quality Assurance ("QA") Program policies and procedures, blank incident reporting forms, and some completed reports of prescription errors. Inspector K. reviewed the documents with RPH V. RPH V. stated that when he discovered a prescription error, he documented the information and left it for PIC Ferry, but did not complete a QA report. Inspector K. found copies of two prescription labels in the binder relating to a possible prescription error. RPH V. stated that a prescription was dispensed on or about February 25, 2016, with the wrong label. The label for Rx #8032827 for Uloric 40 mg was placed in error on another patient's prescription bottle, Rx #8038810 for Synthroid 0.137 mg. RPH V. stated that the patient took some of the wrong medication, but did not suffer any ill effects. A QA incident report was not completed and there

was no documentation of any contact with the prescriber. Inspector K. asked RPH V. about Rx # 8034912; the prescription was issued on January 14, 2016, for 32 tablets of Norco 10/325 mg and was dispensed the next day for 120 tablets. RPH V. stated that a QA report was not completed.

**False Expiration Dates on Prescription Labels:**

87. Inspector K. had pharmacy staff print him an inventory of the drugs listed in the Parata ("Parata inventory list"). Inspector K. found in reviewing the pharmacy's prescription labels that they had expiration dates which were one year from the date the prescriptions were dispensed by the Parata. Inspector K. decided to audit certain drugs on the Parata inventory list since their expiration dates were less than one year. Inspector K. had pharmacy staff print examples of labels that were recently dispensed from the Parata inventory lists (a total of 16). All of the prescriptions were labeled and dispensed with expiration dates that were longer than the manufacturer or pharmacy assigned expiration date.

**Drug Losses:**

88. On or about June 29, 2015, the Board received a DEA 106 form from the pharmacy. The report indicated that a non-licensed pharmacy employee was suspected of using drugs illegally. The employee refused a drug test and was terminated. The pharmacy reported a loss of 3,279 tablets of oxycodone 30 mg.

89. On or about June 30, 2015, PIC Ferry was requested to provide the Board with certain information pertaining to the drug loss.

90. On or about July 23, 2015, PIC Ferry informed the Board that the pharmacy had completed an inventory of Schedule II controlled substances on June 22, 2015, revealing a shortage. PIC Ferry conducted an audit using a starting date of September 9, 2014, and an ending date of June 22, 2015, and found a shortage of 3,309 tablets of oxycodone 30 mg.

**Drug Audit:**

91. During the inspection, Inspector K. obtained copies of the pharmacy's inventories of Schedule II to V controlled substances, one conducted on September 9, 2014, and the other conducted on June 22, 2015. Inspector K. had RPH V. complete a count of the pharmacy's stock on hand of certain controlled substances. Inspector K. then had pharmacy staff print a dispensing

report of all controlled substances filled on March 23, 2016. Inspector K. also obtained the pharmacy's dispensing records for the time period from September 10, 2014 to March 23, 2016.

92. On or about March 28, 2016, Inspector K. sent Ferrys Pharmacy's three wholesalers letters requesting that they provide him with records of all sales of Schedule II to V controlled substances purchased by the pharmacy from September 10, 2014 through March 23, 2016, including all credits. The wholesalers provided the records to Inspector K. as requested.

93. Inspector K. conducted an audit based on the documents provided by Ferrys Pharmacy and their wholesalers. Inspector K. found that the pharmacy had significant shortages of certain controlled substances, and a significant overage of the controlled substances hydrocodone/APAP 5/325 mg and hydrocodone/APAP 10/325 mg, as set forth below.

**Deficiencies in Controlled Substance Prescriptions**

94. On or about April 25, 2016, Inspector K. received original prescription documents from Ferrys Pharmacy. Inspector K. found that certain controlled substance prescriptions were filled and dispensed by the pharmacy pursuant to faxed prescriptions that were not signed and dated in ink (handwritten) by the prescriber, as set forth below.

95. While reviewing the pharmacy's CURES data, Inspector K. noted some controlled substance prescriptions from out of state prescribers. PIC Ferry sent Inspector K. some of these prescriptions. Inspector K. found two prescriptions that were dispensed on forms which were not in compliance with the law, as more particularly set forth below.

## EIGHTEENTH CAUSE FOR DISCIPLINE

**(Failure to Report Controlled Substance Prescriptions to CURES)**

96. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (j), in that Respondent violated Health and Safety Code section 11165, subdivision (d), as follows: On and between February 28, 2013 and June 21, 2013, November 8, 2013 and November 26, 2013, October 18, 2014 and October 27, 2014, and November 15, 2014 and November 24, 2014, Respondent dispensed prescriptions for Schedule II, III, and IV controlled substances without reporting the information to CURES within seven days of the dispensing dates.

## NINETEENTH CAUSE FOR DISCIPLINE

**(Failure to Comply with Quality Assurance Program)**

97. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent violated Title 16, CCR, section 1711, as follows:

a. Respondent failed to document on the pharmacy's incident reporting forms the medication errors described in paragraph 84 above as required by their QA Program policies and procedures; and failed to engage in a QA Program in a manner to advance error prevention by analyzing, individually and collectively, investigative and other pertinent data collected in response to medication errors to assess the cause and any contributing factors such as system or process failures.

b. Respondent failed to keep or have available at the pharmacy in an immediately retrievable form the date, location, and participants involved in the QA review; pertinent data and other information relating to the medication error(s) reviewed; documentation of any patient contact; the findings and determinations generated by the QA review; and recommended changes to pharmacy policy, procedure, systems, or processes.

## TWENTIETH CAUSE FOR DISCIPLINE

**(False or Misleading Prescription Labels)**

98. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent violated Code sections 4078, subdivision (a)(1), and 4076, subdivision (a)(9), as follows: Respondent dispensed prescriptions with labels which were false or misleading in that the prescription bottles were labeled with expiration dates that were longer than the manufacturers' expiration dates or the expiration dates that were labeled on the cells of the pharmacy's Parata machine, as follows:

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| Prescription No. | Date | Drug | Exp. Date on Label | Exp. Date on Parata List |
|---|---|---|---|---|
| 8035839 | 03/18/2016 | carisoprodol 350 mg | 03/18/2017 | 12/01/2016 |
| 8040707 | 03/18/2016 | carisoprodol 350 mg | 03/18/2017 | 12/01/2016 |
| 8041286 | 03/18/2016 | carisoprodol 350 mg | 03/18/2017 | 12/01/2016 |
| 8028008 | 02/29/2016 | metoprolol ER 50 mg | 02/28/2017 | 12/01/2015 |
| 8039175 | 02/29/2016 | metoprolol ER 50 mg | 02/28/2017 | 12/01/2015 |
| 8014007 | 03/12/2016 | metoprolol ER 50 mg | 03/12/2017 | 12/01/2015 |
| 8031950 | 03/11/2016 | levothyroxine 50 mcg | 03/11/2017 | 11/01/2016 |
| 8037256 | 03/11/2016 | levothyroxine 50 mcg | 03/11/2017 | 11/01/2016 |
| 8023760 | 03/21/2016 | levothyroxine 50 mcg | 03/11/2017 | 11/01/2016 |
| 8041350 | 03/18/2016 | prednisone 20 mg | 03/17/2017 | 07/01/2016 |
| 8041067 | 03/16/2016 | prednisone 20 mg | 03/16/2017 | 07/01/2016 |
| 8041044 | 03/16/2016 | prednisone 20 mg | 03/16/2017 | 07/01/2016 |
| 8038371 | 02/19/2016 | prednisone 20 mg | 02/18/2017 | 07/01/2016 |
| 8024502 | 03/22/2016 | diazepam 5 mg | 03/22/2017 | 12/01/2016 |
| 8033502 | 03/22/2016 | diazepam 5 mg | 03/22/2017 | 12/01/2016 |
| 8041616 | 03/22/2016 | diazepam 5 mg | 03/22/2017 | 12/01/2016 |

## TWENTY-FIRST CAUSE FOR DISCIPLINE

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

99. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (o) and (j), in that Respondent violated title 16, CCR, section 1714, subdivisions (b) and (d), as follows:

a. On and between September 9, 2014 and March 23, 2016, Respondent failed to maintain the pharmacy and its facilities, space, fixtures and/or equipment so that drugs were safely and properly secured, resulting in significant shortages of the following controlled substances:

| Drug | Shortage |
|---|---|
| alprazolam 2 mg | -268 |
| buprenorphine 8 mg | -262 |
| methadone 10 mg | -341 |
| Promethazine/codeine liquid | -614 |
| Suboxone film 8/2 mg | -144 |
| Total: | -1,629 |

b. Respondent failed to ensure that the pharmacy's drug stock was secured with sufficient provisions for effective control against theft or diversion of controlled substances, resulting in a loss or shortage of 3,309 oxycodone 30 mg tablets as reported by Ferry's Pharmacy on or about June 29, 2015.

c. On or about March 23, 2016, Respondent held the following expired drugs for sale intermingled with the pharmacy's stock of non-expired drugs:

| Drug | Expiration Date |
|---|---|
| albuterol 2 mg/5 ml | 01/2016 |
| AzaSite | 07/31/2015 |
| **Drug** | **Expiration Date** |
| Comtan 200 mg | 09/2015 |
| Depakote 500 mg | 07/26/2015 |
| Depakote ER 250 mg | 04/11/2015 |
| hydroxyzine pamoate 25 mg | 08/2015 |
| Lipitor 40 mg | 10/2015 |
| Lipitor 80 mg | 08/2015 |
| Marinol 5 mg | 01/2016 |
| Oxycontin 80 mg | 01/2016 |
| Phenadoz 25 mg supp. | 09/2015 |

| | |
|---|---|
| Phenadoz 25 mg supp. | 09/2015 |
| Ritalin LA 30 mg | 02/2016 |
| Sensipar 30 mg | 06/2015 |
| Strattera 25 mg | 10/2015 |
| Theo-24 200 mg | 08/2015 |
| valcyclovir 500 mg | 01/2016 |

d. Respondent held an additional 102 packages of expired drugs for sale in the pharmacy's drug stock, some of which had been expired for up to one year.

**TWENTY-SECOND CAUSE FOR DISCIPLINE**

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

100. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent violated Code sections 4081, subdivision (a), and 4105, subdivisions (a) through (c), and Title 16, CCR, section 1718, as follows: On and between September 9, 2014 and March 23, 2016, Respondent failed to maintain an accurate or current inventory of all dangerous drugs in the pharmacy, resulting in significant shortages and overages of controlled substances, as follows:

| **Drug** | **Shortage or Overage** |
|---|---|
| alprazolam 2 mg | -268 |
| buprenorphine 8 mg | -262 |
| hydrocodone/APAP 10/325 mg | 3,986 |
| hydrocodone/APAP 5/325 mg | 1,135 |
| methadone 10 mg | -341 |
| Promethazine/codeine liquid | -614 |
| Suboxone film 8/2 mg | -144 |

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## TWENTY-THIRD CAUSE FOR DISCIPLINE

**(Violations of Requirements for Controlled Substance Prescriptions)**

101. Respondent Ferrys Pharmacy is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (j), in that Respondent violated state laws regulating controlled substances, as follows:

a. Respondent filled and dispensed the following controlled substance prescriptions pursuant to faxed prescriptions which did not have the signature and date handwritten in ink by the prescriber, in violation of Health and Safety Code section 11164, subdivision (a)(1):

| Date | Number | Drug |
|---|---|---|
| 09/03/2013 | 4645430 | zolpidem 10 mg |
| 10/07/2013 | 3649517 | Estratest |
| 11/05/2013 | 4652898 | modafinil 200 mg |
| 12/03/2013 | 4656206 | carisoprodol 350 mg |
| 01/17/2014 | 3661590 | Depo-Testosterone |
| 04/04/2014 | 3671249 | estrogens-methyltestosterone |
| 12/11/2014 | 4702921 | zolpidem 10 mg |
| 05/09/2015 | 8009173 | estrogens-methyltestosterone |

b. Respondent dispensed controlled substance prescriptions, specifically, prescription number 3642972 issued on August 13, 2013, for 240 tablets of hydrocodone/APAP 10/325 mg (the prescriber was from the state of Oregon), and prescription number 3644395 issued on August 23, 2013, for 90 tablets of hydrocodone/APAP 10/325 mg (the prescriber was from the state of Maryland), that were not in compliance with Health and Section 11162.1 in that the prescription forms were not printed with the following features:

1. A latent, repetitive "void" pattern printed across the entire front of the prescription if the prescription was scanned or photocopied;

2. A watermark printed on the backside of the prescription blank with the words

"California Security Prescription";

3. A description of the security features included on the prescription form;

4. Six quantity check off boxes printed on the form so that the prescriber may indicate the quantity by checking the applicable box;

5. A statement printed on the bottom of the prescription blank that the "Prescription is void if the number of drugs prescribed is not noted;

6. A check box indicating the prescriber's order not to substitute;

7. An identifying number assigned to the approved security printer by the Department of Justice; and/or

8. The lot number printed on the form and each form within that batch numbered sequentially.

**TWENTY-FOURTH CAUSE FOR DISCIPLINE**

**(Failure to Report Controlled Substance Prescriptions to CURES)**

102. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (j), in that Respondent, as pharmacist-in-charge of Ferry's Pharmacy, violated Health and Safety Code section 11165, subdivision (d), as follows: On and between February 28, 2013 and June 21, 2013, November 8, 2013 and November 26, 2013, October 18, 2014 and October 27, 2014, and November 15, 2014 and November 24, 2014, Respondent dispensed prescriptions for Schedule II, III, and IV controlled substances without reporting the information to CURES within seven days of the dispensing dates.

**TWENTY-FIFTH CAUSE FOR DISCIPLINE**

**(Failure to Comply with Quality Assurance Program)**

103. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent, as pharmacist-in-charge of Ferry's Pharmacy, violated Title 16, CCR, section 1711, as follows:

a. Respondent failed to document on the pharmacy's incident reporting forms the medication errors described in paragraph 84 above as required by their QA Program policies and procedures; and failed to engage in a QA Program in a manner to advance error prevention by

analyzing, individually and collectively, investigative and other pertinent data collected in response to medication errors to assess the cause and any contributing factors such as system or process failures.

b. Respondent failed to keep or have available at the pharmacy in an immediately retrievable form the date, location, and participants involved in the QA review; pertinent data and other information relating to the medication error(s) reviewed; documentation of any patient contact; the findings and determinations generated by the QA review; and recommended changes to pharmacy policy, procedure, systems, or processes.

## TWENTY-SIXTH CAUSE FOR DISCIPLINE

### (False or Misleading Prescription Labels)

104. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated Code sections 4078, subdivision (a)(1), and 4076, subdivision (a)(9), as follows: Respondent dispensed prescriptions with labels which were false or misleading in that the prescription bottles were labeled with expiration dates that were longer than the manufacturers' expiration dates or the expiration dates that were labeled on the cells of the pharmacy's Parata machine, as follows:

| Prescription No. | Date | Drug | Exp. Date on Label | Exp. Date on Parata List |
|---|---|---|---|---|
| 8035839 | 03/18/2016 | carisoprodol 350 mg | 03/18/2017 | 12/01/2016 |
| 8040707 | 03/18/2016 | carisoprodol 350 mg | 03/18/2017 | 12/01/2016 |
| 8041286 | 03/18/2016 | carisoprodol 350 mg | 03/18/2017 | 12/01/2016 |
| 8028008 | 02/29/2016 | metoprolol ER 50 mg | 02/28/2017 | 12/01/2015 |
| 8039175 | 02/29/2016 | metoprolol ER 50 mg | 02/28/2017 | 12/01/2015 |
| 8014007 | 03/12/2016 | metoprolol ER 50 mg | 03/12/2017 | 12/01/2015 |
| 8031950 | 03/11/2016 | levothyroxine 50 mcg | 03/11/2017 | 11/01/2016 |
| 8037256 | 03/11/2016 | levothyroxine 50 mcg | 03/11/2017 | 11/01/2016 |
| 8023760 | 03/21/2016 | levothyroxine 50 mcg | 03/11/2017 | 11/01/2016 |

| | | | | |
|---|---|---|---|---|
| 8041350 | 03/18/2016 | prednisone 20 mg | 03/17/2017 | 07/01/2016 |
| 8041067 | 03/16/2016 | prednisone 20 mg | 03/16/2017 | 07/01/2016 |
| 8041044 | 03/16/2016 | prednisone 20 mg | 03/16/2017 | 07/01/2016 |
| 8038371 | 02/19/2016 | prednisone 20 mg | 02/18/2017 | 07/01/2016 |
| 8024502 | 03/22/2016 | diazepam 5 mg | 03/22/2017 | 12/01/2016 |
| 8033502 | 03/22/2016 | diazepam 5 mg | 03/22/2017 | 12/01/2016 |
| 8041616 | 03/22/2016 | diazepam 5 mg | 03/22/2017 | 12/01/2016 |

## TWENTY-SEVENTH CAUSE FOR DISCIPLINE

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

105. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (o) and (j), in that Respondent, as pharmacist-in-charge of Ferry Pharmacy, violated title 16, CCR, section 1714, subdivisions (b) and (d), as follows:

a. On and between September 9, 2014 and March 23, 2016, Respondent failed to maintain the pharmacy and its facilities, space, fixtures and/or equipment so that drugs were safely and properly secured, resulting in significant shortages of the following controlled substances:

| **Drug** | **Shortage** |
|---|---|
| alprazolam 2 mg | -268 |
| buprenorphine 8 mg | -262 |
| methadone 10 mg | -341 |
| Promethazine/codeine liquid | -614 |
| Suboxone film 8/2 mg | -144 |
| Total: | -1,629 |

b. Respondent failed to ensure that the pharmacy's drug stock was secured with sufficient provisions for effective control against theft or diversion of controlled substances, resulting in a loss or shortage of 3,309 oxycodone 30 mg tablets as reported by Ferry's Pharmacy on or about June 29, 2015.

c. On or about March 23, 2016, Respondent held the following expired drugs for sale intermingled with the pharmacy's stock of non-expired drugs:

| **Drug** | **Expiration Date** |
|---|---|
| albuterol 2 mg/5 ml | 01/2016 |
| AzaSite | 07/31/2015 |
| Comtan 200 mg | 09/2015 |
| Depakote 500 mg | 07/26/2015 |
| Depakote ER 250 mg | 04/11/2015 |
| hydroxyzine pamoate 25 mg | 08/2015 |
| Lipitor 40 mg | 10/2015 |
| Lipitor 80 mg | 08/2015 |
| Marinol 5 mg | 01/2016 |
| Oxycontin 80 mg | 01/2016 |
| Phenadoz 25 mg supp. | 09/2015 |
| Phenadoz 25 mg supp. | 09/2015 |
| **Drug** | **Expiration Date** |
| Ritalin LA 30 mg | 02/2016 |
| Sensipar 30 mg | 06/2015 |
| Strattera 25 mg | 10/2015 |
| Theo-24 200 mg | 08/2015 |
| valcyclovir 500 mg | 01/2016 |

d. Respondent held an additional 102 packages of expired drugs for sale in the pharmacy's drug stock, some of which had been expired for up to one year.

**TWENTY-EIGHTH CAUSE FOR DISCIPLINE**

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

106. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (o), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated Code sections 4081, subdivision (a), and 4105, subdivisions (a) through (c), and Title 16, CCR, section 1718, as follows: On and between September 9, 2014 and March 23, 2016, Respondent failed to maintain an accurate or current inventory of all dangerous drugs in the pharmacy, resulting in significant shortages and overages of controlled substances, as follows:

| Drug | Shortage or Overage |
|---|---|
| alprazolam 2 mg | -268 |
| buprenorphine 8 mg | -262 |
| hydrocodone/APAP 10/325 mg | 3,986 |
| hydrocodone/APAP 5/325 mg | 1,135 |
| methadone 10 mg | -341 |
| Promethazine/codeine liquid | -614 |
| Suboxone film 8/2 mg | -144 |

**TWENTY-NINTH CAUSE FOR DISCIPLINE**

**(Violations of Requirements for Controlled Substance Prescriptions)**

107. Respondent Ferry is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (j), in that Respondent, as pharmacist-in-charge of Ferrys Pharmacy, violated state laws regulating controlled substances, as follows:

a. Respondent filled and dispensed the following controlled substance prescriptions pursuant to faxed prescriptions which did not have the signature and date handwritten in ink by the prescriber, in violation of Health and Safety Code section 11164, subdivision (a)(1):

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| Date | Number | Drug |
|---|---|---|
| 09/03/2013 | 4645430 | zolpidem 10 mg |
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| 11/05/2013 | 4652898 | modafinil 200 mg |
| 12/03/2013 | 4656206 | carisoprodol 350 mg |
| 01/17/2014 | 3661590 | Depo-Testosterone |
| 04/04/2014 | 3671249 | estrogens-methyltestosterone |
| 12/11/2014 | 4702921 | zolpidem 10 mg |
| 05/09/2015 | 8009173 | estrogens-methyltestosterone |

b. Respondent dispensed controlled substance prescriptions, specifically, prescription number 3642972 issued on August 13, 2013, for 240 tablets of hydrocodone/APAP 10/325 mg (the prescriber was from the state of Oregon), and prescription number 3644395 issued on August 23, 2013, for 90 tablets of hydrocodone/APAP 10/325 mg (the prescriber was from the state of Maryland), that were not in compliance with Health and Section 11162.1 in that the prescription forms were not printed with the following features:

1. A latent, repetitive "void" pattern printed across the entire front of the prescription if the prescription was scanned or photocopied;

2. A watermark printed on the backside of the prescription blank with the words "California Security Prescription";

3. A description of the security features included on the prescription form;

4. Six quantity check off boxes printed on the form so that the prescriber may indicate the quantity by checking the applicable box;

5. A statement printed on the bottom of the prescription blank that the "Prescription is void if the number of drugs prescribed is not noted;

6. A check box indicating the prescriber's order not to substitute;

7. An identifying number assigned to the approved security printer by the Department of Justice; and/or

8. The lot number printed on the form and each form within that batch numbered sequentially.

**OTHER MATTERS**

108. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 19913, issued to Ferrys Pharmacy, Inc., doing business as Ferrys Pharmacy, then Ferrys Pharmacy, Inc. shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 19913 is placed on probation or until Pharmacy Permit Number PHY 19913 is reinstated if it is revoked.

109. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 19913, issued to Ferrys Pharmacy, Inc., doing business as Ferrys Pharmacy, then while Respondent Daniel Owen Ferry has been an officer and owner and had knowledge of or knowingly participated in any conduct for which the licensee was disciplined, Respondent Daniel Owen Ferry shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 19913 is placed on probation or until Pharmacy Permit Number PHY 19913 is reinstated if it is revoked.

110. Pursuant to Code section 4307, if discipline is imposed on Pharmacist License Number RPH 24741, issued to Daniel Owen Ferry, then Respondent Ferry shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacist License Number RPH 24741 is placed on probation or until Pharmacist License Number RPH 24741 is reinstated if it is revoked.

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## PRAYER

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

1. Revoking or suspending Pharmacy Permit Number PHY 19913, issued to Ferrys Pharmacy, Inc., doing business as Ferrys Pharmacy;

2. Revoking or suspending Pharmacist License Number RPH 24741, issued to Daniel Owen Ferry;

3. Prohibiting Ferrys Pharmacy, Inc., doing business as Ferrys Pharmacy from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 19913 is placed on probation or until Pharmacy Permit Number PHY 19913 is reinstated if Pharmacy Permit Number PHY 19913 is revoked;

4. Prohibiting Daniel Owen Ferry and Dorothy Ann Ferry from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 19913 is placed on probation or until Pharmacy Permit Number PHY 19913 is reinstated if Pharmacy Permit Number PHY 19913 is revoked;

5. Prohibiting Daniel Owen Ferry and Dorothy Ann Ferry from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacist License Number RPH 24741 is placed on probation or until Pharmacist License Number RPH 24741 is reinstated if Pharmacist License Number RPH 24741 is revoked;

6. Ordering Ferrys Pharmacy, Inc., doing business as Ferrys Pharmacy, and Daniel Owen Ferry, to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

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

DATED: 9/16/17

Virginia Herold

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

SA2016103633