

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

**In the Matter of the Accusation Against:**

**SANTA MARIA PHARMACY, INC. DBA  
SANTA MARIA COMMUNITY PHARMACY,  
MARCOS ADEEB SOLIMAN,  
Pharmacy Permit No. PHY 50309; and**

**MARCOS ADEEB SOLIMAN,  
Pharmacist License No. RPH 59078; and**

**ROUFES RIMON MARKOS,  
Pharmacist License No. RPH 74602; and**

**ELIZABETH REYES,  
Pharmacy Technician Registration No. TCH 145367,**

**Respondents**

**Agency Case No. 6171**

**OAH No. 2019060105**

## DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order for Public Repeval is hereby adopted by the Board of Pharmacy, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective at 5:00 p.m. on January 20, 2021.

It is so ORDERED on December 21, 2020.

BOARD OF PHARMACY  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA



By

Greg Lippe  
Board President

1 XAVIER BECERRA  
Attorney General of California  
2 THOMAS L. RINALDI  
Supervising Deputy Attorney General  
3 CRISTINA FELIX  
Deputy Attorney General  
4 State Bar No. 195663  
300 So. Spring Street, Suite 1702  
5 Los Angeles, CA 90013  
Telephone: (213) 269-6321  
6 Facsimile: (916) 731-2126  
*Attorneys for Complainant*  
7

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

12 In the Matter of the Accusation Against:

13 **SANTA MARIA PHARMACY, INC. DBA**  
14 **SANTA MARIA COMMUNITY**  
15 **PHARMACY, MARCOS ADEEB**  
16 **SOLIMAN**  
17 **11004 Valley Mall**  
18 **El Monte, CA 91731**  
19 **Permit No. PHY 50309,**

20 **MARCOS ADEEB SOLIMAN**  
21 **691 Featherwood Dr.**  
22 **Diamond Bar, CA 91765**  
23 **Pharmacist License No. RPH 59078,**

24 **ROUFES RIMON MARKOS**  
25 **35894 Anderson Street**  
26 **Beaumont, CA 92223**  
27 **Pharmacist License No. RPH 74602,**

28 **and**

**ELIZABETH REYES**  
**4117 Cogswell Rd**  
**El Monte, CA 91732**  
**Pharmacy Technician Registration No. TCH**  
**145367**

Respondents.

Case No. 6171

OAH No. 2019060105

**STIPULATED SETTLEMENT AND**  
**DISCIPLINARY ORDER FOR PUBLIC**  
**REPROVAL AS TO ROUFES RIMON**  
**MARKOS ONLY**

[Bus. & Prof. Code § 495]

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

3 **PARTIES**

4 1. Anne Sodergren (Complainant) is the Interim Executive Officer of the Board of  
5 Pharmacy (Board). She brought this action solely in her official capacity and is represented in  
6 this matter by Xavier Becerra, Attorney General of the State of California, by Cristina Felix,  
7 Deputy Attorney General.

8 2. Respondent Roufes Rimon Markos (Respondent) is represented in this proceeding by  
9 attorney Noah E. Jussim Esq., whose address is: 633 West 5th Street, 47th Floor, Los Angeles,  
10 California, 90071.

11 3. On or about April 14, 2016, the Board issued Original Pharmacists License Number  
12 RPH 74602 to Respondent. The License was in full force and effect at all times relevant to the  
13 charges brought in Accusation No. 6171 and will expire on August 31, 2021.

14 **JURISDICTION**

15 4. The Second Amended Accusation (Accusation) No. 6171 was filed before the Board  
16 of Pharmacy (Board), Department of Consumer Affairs, and is currently pending against  
17 Respondent. The Accusation and all other statutorily required documents were properly served  
18 on Respondent on December 5, 2019. Respondent timely filed its Notice of Defense contesting  
19 the Accusation. A copy of Accusation No. 6171 is attached as exhibit A and incorporated herein  
20 by reference.

21 **ADVISEMENT AND WAIVERS**

22 5. Respondent has carefully read, fully discussed with counsel, and understands the  
23 charges and allegations in Accusation No. 6171. Respondent has also carefully read, fully  
24 discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary  
25 Order for Public Repeval.

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1 between the parties, and the Board shall not be disqualified from further action by having  
2 considered this matter.

3 12. The parties understand and agree that Portable Document Format (PDF) and facsimile  
4 copies of this Stipulated Settlement and Disciplinary Order for Public Repeval, including  
5 Portable Document Format (PDF) and facsimile signatures thereto, shall have the same force and  
6 effect as the originals.

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

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

17 **DISCIPLINARY ORDER**

18 IT IS HEREBY ORDERED that Original Pharmacists License Number RPH 74602 to  
19 Respondent Roufes Rimon Markos (Respondent) shall be publicly reprovved by the Board of  
20 Pharmacy under Business and Professions Code section 495 in resolution of Accusation No.  
21 6171, attached as exhibit A.

22 **Cost Recovery.** Respondent shall pay \$2,500 to the Board for its costs associated with the  
23 investigation and enforcement of this matter. Respondent shall be permitted to pay these costs in  
24 a payment plan approved by the Board. If Respondent fails to pay the Board costs as ordered,  
25 Respondent shall not be allowed to renew his license until Respondent pays costs in full.

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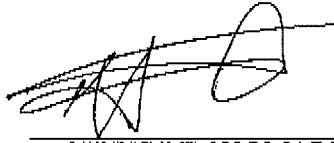
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1 ACCEPTANCE

2 I have carefully read the above Stipulated Settlement and Disciplinary Order for Public  
3 Reapproval and have fully discussed it with my attorney, Noah E. Jussim Esq. I understand the  
4 stipulation and the effect it will have on my Original Pharmacists License Number RPH 74602. I  
5 enter into this Stipulated Settlement and Disciplinary Order for Public Reapproval voluntarily,  
6 knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of  
7 Pharmacy.


8  
9 DATED: 1/6/20



10 \_\_\_\_\_  
11 ROUFES RIMON MARKOS  
12 Respondent

13 I have read and fully discussed with Respondent Roufes Rimon Markos the terms and  
14 conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order  
15 for Public Reapproval. I approve its form and content.

16 DATED: 1/6/20

  
17 \_\_\_\_\_  
18 NOAH E. JUSSIM ESQ.  
19 Attorney for Respondent

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**ENDORSEMENT**

The foregoing Stipulated Settlement and Disciplinary Order for Public Repeval is hereby respectfully submitted for consideration by the Board of Pharmacy of the Department of Consumer Affairs.

DATED: \_\_\_\_\_

Respectfully submitted,  
XAVIER BECERRA  
Attorney General of California  
THOMAS L. RINALDI  
Supervising Deputy Attorney General

CRISTINA FELIX  
Deputy Attorney General  
*Attorneys for Complainant*

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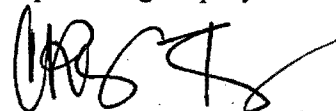
**ENDORSEMENT**

The foregoing Stipulated Settlement and Disciplinary Order for Public Repeval is hereby respectfully submitted for consideration by the Board of Pharmacy of the Department of Consumer Affairs.

DATED: January 7, 2020

Respectfully submitted,

XAVIER BECERRA  
Attorney General of California  
THOMAS L. RINALDI  
Supervising Deputy Attorney General



CRISTINA FELIX  
Deputy Attorney General  
*Attorneys for Complainant*

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**Exhibit A**

**Accusation No. 6171**

1 XAVIER BECERRA  
Attorney General of California  
2 THOMAS L. RINALDI  
Supervising Deputy Attorney General  
3 CRISTINA FELIX  
Deputy Attorney General  
4 State Bar No. 195663  
300 So. Spring Street, Suite 1702  
5 Los Angeles, CA 90013  
Telephone: (213) 897-2455  
6 Facsimile: (213) 897-2804  
*Attorneys for Complainant*

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

10 In the Matter of the Accusation Against:

Case No. 6171

11 **SANTA MARIA PHARMACY, INC. DBA**  
12 **SANTA MARIA COMMUNITY**  
13 **PHARMACY**  
14 **Marcos Adeeb Soliman, President & Owner**  
15 **11004 Valley Mall**  
16 **El Monte, CA 91731**  
17 **Pharmacy Permit No. PHY 50309**

**SECOND AMENDED ACCUSATION**

18 **MARCOS ADEEB SOLIMAN**  
19 **691 Featherwood Drive**  
20 **Diamond Bar, CA 91765**  
21 **Original Pharmacist License No. RPH 59078**

22 **ROUFES RIMON MARKOS**  
23 **35894 Anderson Street**  
24 **Beumont, CA 92223**  
25 **Original Pharmacist License No. RPH 74602**

26 **ELIZABETH REYES**  
27 **4117 Cogswell Road**  
28 **El Monte, CA 91732**  
**Pharmacy Technician Registration No. TCH**  
**145367**

Respondents.

Complainant alleges:

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1 **PARTIES**

2 1. Anne Sodergren (Complainant) brings this Second Amended Accusation solely in  
3 her official capacity as the Interim Executive Officer of the Board of Pharmacy, Department of  
4 Consumer Affairs (the Board).

5 2. On or about July 14, 2010, the Board issued Permit Number PHY 50309 to Santa  
6 Maria Pharmacy, Inc. dba Santa Maria Community Pharmacy (Respondent Santa Maria  
7 Community), Marcos Adeeb Soliman (Respondent PIC Soliman) has been the President and  
8 owner since July 14, 2010. The Permit was in full force and effect at all times relevant to the  
9 charges brought herein and will expire on July 1, 2020, unless renewed. Respondent PIC  
10 Soliman has been the Chief Executive Officer and Chief Financial Officer since October 26, 2010  
11 and the Pharmacist-in-Charge since July 14, 2010.

12 3. On or about October 24, 2006, the Board issued Original Pharmacist License Number  
13 RPH 59078 to Respondent PIC Soliman. The License was in full force and effect at all times  
14 relevant to the charges brought herein and will expire on May 31, 2020.

15 4. On or about April 14, 2016, the Board issued Original Pharmacist License Number  
16 RPH 74602 to Respondent Roufes Rimon Markos (Respondent Markos). The License was in  
17 full force and effect at all times relevant to the charges brought herein and will expire on August  
18 31, 2021.

19 5. On or about February 11, 2015, the Board issued Pharmacy Technician Registration  
20 Number TCH 145367 to Elizabeth Reyes (Respondent Reyes). The Registration was in full force  
21 and effect at all times relevant to the charges brought herein and will expire on October 31, 2020.

22 **JURISDICTION**

23 6. This Second Amended Accusation is brought before the Board, under the authority of  
24 the following laws. All section references are to the Business and Professions Code unless  
25 otherwise indicated.

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28 ///

1 7. Section 4300 of the Code states:

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

3 . . ."

4 8. Section 4300.1 of the Code states, in pertinent part:

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

10 **STATUTORY PROVISIONS**

11 9. Section 4301 of the Code states:

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

15 . . .

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

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

21 . . .

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

26 . . .

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

1       ...”

2       10. Section 4076 of the Code states:

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

5       ...

6       (11)(A) Commencing January 1, 2006, the physical description of the dispensed  
7 medication, including its color, shape, and any identification code that appears on the tablets or  
8 capsules, except as follows:

9       (i) Prescriptions dispensed by a veterinarian.

10       (ii) An exemption from the requirements of this paragraph shall be granted to a new drug  
11 for the first 120 days that the drug is on the market and for the 90 days during which the national  
12 reference file has no description on file.

13       (iii) Dispensed medications for which no physical description exists in any commercially  
14 available database.

15       ...”

16       11. Section 4077 of the Code states:

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

20       ...”

21       12. Section 4081 of the Code states:

22       “(a) All records of manufacture and of sale, acquisition, receipt, shipment, or disposition of  
23 dangerous drugs or dangerous devices shall be at all times during business hours open to  
24 inspection by authorized officers of the law, and shall be preserved for at least three years from  
25 the date of making. A current inventory shall be kept by every manufacturer, wholesaler, third  
26 party logistics provider, pharmacy, veterinary food-animal drug retailer, physician, dentist,  
27 podiatrist, veterinarian, laboratory, clinic, hospital, institution, or establishment holding a  
28 currently valid and unrevoked certificate, license, permit, registration, or exemption under

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

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

8 ...”

9 13. Section 4105, subdivision (d)(1) states: “Any records that are maintained  
10 electronically shall be maintained so that the pharmacist-in-charge, or the pharmacist on duty if  
11 the pharmacist-in-charge is not on duty, shall, at all times during which the licensed premises are  
12 open for business, be able to produce a hardcopy and electronic copy of all records of acquisition  
13 or disposition or other drug or dispensing-related records maintained electronically.”

14 14. Section 4113 states in pertinent part:

15 “(a) Every pharmacy shall designate a pharmacist-in-charge and within 30 days thereof,  
16 shall notify the board in writing of the identity and license number of that pharmacist and the date  
17 he or she was designated.

18 ...

19 (c) The pharmacist-in-charge shall be responsible for a pharmacy’s compliance with all  
20 state and federal laws and regulations pertaining to the practice of pharmacy.

21 ...”

22 15. Section 4114 states in pertinent part:

23 “(a) An intern pharmacist may perform all functions of a pharmacists at the discretion of  
24 and under the direct supervision and control of a pharmacist whose license is in good standing  
25 with the board.

26 (b) A pharmacists may not supervise more than two intern pharmacists at any one time.”

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1           16. Section 4115 states in pertinent part:

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

6           (b) This section does not authorize the performance of any tasks specified in subdivision (a)  
7 by a pharmacy technician without a pharmacist on duty.

8           ...

9           (e) A person shall not act as a pharmacy technician without first being licensed by the  
10 board as a pharmacy technician.

11           (f)(1) A pharmacy with only one pharmacist shall have no more than one pharmacy  
12 technician performing the tasks specified in subdivision (a). The ratio of pharmacy technicians  
13 performing the tasks specified in subdivision (a) to any additional pharmacist shall not exceed  
14 2:1, except that this ratio shall not apply to personnel performing clerical functions pursuant to  
15 Section 4116 or 4117. This ratio is applicable to all practice settings, except for an inpatient of a  
16 licensed health facility, a patient of a licensed home health agency, as specified in paragraph (2),  
17 an inmate of a correctional facility of the Department of Corrections and Rehabilitation, and for a  
18 person receiving treatment in a facility operated by the State Department of State Hospitals, the  
19 State Department of Developmental Services, or the Department of Veterans Affairs.”

20           17. Section 4115.5 states in pertinent part:

21           “(b) (4) A pharmacist may only supervise one pharmacy technician trainee at any given  
22 time.

23           ...

24           (e) A pharmacy technician trainee participating in an externship as described in subdivision  
25 (a) shall wear identification that indicates his or her trainee status.”

26           18. Section 4169 states in pertinent part:

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

28           ...

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

4 19. Section 4307 of the Code states:

5 “(a) Any person who has been denied a license or whose license has been revoked or is  
6 under suspension, or who has failed to renew his or her license while it was under suspension, or  
7 who has been a manager, administrator, owner, member, officer, director, associate, partner, or  
8 any other person with management or control of any partnership, corporation, trust, firm, or  
9 association whose application for a license has been denied or revoked, is under suspension or has  
10 been placed on probation, and while acting as the manager, administrator, owner, member,  
11 officer, director, associate, partner, or any other person with management or control had  
12 knowledge of or knowingly participated in any conduct for which the license was denied,  
13 revoked, suspended, or placed on probation, shall be prohibited from serving as a manager,  
14 administrator, owner, member, officer, director, associate, partner, or in any other position with  
15 management or control of a licensee as follows:

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

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

20 (b) “Manager, administrator, owner, member, officer, director, associate, partner, or any  
21 other person with management or control of a license” as used in this section and Section 4308,  
22 may refer to a pharmacist or to any other person who serves in such capacity in or for a licensee.

23 (c) The provisions of subdivision (a) may be alleged in any pleading filed pursuant to  
24 Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code.  
25 However, no order may be issued in that case except as to a person who is named in the caption,  
26 as to whom the pleading alleges the applicability of this section, and where the person has been  
27 given notice of the proceeding as required by Chapter 5 (commencing with Section 11500) of Part  
28 1 of Division 3 of the Government Code. The authority to proceed as provided by this subdivision

1 shall be in addition to the board’s authority to proceed under Section 4339 or any other provision  
2 of law.”

3 20. Health and Safety Code Section 111295 states: “It is unlawful for any person to  
4 manufacture, sell, deliver, hold, or offer for sale any drug or device that is adulterated.”

5 21. Health and Safety Code Section 111335 states: “Any drug or device is misbranded if  
6 its labeling or packaging does not conform to the requirements of Chapter 4 (commencing with  
7 Section 110290).”

8 22. Health and Safety Code Section 111440 states: “It is unlawful for any person to  
9 manufacture, sell, deliver, hold, or offer for sale any drug or device that is misbranded.”

10 **REGULATORY AUTHORITY**

11 23. Code of Regulations, title 16, section 1793.2, states in pertinent part:

12 ‘Nondiscretionary tasks’ as used in Business and Professions Code section 4115: include:  
13 (a) removing the drug or drugs from stock; (b) counting, pouring, or mixing pharmaceuticals; (c)  
14 placing the product into a container; (d) affixing the label or labels to the container; (e) packaging  
15 and repackaging.”

16 24. Code of Regulations, title 16, section 1793.7, states in pertinent part:

17 “. . .

18 (c) A pharmacy technician must wear identification clearly identifying him or her as a  
19 pharmacy technician.

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

25 (e) A pharmacist shall be responsible for all activities of pharmacy technicians to ensure  
26 that all such activities are performed completely, safely and without risk of harm to patients.”

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1 **COST RECOVERY PROVISION**

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

6 **RELEVANT FACTS**

7 **September 29, 2016 Inspection by Inspectors AY and KS**

8 26. On September 29, 2016, at approximately 2:30 p.m., Board inspectors arrived for an  
9 inspection of Respondent Santa Maria Community located in El Monte. While they were in a  
10 vehicle in Respondent Santa Maria’s parking lot, the inspectors observed pharmacist Respondent  
11 Markos, and a female, enter the pharmacy. At approximately 3:20 p.m., while one inspector, AY  
12 entered through the front door, another inspector, KS stayed near the back door. A few minutes  
13 after Inspector AY entered through the front, approximately eight individuals came running out  
14 the back door of Respondent Santa Maria Community, including, pharmacy technician HRRA,  
15 technician HM and ST, three additional employees that drove off in a car, a man wearing a badge  
16 indicating “Harout” and “driver,” and CB who stated she was a “driver.” The inspector  
17 attempted to get each person to provide identities and provide their position at Respondent Santa  
18 Maria Community. Inspector KS was unable to obtain all the employees’ names because some  
19 ran off.

20 27. Inspector AY entered Respondent Santa Maria Community through the front and  
21 noticed several employees leave through the back of the pharmacy. These employees did not  
22 return to the pharmacy. Inspector AY saw thirteen employees inside and obtained their identities.  
23 Respondent Markos was present and was the only pharmacist on duty. Inspector AY observed  
24 Pharmacy Technicians PO and Respondent Reyes performing technician duties, including pulling  
25 and filling prescriptions. Pharmacy Technicians WB, YP and DM were also present. Inspector  
26 AY also observed extern technician trainees EJ, VV and AS filling prescriptions and bubble  
27 cards. The technician trainees were not wearing any identification badges. Extern technician  
28

1 trainee EJ advised Inspector AY that he lost his badge and extern technician trainee AS left the  
2 pharmacy and did not return. Pharmacy clerks AT, NG and staff AB were also present.

3 28. A copy of the pharmacy work schedule was posted in the pharmacy which indicated  
4 that on September 29, 2016, 17 individuals were scheduled to work that day. The pharmacist,  
5 intern pharmacists, technician trainees and AB were not among the 17 employees listed on the  
6 pharmacy work schedule. The earliest time an employee was scheduled to be off of work was at  
7 6:00 p.m., so all the employees who left the pharmacy and did not return, were not scheduled to  
8 be off from work. According to the schedule, 7 technicians were scheduled to work and perform  
9 technician duties with one pharmacist on duty.

10 29. Inspector KS and Inspector AY conducted an inspection of Respondent Santa Maria  
11 Community which consisted of several areas, including a customer waiting area in the front, a  
12 prescription pick up area with a cash register adjacent to the prescription will call area, a large  
13 pharmacy drug dispensing area separated between the retail drug dispensing area in the front and  
14 board and care area in the back, pharmacy record storage area, and offices for AB and the  
15 pharmacist-in-charge.

16 30. AB's office led into Respondent PIC Soliman's office which had a second exit door  
17 opening into the rear of the dispensing area. Inspector AY walked into both offices. Inspector  
18 AY found approximately 15 amber prescription vials labeled with drug name and expiration date  
19 written on a white label or directly on the vial and the medications appeared to be brand name  
20 medications and appeared to still be in date. AB advised Inspector AY that these drugs were  
21 going to be sent to RX Distributors for destruction. The drugs were not yet expired. Inspector AY  
22 photographed the contents of the box.

23 31. When Inspector AY re-entered Respondent PIC Soliman's office at a later time, she  
24 noticed that the prescription vials appeared different from the ones she had originally inspected.  
25 She reviewed the pictures she had of the original box and confirmed the contents of the box had  
26 been changed by someone during the inspection. After being advised of the missing vials, AB  
27 appeared to be searching for the missing medication. AB eventually admitted that she pulled the  
28 missing prescription vials from the box herself and moved them to another location.

1           32. Next to the center work station by the board and care dispensing area, Inspector AY  
2 saw a large box, marked with “AM” on the top flap, filled with empty punched out medication  
3 bubble cards. A smaller box was located next to the large box which was filled with full and  
4 partially used bubble cards. She also observed rows of hundreds of bubble cards, both full and  
5 used cards, arranged in alphabetical order located in the drawers under two separate pharmacy  
6 workstations in the board and care filling area.

7           33. Towards the rear area of Respondent Santa Maria Community, Inspector AY saw  
8 numerous bags and boxes of returned medication and bubble cards on the ground, boxes of  
9 medication overstock, overstock medication stored on shelving units against the back wall, boxes  
10 of medication labeled as expired, box of empty amber prescription vials labeled with drug name  
11 and expiration date, box of amber prescription vials labeled with drug name and expiration date  
12 containing various quantities of medication which were then placed in individual plastic baggies.

13           34. In the area designated for filling 30 day bubble cards, Board Inspectors saw hundreds  
14 of used bubble cards organized in alphabetical order and stored adjacent to where the technicians  
15 processed and filled new 30 day bubble cards. Some of the cards contained the address of  
16 Respondent Santa Maria. Also, nearby were trash bags with empty bubble cards and a box with  
17 prescription vials of loose tablets of drugs.

18           35. While at the pharmacy dispensing area near where the bubble cards were located,  
19 trainee EJ advised Inspector KS that technicians filled bubble cards. Trainee EJ saw technicians  
20 package the bubble cards and that technicians filling the bubble cards would take the drugs from  
21 the partially used cards if there was a drug they needed.

22           36. Respondent PIC Soliman, the pharmacist-in-charge of Respondent Santa Maria  
23 Community, arrived at the pharmacy at approximately 4:20 p.m. and assisted with the Inspection.  
24 When discussing the employees, Respondent PIC Soliman advised Inspector KS that employees  
25 rushed out as it was probably their lunchtime. When Inspector KS advised him that it was now  
26 7:00 p.m. and none had returned, Respondent PIC Soliman did not have a response. When  
27 questioned regarding the compounded preparation labels, Respondent PIC Soliman stated that his  
28 pharmacy no longer compounded and compounding was conducted at another pharmacy, San

1 Marcos Pharmacy, Inc. dba Santa Maria Pharmacy, which was located in Paramount, and he  
2 believed they were there due to a delivery error.

3 37. The Board inspectors also observed numerous bottles of pre-packed medication  
4 prescription vials in the shelves under the center board and care workstation. Some were labeled  
5 with a black marker with the quantity and expiration date, while others were not labeled at all. A  
6 few of the vials were labeled with a prescriber office information and drug name, quantity,  
7 expiration date and drug directions. Respondent PIC Soliman advised Inspectors that the vials  
8 contained cephalexin 500 mg, folic acid 1mg and ferrous sulfate 325 mg.

9 38. Inspector AY also reviewed random will call prescriptions and found that the  
10 description printed on the label did not match the description of the actual tablet. Respondent PIC  
11 Soliman acknowledged that the descriptions were incorrect. He also acknowledged that his  
12 pharmacy's current software program did not have the capability of capturing and maintaining the  
13 pharmacist's verification of each and every prescription.

14 **September 30, 2016 Inspection by Inspectors SB and AY**

15 39. Inspectors SB and AY re-inspected Respondent Santa Maria Community on  
16 September 30, 2016. Clerk NG, Respondent Reyes and pharmacist IN were present. Technician  
17 trainee Victor Valencia was also present and was pulling empty bubble cards from a large box  
18 and removing the prescription labels.

19 40. At the back of the pharmacy, the inspectors found that drawers located under the  
20 bubble card filling stations were filled with hundreds of bubble cards alphabetically organized.  
21 They contained labels from Respondent Santa Maria Community and another pharmacy, San  
22 Marcos Pharmacy Inc. dba Santa Maria Pharmacy, which was located in Paramount. The bubble  
23 cards affixed with the yellow top background on the prescription labels were dispensed by  
24 Respondent Santa Maria Community.

25 41. Board inspectors also found two baskets full of prescription vials containing loose  
26 tablets of medication at the rear area of the pharmacy. The vials were labeled with drug name  
27 and expirations dates that had not yet expired.  
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1           42. Respondent PIC Soliman arrived at the pharmacy about an hour after the inspection  
2 began.

3           **October 28, 2016 Inspection by Inspector SB**

4           43. On October 28, 2016, Inspector SB inspected Respondent Santa Maria Community.  
5 Respondent Markos was the only pharmacist on duty. Later, Respondent PIC Soliman arrived at  
6 the pharmacy and assisted the inspection. A stock on hand audit was conducted for several  
7 medications. While the inspector was reviewing pharmacy records on the computer, the  
8 computer shut off and stopped working. Inspector SB requested acquisition and dispensing  
9 records (Drug Utilization Report (DUR)) from Respondent Santa Maria Community to be  
10 produced within seven (7) business days and, as of February 7, 2017, the requested records had  
11 not been provided.

12           44. On February 7, 2017, Respondent PIC Soliman advised Inspector SB that Digital RX  
13 accidentally sent the records she was requesting to him instead. On February 9, 2017, Respondent  
14 PIC Soliman emailed a DUR to Inspector SB. However, some of the borders of the tables on the  
15 spreadsheet appeared to be cut off or altered. Inspector SB went to Respondent Santa Maria  
16 Community to obtain these records.

17           **February 9, 2017 Inspection by Inspector SB**

18           45. On February 9, 2017, Inspector SB again inspected Respondent Santa Maria  
19 Community. Inspector SB asked Respondent PIC Soliman to call Digital RX so that she could  
20 talk with their representatives regarding the pharmacy's records. Respondent Reyes advised the  
21 inspector that they could not generate any reports because Digital DX was conducting  
22 maintenance for the next two hours. Inspector SB requested a new DUR with additional  
23 information.

24           46. The next day, on February 10, 2017, Inspector SB spoke with Digital RX and they  
25 confirmed that they were not doing maintenance the day before as Respondent Reyes had alleged.

26           47. On February 12, 2016, Respondent PIC Soliman sent a new DUR to Inspector SB.

27           48. On February 13, 2017, Inspector SB called Digital RX and confirmed that in October  
28 of 2016, someone from Respondent Santa Maria Community called them regarding technical

1 support in generating a DUR and they were provided instructions as to how to print the report.  
2 Digital RX was not supposed to send any reports directly to the Board. Digital RX also  
3 confirmed that on February 9, 2017, Respondent Santa Maria Community attempted to generate a  
4 prescription details report for records in 2014 to 2016 and, due to the date range, the report server  
5 responded slowly and therefore, Respondent Santa Maria Community was unable to generate the  
6 report at that time. Digital RX was not conducting maintenance on February 9, 2017.

7 **FIRST CAUSE FOR DISCIPLINE**

8 **(Violation of Technician Ratios)**

9 **(Respondent Santa Maria Community,**

10 **Respondent PIC Soliman, and Respondent Markos)**

11 49. Respondent Santa Maria Community, Respondent PIC Soliman, and Respondent  
12 Markos are subject to disciplinary action under section 4115, subdivision (f)(1), and section 4113,  
13 subdivision (c), in that, on September 29, 2016, Technicians PO and Respondent Reyes were  
14 performing technician duties with only one pharmacist, Respondent Markos present and on duty  
15 at Respondent Santa Maria Community, as set forth in paragraphs 26 through 28, which are  
16 incorporated herein.

17 **SECOND CAUSE FOR DISCIPLINE**

18 **(Violation of Technician Trainee Ratios)**

19 **(Respondent Santa Maria Community,**

20 **Respondent PIC Soliman, and Respondent Markos)**

21 50. Respondent Santa Maria Community, Respondent PIC Soliman, and Respondent  
22 Markos are subject to disciplinary action under section 4115.5, subdivision (b)(4) and section  
23 4113, subdivision (c), in that, on September 29, 2016, only one pharmacist Respondent Markos  
24 was present on duty at Respondent Santa Maria Community supervising three technician trainees  
25 EJ, VV, AS, as set forth in paragraphs 26 through 28, which are incorporated herein.

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1 **THIRD CAUSE FOR DISCIPLINE**

2 **(Violation of Technician Trainee Identification)**

3 **(Respondent Santa Maria Community,**

4 **Respondent PIC Soliman, and Respondent Markos)**

5 51. Respondent Santa Maria Community, Respondent PIC Soliman, and Respondent  
6 Markos are subject to disciplinary action under section 4115.5, subdivision (e), and section 4113,  
7 subdivision (c), in that, on September 29, 2016, technician trainees EJ, VV, AS were not wearing  
8 identification, as set forth in paragraph 27, which is incorporated herein.

9 **FOURTH CAUSE FOR DISCIPLINE**

10 **(Violation of Prescription Container Labeling Requirements)**

11 **(Respondent Santa Maria Community and Respondent PIC Soliman)**

12 52. Respondents Santa Maria Community and PIC Soliman are subject to disciplinary  
13 action under sections 4076, subdivision (a)(11)(A), section 4077, subdivision (a), and section  
14 4113, subdivision (c), in that, on September 29, 2016, in an inspection by the Board, nine out of  
15 the ten randomly reviewed prescriptions from the will call area were printed with the incorrect  
16 physical description of the medication contained inside the prescription container as follows, as  
17 set forth in paragraph 38, which is incorporated herein:

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Date	RX#	Drug	Incorrect Label ID	Actual ID
9/27/2016	966850	Metformin 1000mg	White, oval, IP220, 1000	White, H, 104
9/27/2016	966855	Lisinopril 20mg	White, round, V 3973	Pink, round, Lupin, 20
9/21/2016	964238	Vitamin D3 5000U	White, oblong	Yellow gelcap
9/27/2016	966959	Famotidine 40 mg	Brown, BicL 114	White, round, CTI122
9/27/2016	966962	Ondansetron 4 mg	White, oval, 130	White, oval, F,91
9/23/2016	965680	Cephalexin 500 mg	Dark, green, oblong, J2 J2	Red, capsule, 3147, Teva
N/A	962353	Cephalexin 500 mg	Dark green, oblong, A43, 500 mg	Red, capsule, 3147, Teva
9/27/2016	966852	Atrovastatin 40 mg	HLA40	White, oblong, 40

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9/26/2016	966616	Folic Acid 1 mg	Light Yellow, round, V 3162	Yellow, round, AN 361
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**FIFTH CAUSE FOR DISCIPLINE**

**(Possession of Misbranded Drugs)**

**(Respondent Santa Maria Community and Respondent PIC Soliman)**

53. Respondents Santa Maria Community and PIC Soliman are subject to disciplinary action under section 4169, subdivision (a)(3), section 4113, subdivision (c), and Health and Safety Code sections 111335 and 111440 in that, on September 29, 2016, Respondent Santa Maria Community was in possession of misbranded medications. Respondent Santa Maria Community pre-packaged medications but the pre-packaged prescription vials were not properly labeled with the drug name, strength, lot number, expiration date and/or quantity of the drug, as set forth in paragraph 37, which is incorporated herein.

**SIXTH CAUSE FOR DISCIPLINE**

**(Possession of Adulterated Drugs)**

**(Respondent Santa Maria Community and Respondent PIC Soliman)**

54. Respondents Santa Maria Community and PIC Soliman are subject to disciplinary action under section 4113, subdivision (c), and Health and Safety Code section 111295, in that, on September 29, 2016 and on September 30, 2016, Respondent Santa Maria Community was in possession of hundreds of adulterated medication bubble cards, as set forth in paragraphs 29 through 35 and 40 through 41, which are incorporated herein.

**SEVENTH CAUSE FOR DISCIPLINE**

**(Subverting an Investigation by the Board)**

**(Respondent Santa Maria Community and Respondent PIC Soliman)**

55. Respondents Santa Maria Community and PIC Soliman are subject to disciplinary action under section 4301, subdivisions (f) and (q), and section 4113, subdivision (c), in that, on September 29, 2016, at an inspection by the Board, an Santa Maria Community employee, AB, hid medication prescription vials and switched them with different medication prescription vials and claimed to have no knowledge of the switching or whereabouts of the original prescriptions

1 vials as set forth in paragraphs 30 through 31, which are incorporated herein. AB then admitted  
2 that she removed the prescription vials from the original location and replaced them with other  
3 vials.

4 **EIGHTH CAUSE FOR DISCIPLINE**

5 **(Subverting an Investigation by the Board- Records and False Statement)**

6 **(Respondent Santa Maria Community and Respondent PIC Soliman)**

7 56. Respondents Santa Maria Community and PIC Soliman are subject to disciplinary  
8 action under section 4301, subdivisions (f) and (q), section 4105, subdivision (d)(1), section 4081,  
9 subdivision (a), and section 4113, subdivision (c), in that, on October 28, 2016, Inspector SB  
10 requested Respondent PIC Soliman to submit dispensing and acquisition records for an audit  
11 within seven (7) days and Respondent PIC Soliman failed to provide the requested documents by  
12 that deadline, and falsely stated that Digital RX, a pharmacy software programmer, should have  
13 sent the records directly to Inspector SB, as set forth in paragraphs 43, through 44, which are  
14 incorporated herein.

15 **NINTH CAUSE FOR DISCIPLINE**

16 **(Subverting an Investigation by the Board - False Statement)**

17 **(Respondent Santa Maria Community and Respondent Reyes)**

18 57. Respondent Santa Maria Community and Respondent Reyes are subject to  
19 disciplinary action under section 4301, subdivisions (f) and (q), in that on February 9, 2017,  
20 Respondent Reyes falsely told Inspector SB that Digital RX was conducting maintenance and,  
21 therefore, they were allegedly not able to generate and print the dispensing records at the  
22 pharmacy, as set forth in paragraphs 45 through 46, which are incorporated herein.

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1                   **September 18, 2017 Inspection by Inspector AY, SB and KS**

2                   58. On May 3, 2017, the Board received an anonymous complaint alleging multiple  
3 violations of Pharmacy Law at Respondent Santa Maria Community.

4                   59. On September 18, 2017, Inspectors AY, S.B and KS again inspected Respondent  
5 Santa Maria Community. Inspector SB and KS entered the pharmacy through the front main  
6 entrance. Inspector AY entered from the back of the pharmacy.

7                   60. Because various employees ran out of pharmacy at a prior inspection, Inspector KS  
8 recorded her entry into the pharmacy and Inspector AY recorded her entry through the back of the  
9 pharmacy.

10                  61. When they began the inspection, Inspector AY saw several employees exit the rear of  
11 the pharmacy, including 1) HJ who identified himself as a pharmacy driver; 2) a female who  
12 refused to provide her name but was later identified by other pharmacy staff as AL, a pharmacy  
13 clerk; 3) BJ, who stated she was responsible for cleaning and completing paperwork; and 4) SS, a  
14 male who went back inside the pharmacy.

15                  62. While inside the pharmacy, Inspector KS walked into a small rear office where  
16 Respondent Markos was standing, said hello to the inspector and immediately got up and left.  
17 Three individuals in three distinct areas were left in the room with the inspector: 1) MB, who was  
18 seated before a computer and identified himself as a clerk; 2) YZ, also known as “Joe,” who was  
19 seated at a desk and had numerous drug stock bottles, prefilled prescription vials, counting trays,  
20 and order form in front of him. He was counting medications and was holding a prescription vial  
21 with pills inside, and 3) MP, stationed at another computer terminal and identified herself as a  
22 clerk.

23                  63. After questioning YZ, Inspector KS determined that he was counting pills, that he  
24 would label the bottles after he finished counting the pills, that the labels were located in the  
25 drawer, and that Joe had worked for the pharmacy for a year and a half to two years. During the  
26 inspection, YZ left the pharmacy and did not return. Other staff, including technician supervisor  
27 YP, and Respondent Markos referred to YZ as “Joe.” Respondent Markos advised the inspector  
28 that he did not know YZ’s last name. Respondent Markos also identified YZ as “Joe,” a

1 “pharmacy student” at “Western.” After questioning employee MP, Inspector SB confirmed that  
2 YZ was working on filling the amber vials. YP also provided the spelling of YZ’s last name to the  
3 inspector.

4 64. As Inspector AY entered the pharmacy through the rear door, she observed technician  
5 WB and clerks MS and MC on their lunch break in the break room. She also observed technician  
6 EJ filling prescriptions and not wearing any form of identification. EJ was seen wearing a name  
7 badge later in the inspection.

8 65. Inspectors AY, SB and KS inspected the medications at Joe’s work station. The top  
9 of the work area was filled with numerous prescriptions vials containing medications, bulk  
10 medication stock bottles, and a medication counting tray. Next to the medications was a two page  
11 medication order form which appeared to have been faxed to Respondent Santa Maria  
12 Community from Clinica Medica del Sol Group, Inc., on September 17, 2017.

13 66. The medication on the desk matched the medication listed on the medication order  
14 form. The number of prefilled medication vials corresponded exactly to the quantity ordered for  
15 each item on the order form. The only two medications listed on the medication order form not  
16 found on the desk were for amlodipine and over-the-counter acetaminophen drops.

17 67. Inspector KS found a badge with the name “Joe Z, Clerk” printed on it.

18 68. Michael Soliman, a pharmacist, came out of his office during the inspection and  
19 identified YZ also known as Joe as the “IT person” who worked three hours per day. He was  
20 unable to provide YZ’s name in full during the inspection.

21 69. Inspector AY obtained a copy of the pharmacy work schedule and noticed that there  
22 were many employees present at the time of the inspection that were not listed on the schedule.  
23 Several of these employees fled when the inspectors arrived.

24 70. Inspector AY issued written notices of non-compliance following the inspection and  
25 requested the pharmacy’s surveillance camera’s footage and additional documentation from  
26 Respondent PIC Soliman.

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1           **April 25, 2017 Inspection of West Glen Manor**

2           75. On April 25, 2017, Inspector AY inspected West Glen Manor, a licensed assisted  
3 living facility located in Westminister. Respondent Santa Maria Community provided their  
4 pharmaceutical services to this facility and used a pharmacy delivery driver, which included  
5 monthly cycle medication deliveries. Respondent Santa Maria Community provided West Glen  
6 Manor with “Take Away” medication disposal boxes for medication destruction and arranged for  
7 the destruction of medications by a third party. West Glen Manor placed medication cards into  
8 these destruction box for destruction. West Glen Manor would notify Respondent Santa Maria  
9 Community that the box was full and they would arrange for delivery of a new box.

10          76. Inspector AY’s investigation revealed that Respondent Santa Maria Community had  
11 purchased several Take Away Boxes from Sharps Compliance Inc. in April of 2017. However,  
12 the box Inspector AY saw at West Glen Manor on April 25, 2017 was not a Sharps Compliance  
13 Take Away box. The box contained a logo that was not found in Sharps Compliance Take Away  
14 Boxes. A “Take Away” envelope artwork was placed on a box to make it resemble a Sharps  
15 “Take Away” box.

16          77. After the inspection, Respondent Santa Maria Community arranged for the exchange  
17 of West Glen Manor’s destruction box.

18          78. On May 1, 2017, Respondent PIC Soliman advised Inspector AY that after a Board  
19 inspection last year, the pharmacy discontinued accepting any drugs back from facilities and that  
20 they provided guidance to the facilities on how to dispose of the medications themselves.  
21 Respondent PIC Soliman stated that he did not refer them to any destruction companies.

22          79. On May 8, 2017, Respondent PIC Soliman provided a written statement, via email, to  
23 Inspector AY stating that Respondent Santa Maria Community was not currently involved in any  
24 drug take-back service program and that facilities were advised to use their own take-back  
25 services. On May 17, 2017, Respondent PIC Soliman provided a signed copy of his written  
26 statement to Inspector AY

27          80. On June 19, 2017, written notices of non-compliance were served on Respondents.

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1 **TWELFTH CAUSE FOR DISCIPLINE**

2 **(Unprofessional Conduct- Fraudulent “Take- Away” Disposal Box)**

3 **(Respondent Santa Maria Community and Respondent PIC Soliman)**

4 81. Respondent Santa Maria Community and Respondent PIC Soliman are subject to  
5 disciplinary action under section 4301, subdivision (f), and 4113, subdivision (c), in that,  
6 Respondent Santa Maria Community created a fraudulent “Take Away” drug take-back box and  
7 provided it to West Glen Manor in April of 2017 to dispose of the facility’s destruction  
8 medications, as set forth in paragraphs 75 through 80, which are incorporated herein.

9 **THIRTEENTH CAUSE FOR DISCIPLINE**

10 **(Unprofessional Conduct- False Statement)**

11 **(Respondent Santa Maria Community and Respondent PIC Soliman)**

12 82. Respondent Santa Maria Community and Respondent PIC Soliman are subject to  
13 disciplinary action under section 4301, subdivisions (f) and (g), and section 4113, subdivision (c),  
14 in that, on May 8, 2017, Respondent PIC Soliman provided a false signed statement advising the  
15 Board that Respondent Santa Maria Community did not offer any kind of medication take-back  
16 service to the facilities it serviced and was not currently involved in any drug take-back program,  
17 as set forth in paragraphs 75 through 80, which are incorporated herein.

18 **OWNERSHIP PROHIBITION**

19 83. As set forth above, section 4307, subdivision (a), provides, in pertinent part, that any  
20 person whose license has been revoked or is under suspension shall be prohibited from serving as  
21 a manager, administrator, owner, member, officer, director, associate or partner of a licensee.

22 84. Pursuant to section 4307, if Marcos Adeeb Soliman had knowledge of, or knowingly  
23 participated in, any conduct for which Pharmacy Permit PHY 50309 was revoked, suspended or  
24 placed on probation, while acting as administrator, owner, officer, director, or any other person  
25 with management or control of Santa Maria Pharmacy, Inc. dba Santa Maria Community  
26 Pharmacy he shall be prohibited from serving as administrator, owner, member, officer, director,  
27 associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 50309 is  
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1 placed on probation, or until Pharmacy Permit Number PHY 50309 is reinstated if Pharmacy  
2 Permit Number PHY 50309 is revoked.

3 **PRAYER**

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

6 1. Revoking or suspending Permit Number PHY 50309, issued to Santa Maria  
7 Pharmacy, Inc. dba Santa Maria Community Pharmacy;

8 2. Prohibiting Marcos Adeeb Soliman from serving as a manager, administrator, owner,  
9 member, officer, director, associate, partner, or in any other position with management or control  
10 of a licensee, for five years if Pharmacy Permit Number PHY 50309 is placed on probation, or  
11 until Pharmacy Permit Number PHY 50309 is reinstated if Pharmacy Permit Number PHY 50309  
12 is revoked;

13 3. Revoking or suspending Pharmacist License No. RPH 59078 issued to Marcos Adeeb  
14 Soliman;

15 4. Revoking or suspending Pharmacist License No. RPH 74602 issued to Roufes Rimon  
16 Markos;

17 5. Revoking or suspending Pharmacy Technician Registration No. TCH 145367 issued  
18 to Elizabeth Reyes;

19 6. Ordering Santa Maria Pharmacy, Inc. dba Santa Maria Community Pharmacy,  
20 Marcos Adeeb Soliman, Roufes Rimon Markos and Elizabeth Reyes to pay the Board of  
21 Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to  
22 Business and Professions Code section 125.3; and,

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

DATED: December 4, 2019



Anne Sodergren  
Interim Executive Officer  
Board of Pharmacy  
Department of Consumer Affairs  
State of California  
*Complainant*

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