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

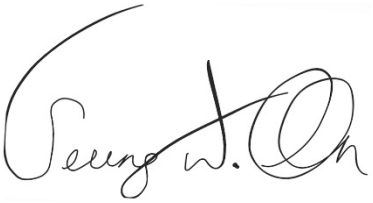
DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order for Public Reproval 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 February 24, 2022.

It is so ORDERED on January 25, 2022.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA



By

Seung W. Oh, Pharm.D.
Board President

ROB BONTA
Attorney General of California
THOMAS L. RINALDI
Supervising Deputy Attorney General
CRISTINA FELIX
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Attorneys for Complainant

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** **11004 Valley Mall** **El Monte, CA 91731** **Permit No. PHY 50309,** **MARCOS ADEEB SOLIMAN** **691 Featherwood Dr.** **Diamond Bar, CA 91765** **Pharmacist License No. RPH 59078,** **ROUFES RIMON MARKOS** **35894 Anderson Street** **Beaumont, CA 92223** **Pharmacist License No. RPH 74602,** **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 <u>AS TO ELIZABETH REYES ONLY</u>** **[Bus. & Prof. Code § 495]**

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

PARTIES

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

2. Respondent Elizabeth Reyes (Respondent) is represented in this proceeding by attorney Armond Marcarian, Esq., 21650 Oxnard Street, Suite 1980, Woodland Hills, CA 91367.

3. On or about February 11, 2015, the Board issued Pharmacy Technician Registration Number TCH 145367 to Respondent. The Registration was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2022.

JURISDICTION

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

ADVISEMENT AND WAIVERS

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

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

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

CULPABILITY

8. Respondent understands and agrees that the charges and allegations in Accusation No. 6171, if proven at a hearing, constitute cause for imposing discipline upon her registration.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up its right to contest those charges.

10. Respondent agrees that her pharmacy technician registration is subject to discipline and she agree to be bound by the Disciplinary Order below.

CONTINGENCY

11. This stipulation shall be subject to approval by the Board of Pharmacy. Respondent understands and agrees that counsel for Complainant and the staff of the Board of Pharmacy may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order for Public Reproval shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action

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

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

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Pharmacy Technician Registration Number TCH 145367 issued to Respondent Elizabeth Reyes (Respondent) shall be publicly reproved by the Board of Pharmacy under Business and Professions Code section 495 in resolution of Accusation No. 6171, attached as exhibit A.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order for Public Reproval and have fully discussed it with my attorney, Armond Marcarian, Esq. I understand the stipulation and the effect it will have on my pharmacy technician registration. I enter into this Stipulated Settlement and Disciplinary Order for Public Reproval voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: _____

ELIZABETH REYES
Respondent

I have read and fully discussed with Respondent Elizabeth Reyes the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order for Public Reproval. I approve its form and content.

DATED: _____

ARMOND MARCARIAN, ESQ.
Attorney for Respondent

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order for Public Reproval and have fully discussed it with my attorney, Armond Marcarian, Esq. I understand the stipulation and the effect it will have on my pharmacy technician registration. I enter into this Stipulated Settlement and Disciplinary Order for Public Reproval voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: 10/26/2021

ELIZABETH REYES
Respondent

I have read and fully discussed with Respondent Elizabeth Reyes the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order for Public Reproval. I approve its form and content.

DATED: October 27, 2021

ARMOND MARCARIAN, ESQ.
Attorney for Respondent

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ENDORSEMENT

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

DATED: _____

Respectfully submitted,

ROB BONTA
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 Reproval is hereby respectfully submitted for consideration by the Board of Pharmacy of the Department of Consumer Affairs.

DATED: 10/27/2021

Respectfully submitted,

ROB BONTA
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

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Attorney General of California
THOMAS L. RINALDI
Supervising Deputy Attorney General
CRISTINA FELIX
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Attorneys for Complainant

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, President & Owner** **11004 Valley Mall** **El Monte, CA 91731** **Pharmacy Permit No. PHY 50309** **MARCOS ADEEB SOLIMAN** **691 Featherwood Drive** **Diamond Bar, CA 91765** **Original Pharmacist License No. RPH 59078** **ROUFES RIMON MARKOS** **35894 Anderson Street** **Beumont, CA 92223** **Original Pharmacist License No. RPH 74602** **ELIZABETH REYES** **4117 Cogswell Road** **El Monte, CA 91732** **Pharmacy Technician Registration No. TCH 145367** Respondents.	Case No. 6171 **SECOND AMENDED ACCUSATION**

Complainant alleges:

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PARTIES

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

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

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

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

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

JURISDICTION

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

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7. Section 4300 of the Code states:

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

. . ."

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

"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."

STATUTORY PROVISIONS

9. Section 4301 of the Code states:

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

. . .

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

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

. . .

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

. . .

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

. . ."

10. Section 4076 of the Code states:

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

. . .

(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, except as follows:

(i) Prescriptions dispensed by a veterinarian.

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

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

. . ."

11. Section 4077 of the Code states:

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

…"

12. Section 4081 of the Code states:

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

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

. . ."

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

14. Section 4113 states in pertinent part:

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

. . .

(c) 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.

. . ."

15. Section 4114 states in pertinent part:

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

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

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16. Section 4115 states in pertinent part:

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

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

. . .

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

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

17. Section 4115.5 states in pertinent part:

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

. . .

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

18. Section 4169 states in pertinent part:

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

. . .

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

19. Section 4307 of the Code states:

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

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

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

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

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

shall be in addition to the board's authority to proceed under Section 4339 or any other provision of law."

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

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

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

REGULATORY AUTHORITY

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

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

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

" . . .

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

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

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

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COST RECOVERY PROVISION

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

RELEVANT FACTS

September 29, 2016 Inspection by Inspectors AY and KS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

September 30, 2016 Inspection by Inspectors SB and AY

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

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

41. Board inspectors also found two baskets full of prescription vials containing loose tablets of medication at the rear area of the pharmacy. The vials were labeled with drug name and expirations dates that had not yet expired.

42. Respondent PIC Soliman arrived at the pharmacy about an hour after the inspection began.

October 28, 2016 Inspection by Inspector SB

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

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

February 9, 2017 Inspection by Inspector SB

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

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

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

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

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

FIRST CAUSE FOR DISCIPLINE

(Violation of Technician Ratios)

(Respondent Santa Maria Community,

Respondent PIC Soliman, and Respondent Markos)

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

SECOND CAUSE FOR DISCIPLINE

(Violation of Technician Trainee Ratios)

(Respondent Santa Maria Community,

Respondent PIC Soliman, and Respondent Markos)

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

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THIRD CAUSE FOR DISCIPLINE

(Violation of Technician Trainee Identification)

(Respondent Santa Maria Community,

Respondent PIC Soliman, and Respondent Markos)

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

FOURTH CAUSE FOR DISCIPLINE

(Violation of Prescription Container Labeling Requirements)

(Respondent Santa Maria Community and Respondent PIC Soliman)

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

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

9/26/2016	966616	Folic Acid 1 mg	Light Yellow, round, V 3162	Yellow, round, AN 361

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 Adultered 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

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

EIGHTH CAUSE FOR DISCIPLINE

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

(Respondent Santa Maria Community and Respondent PIC Soliman)

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

NINTH CAUSE FOR DISCIPLINE

(Subverting an Investigation by the Board - False Statement)

(Respondent Santa Maria Community and Respondent Reyes)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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71. On or about September 20, 2017, Michael Soliman provided YZ's contact information, a copy of his driver's license and a copy of his employee verification form. YZ was an unlicensed employee.

72. On November 8, 2017, Respondent Markos admitted to Inspector AY that he and Michael Soliman were the pharmacists on duty and working at the time the inspectors entered the pharmacy for the inspection on September 18, 2017. Respondent Markos also stated that Michael Soliman was always at the pharmacy daily.

TENTH CAUSE FOR DISCIPLINE

(Pharmacy Technician Identification)

(Respondent Santa Maria Community and Respondent PIC Soliman)

73. Respondent Santa Maria Community and Respondent PIC Soliman are subject to disciplinary action under section 1793.7, subdivision (c), and section 4113, subdivision (c), in that on September 18, 2017, while Respondent PIC Soliman was the pharmacist-in-charge, technician EJ was performing technician functions but was not wearing a badge identifying him as a technician, as set forth in paragraph 64, which is incorporated herein.

ELEVENTH CAUSE FOR DISCIPLINE

(Unlicensed Activity)

(Respondents Santa Maria Community and Respondent PIC Soliman)

74. Respondents Santa Maria Community and Respondent PIC Soliman are subject to disciplinary action under section 4301, subdivision (f), section 4114, subdivisions (a), section 4113, subdivision (c), section 4115, subdivision (e), California Code of Regulations, title 16, section 1793.2, in that on September 18, 2017, YZ, also known as "Joe," an unlicensed employee, was observed pre-packaging prescription vials of medication while Respondent Markos was a pharmacist in the pharmacy, as set forth in paragraphs 62 through 63, and 65 through 69, which are incorporated herein.

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April 25, 2017 Inspection of West Glen Manor

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

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

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

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

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

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

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TWELFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct- Fraudulent "Take- Away" Disposal Box)

(Respondent Santa Maria Community and Respondent PIC Soliman)

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

THIRTEENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct- False Statement)

(Respondent Santa Maria Community and Respondent PIC Soliman)

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

OWNERSHIP PROHIBITION

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

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

placed on probation, or until Pharmacy Permit Number PHY 50309 is reinstated if Pharmacy Permit Number PHY 50309 is revoked.

PRAYER

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

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

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

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

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

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

6. Ordering Santa Maria Pharmacy, Inc. dba Santa Maria Community Pharmacy, Marcos Adeeb Soliman, Roufes Rimon Markos and Elizabeth Reyes 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,

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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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