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

In the Matter of the Accusation Against: **SGP INC. DBA PROFESSIONAL PRESCRIPTION PHARMACY, PHILENA LONG, VICE PRESIDENT** **2863 Atlantic Boulevard** **Long Beach, CA 90806** **Pharmacy Permit No. PHY 47176,** **HENRY NGUYEN** **17078 San Ricardo Street** **Fountain Valley, CA 92708** **Pharmacist License No. RPH 52399,** **and** **LAUREN E. CHUNG** **13253 Droxford Street** **Cerritos, CA 90703** **Pharmacist License No. RPH 54812** Respondents.	Case No. 6467 **DEFAULT DECISION AND ORDER AS TO PHARMACY PERMIT NO. 47176 ONLY** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about June 7, 2019, Complainant Anne Sodergren, in her official capacity as the Interim Executive Officer of the Board of Pharmacy, Department of Consumer Affairs, filed Accusation No. 6467 against SGP Inc. dba Professional Prescription Pharmacy, Philena Long, Vice President (Respondent Professional Pharmacy) before the Board of Pharmacy. (Accusation attached as Exhibit A.)

2. On or about November 14, 2005, the Board of Pharmacy (Board) issued Pharmacy Permit No. PHY 47176 to Respondent Professional Pharmacy. The Pharmacy Permit was cancelled on August 3, 2017.

3. On or about June 11, 2019, Respondent Professional Pharmacy was served by Certified and First Class Mail copies of the Accusation No. 6467, Statement to Respondent, Notice of Defense, Request for Discovery, Discovery Statutes (Government Code sections 11507.5, 11507.6, and 11507.7), and Notice of Hearing at Respondent Professional Pharmacy's address of record which, pursuant to Business and Professions Code section 4100, is required to be reported and maintained with the Board. Respondent Professional Pharmacy's address of record was and is: 2863 Atlantic Boulevard, Long Beach, CA 90806.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505(c) and/or Business and Professions Code section 124.

5. Government Code section 11506(c) states, in pertinent part:

> (c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense . . . and the notice shall be deemed a specific denial of all parts of the accusation . . . not expressly admitted. Failure to file a notice of defense . . . shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

6. The Board takes official notice of its records and the fact that Respondent Professional Pharmacy failed to file a Notice of Defense within 15 days after service upon them of the Accusation, and therefore waived its right to a hearing on the merits of Accusation No. 6467.

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7. California Government Code section 11520(a) states, in pertinent part:

> (a) If the respondent either fails to file a notice of defense . . . or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent . . . .

8. Pursuant to its authority under Government Code section 11520, the Board finds Respondent Professional Pharmacy is in default. The Board will take action without further hearing and, based on the relevant evidence contained in the Default Decision Investigatory Evidence Packet in this matter, as well as taking official notice of all the investigatory reports, exhibits and statements contained therein on file at the Board's offices regarding the allegations contained in Accusation No. 6467, finds that the charges and allegations in Accusation No. 6467, are separately and severally, found to be true and correct by clear and convincing evidence.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Professional Pharmacy has subjected its Pharmacy Permit No. PHY 47176 to discipline.

2. The agency has jurisdiction to adjudicate this case by default.

3. The Board of Pharmacy is authorized to revoke Respondent Professional Pharmacy's Pharmacy Permit based upon the following violations alleged in the Accusation which are supported by the evidence contained in the Default Decision Investigatory Evidence Packet in this case:

a. Violation of Corresponding Responsibility [pursuant to Code section 4301(d), (j) and/or (o), and California Code of Regulations, title 16, section 1761(a) and (b), in conjunction with Code sections 4036.5, 4306.5(a)-(d), and 4113, Health and Safety Code section 11153(a), and Code of Federal Regulations, title 21, section 1306.04(a)];

b. Failure to Provide Policies and Procedures [pursuant to Code sections 4104(a) and (b), and 4301(j) and/or (o), and California Code of Regulations, title 16, sections 1707.5(d) and 1711(a) and (c)(1), in conjunction with Code sections 4036.5 and 4113]; and

c. Failure to Notify Board of Loss of Controlled Substances [pursuant to Code sections 4005, 4300 and 4301(o) and/or (j), in conjunction with Section 4113(c), for violating title 16, California Code of Regulations, section 1715.6].

ORDER

IT IS SO ORDERED that Pharmacy Permit No. PHY 47176, issued to Respondent SGP Inc. dba Professional Prescription Pharmacy, Philena Long, Vice President is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on January 23, 2020 at 5:00 p.m..

It is so ORDERED December 24, 2019.

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

By _____

Greg Lippe
Board President

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DOJ Matter ID:LA2018501408

Attachment:
Exhibit A: Accusation

Exhibit A

Accusation

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In the Matter of the Accusation Against: **SGP INC. DBA PROFESSIONAL PRESCRIPTION PHARMACY, PHILENA LONG, VICE PRESIDENT** 2863 Atlantic Boulevard Long Beach, CA 90806 **Pharmacy Permit No. PHY 47176,** **HENRY NGUYEN** 17078 San Ricardo St. Fountain Valley, CA 92708 **Pharmacist License No. RPH 52399,** **and** **LAUREN E. CHUNG** 13253 Droxford Street Cerritos, CA 90703 **Pharmacist License No. RPH 54812,** Respondents.	Case No. 6467 **ACCUSATION**

Complainant alleges:

PARTIES

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

LICENSE HISTORIES

2. On or about November 14, 2005, the Board issued Pharmacy Permit Number PHY 47176 to SGP Inc. to do business as Professional Prescription Pharmacy (Respondent Professional Pharmacy). Harry Long (now deceased) was the President, 100% shareholder from November 14, 2005 to June 23, 2017 and was the Pharmacist-in-Charge (PIC) from November 14, 2005 to January 10, 2014. Philena Long was the Vice President of Respondent Professional Pharmacy from November 14, 2005 to June 23, 2017. The Pharmacy Permit was cancelled on August 3, 2017 due to a Discontinuance of Business, effective June 23, 2017.

3. On or about March 28, 2001, the Board issued Pharmacist License Number RPH 52399 to Henry Nguyen (Respondent Nguyen). Respondent Nguyen was the PIC of Professional Pharmacy from January 27, 2014 to June 23, 2017. The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2019, unless renewed.

4. On or about August 22, 2003, the Board issued Pharmacist License Number RPH 54812 to Lauren E. Chung (Respondent Chung). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2019, unless renewed.

JURISDICTION

5. This 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.

6. Under Section 4300, the Board may discipline any license, for any reason provided in the Pharmacy Law, (i.e., Sections 4000 et. seq.).

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7. Section 4300.1 states:

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

8. Section 4402, subdivision (a) provides that any pharmacist license that is not renewed within three years following its expiration may not be renewed, restored, or reinstated and shall be canceled by operation of law at the end of the three-year period. Under Section 4402, subdivision (d), the Board has authority to proceed with an accusation that has been filed prior to the expiration of the three-year period.

STATUTORY PROVISIONS

9. Section 4022 of the Code states

> "Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:
>
> (a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.
>
> (b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.
>
> (c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

10. Section 4036.5 states that "'Pharmacist-in-charge' means a pharmacist proposed by a pharmacy and approved by the board as the supervisor or manager responsible for ensuring the pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy."

11. Section 4059, subdivision (a), in pertinent part, prohibits furnishing of any dangerous drug or dangerous device except upon the prescription of an authorized prescriber.

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12. Section 4113 states, in pertinent part, that: "(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."

13. Section 4115, subdivision (c) states: "This section does not authorize a pharmacy technician to perform any act requiring the exercise of professional judgment by a pharmacist."

14. Section 4301 of the Code states:

> The board shall take action against any holder of a license who is guilty of unprofessional conduct or whose license has been issued by mistake. Unprofessional conduct shall include, but is not limited to, any of the following:
>
> * * * *
>
> (d) The clearly excessive furnishing of controlled substances in violation of subdivision (a) of Section 11153 of the Health and Safety Code.
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> * * * *
>
> (j) The violation of any of the statutes of this state, of any other state, or of the United States regulating controlled substances and dangerous drugs.
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> * * * *
>
> (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.

15. Section 4306.5 of the Code states:

> Unprofessional conduct for a pharmacist may include any of the following:
>
> (a) Acts or omissions that involve, in whole or in part, the inappropriate exercise of his or her education, training, or experience as a pharmacist, whether or not the act or omission arises in the course of the practice of pharmacy or the ownership, management, administration, or operation of a pharmacy or other entity licensed by the board.
>
> (b) Acts or omissions that involve, in whole or in part, the failure to exercise or implement his or her best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances, dangerous drugs, or dangerous devices, or with regard to the provision of services.
>
> (c) Acts or omissions that involve, in whole or in part, the failure to consult appropriate patient, prescription, and other records pertaining to the performance of any pharmacy function.

(d) Acts or omissions that involve, in whole or in part, the failure to fully maintain and retain appropriate patient-specific information pertaining to the performance of any pharmacy function.

16. Section 4307(a) of the Code provides, in pertinent part:

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

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

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

17. Health and Safety Code section 11153 provides, in pertinent part:

(a) A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. Except as authorized by this division, the following are not legal prescriptions: (1) an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of controlled substances, which is issued not in the course of professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use.

18. Health and Safety Code section 11162.1 provides, in pertinent part:

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

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

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

(3) A chemical void protection that prevents alteration by chemical washing.

(4) A feature printed in thermochromic ink.

(5) An area of opaque writing so that the writing disappears if the prescription is lightened.

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

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

1–24

25–49

50–74

75–100

101–150

151 and over.

(B) In conjunction with the quantity boxes, a space shall be provided to designate the units referenced in the quantity boxes when the drug is not in tablet or capsule form.

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

(9) The preprinted name, category of licensure, license number, federal controlled substance registration number, and address of the prescribing practitioner.

(10) Check boxes shall be printed on the form so that the prescriber may indicate the number of refills ordered.

(11) The date of origin of the prescription.

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

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

(14) (A) A check box by the name of each prescriber when a prescription form lists multiple prescribers.

(B) Each prescriber who signs the prescription form shall identify himself or herself as the prescriber by checking the box by his or her name.

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

19. Health and Safety Code section 11164 provides, in pertinent part:

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

(a) Each prescription for a controlled substance classified in Schedule II, III, IV, or V, except as authorized by subdivision (b), shall be made on a controlled substance prescription form as specified in Section 11162.1 . . .

REGULATORY PROVISIONS

20. California Code of Regulations (CCR), title 16, section 1707.5, provides, in relevant part:

(d) The pharmacy shall have policies and procedures in place to help patients with limited or no English proficiency understand the information on the label as specified in subdivision (a) in the patient's language. The pharmacy's policies and procedures shall be specified in writing and shall include, at minimum, the selected means to identify the patient's language and to provide interpretive services in the patient's language. The pharmacy shall, at minimum, provide interpretive services in the patient's language, if interpretive services in such language are available, during all hours that the pharmacy is open, either in person by pharmacy staff or by use of a third-party interpretive service available by telephone at or adjacent to the pharmacy counter.

21. California Code of Regulations, title 16, section 1711 provides as follows:

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

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

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

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

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

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

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

(4) If a pharmacist is notified of a prescription error by the patient, the patient's agent, or a prescriber, the pharmacist is not required to communicate with that individual as required in paragraph (2) of this subdivision.

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

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

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

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

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

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

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

22. California Code of Regulations, title 16, section 1715.6 states that: "The owner shall report to the Board within thirty (30) days of discovery of any loss of the controlled substances, including their amounts and strengths."

23. CCR, title 16, section 1761, states:

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

(b) Even after conferring with the prescriber, a pharmacist shall not compound or dispense a controlled substance prescription where the pharmacist knows or has

objective reason to know that said prescription was not issued for a legitimate medical purpose.

CODE OF FEDERAL REGULATIONS

24. Code of Federal Regulations, title 21, section 1306.04, subdivision (a), states:

> A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a purported prescription as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.

COST RECOVERY

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 of the licensing act to pay a sum not to exceed its reasonable costs of investigation and enforcement.

CONTROLLED SUBSTANCES/DANGEROUS DRUGS

26. **"Alprazolam 2 mg"** (brand name – **"Xanax"**) is a depressant and a Schedule IV controlled substance, as designated by Health & Safety Code section 11057, subdivision (d)(1). It is categorized as a dangerous drug pursuant to Section 4022 and is used to treat anxiety.

27. **"Hydrocodone/APAP 10/325mg",** the generic name for the brand name **"Norco"**, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(I), and a dangerous drug within the meaning of Code section 4022. The drug contains a combination of Acetaminophen (a pain reliever that increases the effects of Hydrocodone) and Hydrocodone (an opioid pain medication) and is used to treat pain.

28. **Oxycodone, the generic name for Roxicodone**, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M) and is a dangerous drug pursuant to Code section 4022.

29. **"Promethazine with Codeine Syrup 10 mg-6.25 mg./5 mL"** (brand name – **"Phenergan-Codeine"**) is a dangerous drug, and a Schedule V controlled substance, as

designated by Health & Safety Code section 11058, subdivision (c)(1). Promethazine with Codeine is a prescription cough syrup.

30. "**Soma 350 mg**", the brand name for "**Carisoprodol**" is a dangerous drug and a Schedule IV controlled substance, as designated by 21 CFR 1308.14(c)(6) and is a dangerous drug pursuant to Code section 4022. Soma is used as a muscle relaxant.

FACTUAL ALLEGATIONS

31. The Board began an investigation after reviewing Professional Pharmacy's dispensing data, as reported to the Controlled Substance Utilization Review and Evaluation System (CURES) [1], that showed a need for an investigation to evaluate the pharmacy's controlled substance dispensing practices. On February 7, 2017, an Inspector with the Board conducted an inspection at Professional Pharmacy. PIC Nguyen was present and assisted in the inspection. Details of the inspection included but were not limited to the following:

32. Professional Pharmacy was an independent retail pharmacy in a medical building and PIC Nguyen estimated the pharmacy filled 90 to 100 prescriptions per day.

33. PIC Nguyen was unable to locate a Quality Assurance policy and procedure.

34. PIC Nguyen was initially unable to locate a policy and procedure to address impairment of or theft and diversion by licensed employees. PIC Nguyen eventually provided a document titled, "Employee Acknowledgement Health Insurance Portability and Accountability Act of 1996 (Privacy Rule) Responsibilities and Obligations" and stated he believed this document served as the pharmacy's Impaired Employee/Theft and Diversion policy and procedure. However, since this document did not address employee impairment or employee theft and diversion, it was not sufficient to satisfy the requirement of Section 4104.

35. PIC Nguyen was unable to locate a policy and procedure to address the provision of interpretive services to patients with limited English proficiency. Additionally, the notice of availability of interpretive services posted in public view in the pharmacy seemed to apply only to

[1] CURES is California's Prescription Drug Monitoring Program (PDMP) which requires mandatory weekly reporting of dispensed Schedule II-IV (CII-IV) controlled substances prescriptions across the state and can be used by healthcare professionals to evaluate and determine whether patients are utilizing controlled substances correctly.

L.A. Care beneficiaries. It read, "L.A. Care members can get free interpreting services including American Sign Language."

36. The Board's Inspector asked PIC Nguyen if Professional Pharmacy recently suffered any losses of controlled substances. PIC Nguyen replied that the pharmacy was burglarized the night of February 17, 2015 and some controlled substances were stolen. PIC Nguyen stated that he reported the loss to the DEA on a DEA Form 106 and to the Long Beach Police Department. PIC Nguyen stated that he did not believe he reported the loss to the Board because he wasn't aware of a requirement to report drug losses to the Board.

37. The Inspector reviewed several "books" of filled, completed prescription documents, and collected a sample of prescription documents from the prescriber. The sample of prescription documents from the following five prescribers identified in the review of the pharmacy's CURES data included the following:

- 23 prescription documents and associated verifications from Dr. Wa.
- 17 prescription documents and associated verifications from Dr. Wi.
- 13 prescription documents and associated verifications from Dr. G.
- Four prescription documents and associated verifications from Dr. A.
- One prescription document from Dr. O.

38. The Inspector told PIC Nguyen to report the drug loss in February of 2017 and requested the following in her inspection report: procedures for quality assurance and interpretive services; the completion of a questionnaire related to PIC Nguyen's evaluation of controlled substance prescriptions and corresponding responsibility; and a file with all prescriptions filled by the pharmacy from February 7, 2014-February 7, 2017.

39. On February 20, 2017, the Inspector received the completed questionnaire signed by PIC Nguyen, which set forth detailed information about the pharmacy's record keeping, as well as the dispensing of controlled substances and verifying of the legitimacy of prescriptions for controlled substances. Specifically, PIC Nguyen responded that the pharmacy generally does not dispense controlled substance prescriptions to out of the area patients, and an acceptable distance is about 10-11 miles radius maximum. In addition, the pharmacy gained access to the CURES

database in September 2014, which the pharmacy checked to make sure patients are not filling controlled substances too early or obtaining excessive amounts. PIC Nguyen indicated they check the CURES database for almost all controlled medications CII-CV and for the last filled dates, quantity, frequency, pattern of medication used, doctor(s), and different pharmacies used. For patients who appear to be "doctor shopping", the pharmacy will usually deny the prescriptions. Furthermore, the pharmacy uses different websites (BreEZe (license verification site), DEA) to identify doctors with unethical writing habit(s), or if doctor's license is revoked or not. The pharmacy generally does not dispense controlled substances prescriptions from out of area doctors (an acceptable distance is about a 10-12 miles radius), except for patients who use the pharmacy regularly for their special medications.

40. Based on PIC Nguyen's education and professional experience, he indicated on the questionnaire the appropriate starting doses for the following medications:

- o Alprazolam 0.25 mg TID
- o Hydrocodone/acetaminophen 2.5 mg hydrocodone Q 4-6 hours
- o Oxycodone immediate release 5 mg Q 4-6 hours
- o Oxycodone extended release 10 mg Q 12 hours

41. On June 20, 2017, the Inspector received an Excel file containing records of prescriptions dispensed at Professional Pharmacy from February 7, 2014-February 7, 2017.

42. The Inspector did not receive Professional Pharmacy's policies and procedures related to quality assurance or translation services.

43. The Inspector did not receive confirmation that PIC Nguyen reported the 2015 loss of controlled substances to the Board. However, the Inspector's search of the Board's database revealed that the Board received a report of the 2015 loss of controlled substances at Professional Pharmacy, on February 14, 2017.

44. Professional Pharmacy's records of all prescriptions dispensed from February 7, 2014-February 7, 2017 indicated that:

- Professional Prescription Pharmacy filled 79,869 prescriptions during the query period, or an average of approximately 106 prescriptions per business day.

- Over 75% of the prescriptions filled at Professional Pharmacy were written by prescribers practicing in Long Beach, where the pharmacy was located, or neighboring cities.
- At least 70% of the prescriptions filled at Professional Pharmacy were written for patients with addresses of record in Long Beach or neighboring cities.
- 89.32% of the prescriptions dispensed at Professional Pharmacy during the query period were billed to prescription insurance, which was a typical billing pattern for a retail pharmacy since patients ordinarily prefer to pay for medications with insurance.
- 88.5% of the prescriptions dispensed at Professional Pharmacy during the query period were for non-controlled substances, which is consistent with the fact that there are significantly more non-controlled substances on the market than controlled substances.
- Professional Pharmacy's 20 most commonly dispensed medications included 16 non-controlled substances and four controlled substances. This list included medications to prevent cardiac events and to treat cough, gastroesophageal reflux, pain, high blood pressure, diabetes, nerve pain, anxiety, allergies, high cholesterol, and low bone density.

45. The Inspector reviewed and analyzed records and information related to prescriptions for non-controlled and controlled substances filled by Professional Pharmacy for five doctors: Dr. Wa., Dr. O., Dr. Wi., Dr. A., and Dr. G., from February 7, 2014-February 7, 2017. Moreover, the Inspector reviewed documents related to steps taken by the pharmacy staff to verify the legitimacy of prescriptions filled for patients of these doctors. The pharmacists at Professional Pharmacy would simply confirm that the doctor wrote the prescription, which did not fulfill their corresponding responsibility to confer with the prescriber in the presence of significant factors of irregularity to attempt to determine the legitimacy of the prescription. From February 7, 2014-February 7, 2017, Professional Pharmacy filled 4,758 prescriptions for the foregoing five prescribers, in the presence of objective factors suggesting that the prescriptions were not written for legitimate medical purposes.

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FIRST CAUSE FOR DISCIPLINE
(Violation of Corresponding Responsibility)

46. Respondent Professional Pharmacy and Respondent Nguyen are subject to disciplinary action under Code section 4301, subdivisions (d), (j) and/or (o) and CCR, title 16, section 1761, subdivisions (a) and (b), in conjunction with Code sections 4036.5, 4306.5, subdivisions (a)-(d), and 4113, Health and Safety Code section 11153, subdivision (a) and Code of Federal Regulations, title 21, section 1306.04, subdivision (a), in that they violated their corresponding responsibility by excessively furnishing controlled substances and repeatedly failing to resolve irregularities and red flags of illegitimacy for controlled substances prescribed by five doctors. Respondent Nguyen, while employed as a pharmacist and PIC of Professional Pharmacy during the entire query period, personally approved the dispensing of 47% of the irregular prescriptions. In doing so, Nguyen misused his education and experience as a pharmacist and failed to implement his best professional judgment by excessively dispensing controlled substances with a high potential for abuse despite multiple clues of irregularity and uncertainty related to patient and prescriber factors, as follows:

- Most of the prescriptions written by the listed prescribers were purchased in cash, without the aid of prescription insurance.
- 79% of Dr. O.'s prescriptions, 99% of Dr. Wa.'s prescriptions, and 100% of Dr. Wi.'s, Dr. A.'s, and Dr. G.'s prescriptions were purchased in cash. In contrast, almost 11% of the pharmacy's total prescriptions were purchased in cash during the query period.
- The majority of the prescriptions written by the prescribers in question were for controlled substances. Additionally, the prescribing profiles of these prescribers were unusually limited, with a small number of commonly abused controlled substances accounting for a large percentage of the total prescribing.
- 55.25% of Dr. Wa.'s prescribing consisted of four controlled substances; oxycodone 30 mg, alprazolam 2 mg, carisoprodol 350 mg, and promethazine/codeine syrup. Additionally, all but one of Dr. Wa.'s patients received at least one prescription for oxycodone 30 mg.
- 76.71% of Dr. O's prescribing consisted of two controlled substances, promethazine/codeine syrup and alprazolam 2 mg tablets.

- Four controlled substances, promethazine/codeine syrup, oxycodone 30 mg tablets, alprazolam 2 mg tablets, and hydrocodone/acetaminophen 10/325 mg tablets, represented 75.2% of Dr. Wi.'s prescriptions at Professional Pharmacy. Additionally, 45.9% of Dr. Wi.'s prescriptions were written for promethazine/codeine syrup.
- Dr. A.'s prescribing profile consisted of only three controlled substances; hydrocodone/acetaminophen 10/325 mg, promethazine/codeine syrup, and alprazolam 2 mg tablets.
- 85.44% of Dr. G.'s total prescriptions, were written for oxycodone 30 mg.
- The prescribers in question frequently prescribed the highest available strengths of commonly abused controlled substances.
- Dr. Wa.'s prescribing profile contained 958 prescriptions for oxycodone 30 mg, 500 prescriptions for alprazolam 2 mg, and no prescriptions for any lower strength of either medication.
- Dr. O.'s prescribing profile contained 208 prescriptions for alprazolam 2 mg and no prescriptions for any lower strength.
- Dr. Wi.'s prescribing profile contained 71 prescriptions for oxycodone 30 mg, 28 prescriptions for alprazolam 2 mg, and no prescriptions for any lower strengths.
- The prescribing profiles of the prescribers in question were seemingly incongruent with their self-reported areas of practice on the Medical Board of California's online database.
- Many patients of the listed prescribers paid exceptionally high prices for oxycodone prescriptions. The dispensing record contained 1,034 instances when patients paid between $900 and $1,100 for 100 oxycodone 30 mg tablets.
- Professional Pharmacy frequently dispensed prescriptions for patients of Dr. Wa. in pairs or groups. The dispensing record contained about 304 instances when Professional Pharmacy processed prescriptions from Dr. Wa. in pairs or groups.
- Dr. Wi.'s patients frequently travelled excessive distances, 32.6 miles between his office and the pharmacy, to obtain controlled substances from Professional Pharmacy.

• Professional Pharmacy dispensed many of Dr. Wi.'s prescriptions several weeks after the prescriptions were written. Professional Pharmacy dispensed 137 of Dr. Wi.'s prescriptions more than 30 days after they were written. While Professional Pharmacy produced documentation to indicate pharmacy staff made attempts to verify these prescriptions, Professional Pharmacy did not produce documentation to show that pharmacists there, including Respondent Nguyen, conferred with the prescribers and addressed the irregularities listed above to validate the prescriptions. Under Section 4115, subdivision (c), pharmacists may not delegate their duty of verifying the legitimacy of prescriptions to pharmacy technician or other non-pharmacist staff.

47. Complainant incorporates by reference paragraphs 31 through 45 as though fully set forth herein.

SECOND CAUSE FOR DISCIPLINE
(Failure to Provide Policies and Procedures)

48. Respondents Professional Pharmacy and Nguyen, the PIC of Professional Pharmacy, are subject to disciplinary action under Code sections 4104, subdivisions (a) and (b) and 4301, subdivision (j) and/or (o) and CCR, title 16, sections 1707.5, section (d) and 1711, subdivisions (a) and (c)(1), in conjunction with Code sections 4036.5 and 4113, in that Respondents failed to have and/or produce to the Board's Inspector a quality assurance policy and procedure, a procedure to address impairment of or theft by licensed employees, or a policy and procedure to help patients with limited English or no English proficiency understand the information on the label in the patient's language.

49. Complainant incorporates by reference paragraphs 31 through 45 as though fully set forth herein.

THIRD CAUSE FOR DISCIPLINE
(Failure to Notify Board of Loss of Controlled Substances)

50. Respondent Professional Pharmacy and Respondent Nguyen are subject to disciplinary action under Sections 4005, 4300 and 4301, subdivisions (o) and/or (j), in conjunction with Section 4113, subdivision (c), for violating title 16, California Code of

Regulations, section 1715.6, in that Respondent Nguyen, while employed as the PIC of Professional Pharmacy, failed to report the February 17, 2015 theft of drugs/controlled substances from the pharmacy to the Board within 30 days. Professional Pharmacy reported those losses to the Board on February 14, 2017. The facts supporting this cause are specified in paragraphs 31 through 45 above and incorporated herein by reference.

FOURTH CAUSE FOR DISCIPLINE
(Violation of Corresponding Responsibility)

51. Respondent Lauren Chung is subject to disciplinary action under Code sections 4301, subdivisions (d), (j) and/or (o) and 4306.5, subdivisions (a)-(d), and CCR, title 16, section 1761, subdivisions (a) and (b), in conjunction with Health and Safety Code section 11153, subdivision (a) and Code of Federal Regulations, title 21, section 1306.04, subdivision (a), in that she violated her corresponding responsibility by excessively furnishing controlled substances and repeatedly failing to resolve irregularities and red flags of illegitimacy for controlled substances prescribed by five doctors. Respondent Chung, from February 7, 2014-February 7, 2017, while employed as a pharmacist of Professional Pharmacy, personally approved the dispensing of 27% of the irregular prescriptions. In doing so, Respondent Chung misused her education and experience as a pharmacist and failed to implement her best professional judgment by excessively dispensing controlled substances with a high potential for abuse despite multiple clues of irregularity and uncertainty related to patient and prescriber factors, as set forth above in Paragraph 45 and incorporated here by reference. While Professional Pharmacy produced documentation to indicate pharmacy staff made attempts to verify these prescriptions, Professional Pharmacy did not produce documentation to show that pharmacists there, including Chung, conferred with the prescribers and addressed the irregularities listed above to validate the prescriptions. Under Section 4115, subdivision (c), pharmacists may not delegate their duty of verifying the legitimacy of prescriptions to pharmacy technician or other non-pharmacist staff.

52. Complainant incorporates by reference paragraphs 31 through 45 as though fully set forth herein.

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OTHER MATTERS

53. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 47176 to SGP Inc. to do business as Professional Prescription Pharmacy shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 47176 is placed on probation or until Pharmacy Permit Number PHY 47176 is reinstated if it is revoked.

54. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 47176 to SGP Inc. to do business as Professional Prescription Pharmacy while Philena Long has been an officer and owner arid had knowledge of or knowingly participated in any conduct for which the licensee was disciplined, Philena Long shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 47176 is placed on probation or until Pharmacy Permit Number PHY 47176 is reinstated if it is revoked.

PRAYER

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

1. Revoking or suspending Pharmacy Permit Number PHY 47176, issued to SGP Inc. dba Professional Prescription Pharmacy, Philena Long;

2. Revoking or suspending Pharmacist License Number RPH 52399, issued to Henry Nguyen;

3. Revoking or suspending Pharmacist License Number RPH 54812, issued to Lauren E. Chung;

4. Prohibiting SGP Inc. dba Professional Prescription Pharmacy from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 47176 is placed on probation or until Pharmacy Permit Number PHY 47176 is reinstated if Pharmacy Permit Number PHY 47176 issued to SGP Inc. dba Professional Prescription Pharmacy is revoked;

5. Prohibiting Philena Long from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 47176 is placed on probation or until Pharmacy Permit Number PHY 47176 is reinstated if Pharmacy Permit Number PHY 47176 issued to SGP Inc. dba Professional Prescription Pharmacy is revoked;

6. Ordering Professional Prescription Pharmacy, Henry Nguyen and Lauren E. Chung, jointly and severally, to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

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

DATED: June 7, 2019

Anne Sodegren

ANNE SODEGREN
Interim Executive Officer
Board of Pharmacy
Department of Consumer Affairs
State of California
Complainant

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