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

In the Matter of the Accusation Against:

SIX DEGREES, INC., DBA SIX DEGREES HEALTH, DBA

PRESCRIPTION SHOPPE, ANNA KARINA RUBIO, MARIANNE

CHRISTIANE ANTONIO,

Pharmacy Permit No. PHY 56833,

and

ASHOK POPAT,

Pharmacist License No. RPH 39954,

Respondents.

Agency Case No. 7046

OAH No. 2021070154

NOTICE OF DENIAL OF RECONSIDERATION BY OPERATION OF LAW

NOTICE TO ALL PARTIES:

Respondent timely submitted a Petition for Reconsideration to the Board of Pharmacy. No action having been taken by the board on the petition before the Decision and Order took effect, pursuant to Government Code section 11521, the petition is deemed denied by operation of law.

On or about July 15, 2022, the Board issued an order staying the effective date of the Decision until 5:00 p.m. on July 26, 2022, to allow it time to review Respondent's petition for reconsideration.

The Decision and Order, which became effective on July 26, 2022, at 5:00 p.m., is the Board of Pharmacy's final decision in this matter.

Date: July 28, 2022.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By 

Seung W. Oh, Pharm.D.
Board President

BEFORE THE
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ORDER STAYING EFFECTIVE DATE OF DECISION

Respondent timely requested reconsideration of the decision in the above-entitled matter pursuant to section 11521 of the Government Code. In order to allow the board additional time to consider the petition, in accordance with the provisions of section 11521 of the Government Code,

IT IS HEREBY ORDERED that the effective date of the Decision and Order, in the above-entitled matter is stayed until 5 p.m. on July 26, 2022.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By 

Seung W. Oh, Pharm.D.
Board President

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Agency Case No. 7046

OAH No. 2021070154

DECISION AND ORDER

The attached Proposed Decision 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 July 16, 2022.

It is so ORDERED on June 16, 2022.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By 

Seung W. Oh, Pharm.D.
Board President

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

In the Matter of the Accusation against:

SIX DEGREES, INC., DBA SIX DEGREES HEALTH, DBA PRESCRIPTION SHOPPE, ANNA KARINA RUBIO, MARIANNE CHRISTIANE ANTONIO,

Pharmacy Permit No. PHY 56833,

and

ASHOK POPAT,

Pharmacist License No. RPH 39954,

Respondents.

Agency Case No. 7046

OAH No. 2021070154

PROPOSED DECISION

Julie Cabos-Owen, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on March 8 and 9, and

April 14, 2022. Anne Sodergren (Complainant) was represented by Deputy Attorney General Vinodhini Ramagopal. Ashok Popat (Respondent) represented himself. (The pharmacy respondent, Six Degrees, Inc., failed to file a notice of defense, and it was served with a default decision prior to hearing. The Accusation's first 18 causes for discipline are leveled against only the pharmacy and will not be addressed in this Decision.)

Testimony and documents were received in evidence. The record closed and the matter was submitted for decision on April 14, 2022.

FACTUAL FINDINGS

Jurisdictional Matters

1. On May 4, 2021, Complainant filed the Accusation while acting in her official capacity as Executive Officer of the California Board of Pharmacy (Board), Department of Consumer Affairs.

2. Respondent timely filed a Notice of Defense requesting a hearing.

Respondent's License History and Employer Background

3. On March 18, 1986, the Board issued Pharmacist License Number RPH 39954 to Respondent. His Pharmacist License is scheduled to expire on April 30, 2023. The license has no history of prior discipline.

4. On about August 31, 2018, the Board issued Permit Number PHY 56833 to Six Degrees, Inc. doing business as (dba) Six Degrees Health, dba Prescription Shoppe (Pharmacy), owned by Anna Karina Rubio and Marianne Christiane Antonio.

Pharmacy was purchased from prior owners. The Pharmacy Permit expired on August 1, 2020, and was later revoked by the Board, effective September 8, 2021.

5. In July 2018, prior to purchasing Pharmacy, the corporate owners of Six Degrees, Inc. hired R. W. as Pharmacist-in-Charge (PIC) of Pharmacy. R.W.'s employment at Pharmacy was terminated at the end of August 2018. R.W. sent the Board a letter, dated October 21, 2018, stating he had disassociated as PIC of Pharmacy on August 31, 2018.

6. The Board received a change of PIC application from Pharmacy on November 13, 2018. The application indicated, effective September 4, 2018, R. W. was disassociated from Pharmacy, and Respondent was the new PIC. Only Respondent signed the change of PIC application.

7. On October 9 and 11, 2018, the Board received two complaints from R.W. alleging that Pharmacy was committing fraud in dispensing diabetic supplies and that the compounding room equipment was improperly ventilated for hazardous material compounding.

8. After receipt of the complaints, the Board conducted several inspections of Pharmacy. At the administrative hearing, Board Inspectors James Flores, Anna K. Yamada, and Michael Ajayi testified regarding their investigations and inspections of Pharmacy. Their credible testimony, corroborated by documentary evidence and Respondent's admissions, established the following facts.

November 6, 2018 Inspection

9. On November 6, 2018, Inspector Flores inspected Pharmacy with the assistance of Respondent and pharmacy technician S.R.

10. Respondent informed Inspector Flores that Pharmacy was primarily a compounding pharmacy and that Pharmacy filled about 30 prescriptions per day.

11. Inspector Flores requested to see Pharmacy's Compounding Self-Assessment form, but the form Respondent produced was blank. Inspector Flores informed Respondent the Compounding Self-Assessment form must be completed before engaging in any compounding. Respondent thumbed through the Compounding Self-Assessment form, placed it on a counter, proceeded to the compounding room, and continued to engage in compounding activities.

12. Inspector Flores did not follow Respondent to the compounding area because Inspector Flores had not yet determined if the compounding area was sufficiently ventilated and safe. Instead, Inspector Flores continued inspecting the front area of Pharmacy with S.R.'s assistance.

13. S.R. was not fully knowledgeable about the process for obtaining and providing patients with diabetic supplies. During the inspection, Inspector Flores learned that process was conducted by another individual, B.W., in a side office where diabetic supplies were kept. Purportedly, B.W. received and forwarded prescriptions for diabetic supplies to the pharmacists and technicians. Inspector Flores reviewed purchase invoices from the end of November 2017 forward, and he noted the purchases of diabetic test strips and various creams/gels/ointments were in extremely large quantities atypical of a retail pharmacy.

14. Inspector Flores began reviewing other forms, including a Community Pharmacy Self-Assessment that Respondent did not review and sign until October 7, 2018, more than 30 days after becoming PIC of Pharmacy.

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15. As PIC, Respondent was required by federal rules to complete a biennial inventory of controlled substances. At the front of Pharmacy, Inspector Flores located a binder containing a form entitled Controlled Substances Inventory (CS Form). The CS Form listed a large variety of controlled substances, but the form was almost entirely blank, with no quantities filled in next to names of substances, no documented time and date of inventory, and no signatures. However, the form contained an advisory, "Special Note. The purpose of this list is to assist you in taking your inventory; there is no requirement that it be used. It is provided only to assist registrants in recording their Inventory." (Exhibit 5, p. A195.)

16. At the administrative hearing, Respondent insisted that he provided a handwritten inventory to Inspector Flores at the end of the November 6, 2018 inspection. However, Inspector Flores did not recall receiving a completed inventory from Respondent on November 6, 2018, noting that it would have been his customary practice to take a copy with him along with other evidence he gathered during the inspection. Although Inspector Flores took several documents as evidence during the November 2018 inspection, and he listed them in his report, there was no reference any controlled substance inventory on the list of items recovered during the inspection.

17. At hearing, Respondent produced a 15-page, handwritten inventory on lined paper, with substances and quantities listed. The date, September 26, 2018, was written on every page. The word "evening" was written on the first page. The document did not indicate whether the inventory was taken after close of business, and Respondent did not sign the document.

18. Inspector Flores credibly testified that the first time saw the handwritten inventory was just prior to the hearing. Inspector Flores noted the handwritten

inventory still did not meet all federal requirements because, among other things, it did not indicate whether it was taken at close of business.

19. A pharmacy technician must be licensed by the Board to engage in compounding medications. On October 4, 2018, the Board issued S.R. a pharmacy technician registration. However, upon review of Pharmacy's compounding logs, Inspector Flores discovered S.R. had engaged in pharmacy technician compounding activities prior to her Board licensure. Specifically, on September 4, 10, 11, 12, 17, 18, 19, 20, 21, 24, 25, 26, and 28, 2018, S.R. compounded medications, and Respondent signed off as the pharmacist doing final review of those compounded medications.

20. Pharmacy staff compounded medications classified as hazardous by the National Institute for Occupational Safety and Health (NIOSH) in a compounding room on the premises. At hearing, Inspector Flores explained that applicable regulations governing the compounding of hazardous drugs require the compounding room to have a negative pressure fan to draw exhaust out of the room. However, during the November 2018 inspection, Inspector Flores reviewed documentation that revealed Pharmacy's non-sterile compounding hood and its compounding room were not properly exhausted or certified. The hood and compounding room were not functioning under negative pressure, and repairs were needed to create the requisite negative pressure and pull the exhaust out of the room. Specifically, Inspector Flores reviewed a report from a HEPA filter certification and repair company following its September 19, 2018 inspection of Pharmacy's compounding room and equipment. The report noted:

> Unit is a single HEPA design. Has duct work canopy connected to unit but doesn't have fan on roof. Needs to have a roof fan installed to draw ductwork and canopy

> under negative pressure. Unit is missing work zone top panel. This panel creates negative pressure near wall that controls airflow in unit. Need to replace. Smoke patterns are poor, but still containing.

(Exhibit 5, p. A511.)

21. During the November 6, 2018 inspection, Inspector Flores reviewed several hard copies of prescriptions for diabetic testing equipment and supplies. Most of the prescription documents for the diabetic supplies were on a pre-formatted prescription form that listed a series of diabetic supplies being prescribed (i.e., blood glucose meter, test strips, control solution, lancets, lancing device, alcohol prep swab, insulin syringes, insulin pen needles, blood pressure monitor). Some of the prescription forms had typewritten language, "I am prescribing all items listed below or have crossed off items NOT being prescribed" (e.g., Exhibit 5, p. A480), with items crossed off by the purported prescriber. Other prescription forms indicated, "I am prescribing the item(s) below (as documented in patient's medical record)" (e.g., *Id.* at p. A494), with boxes to be checked next to diagnostic codes and testing frequency (e.g., daily). Many of the forms contained the following note: "78 - 90 days of diabetes testing supplies will be provided to patient unless otherwise indicated by provider." (*Id.* at pp. A490 and A494.) The form prescriptions lacked a section for the prescriber to indicate the specific number of items prescribed. In the space designated for number of refills, some of the forms stated, "This order is good for a year from the signed date shown below, unless otherwise indicated by the physician. Refills 11 unless otherwise indicated." (*Id.* at p. A490.) On other forms, the space designated for refills contained typewritten numbers 1, 2 ,3, 4, and 5. On some of the forms, a number was circled (*Id.* at p. A492), and on others, no number was circled (*Id.* at p. A494). Several

fax numbers were listed on the preformatted prescription forms including the following: (888) 966-0690, (888) 757-2926, (877) 395-7352, and (888) 448-8212. However, Pharmacy's fax number, (760) 245-8303, was not listed on the forms. (See Exhibit 5, p. A486.) None of the preformatted prescription forms indicated to whom the form was being faxed, and Pharmacy's name was not located on the forms. However, the prescriptions were filled by Pharmacy.

22. On January 28, 2019, Inspector Flores received 45 additional pages of hardcopy prescriptions for diabetic medications and supplies that Pharmacy dispensed to patients from August 31, 2018, through January 11, 2019, including diabetic test strips, diabetic test meters, alcohol prep pads, Diclofenac topical formulations (i.e., creams, ointment, and gels), and Lidocaine topical formulations. The prescriptions were on pre-formatted prescription forms similar to those reviewed by Inspector Flores during the November 6, 2018 inspection. The purported prescribers had filled out the forms in a manner similar to those reviewed during the November 2018 inspection. Additionally, on some of the prescription forms after the typewritten language, "I am prescribing all items listed below or have crossed off items NOT being prescribed," the provider instead circled several medications, but did not cross off the remaining medications, resulting in ambiguity about which medications were being prescribed (e.g., Exhibit 7, pp. A752, A755.) Similar to the forms reviewed on November 6, 2018, the newly produced prescriptions listed several toll-free fax numbers, but not Pharmacy's fax number or name, and the forms failed to indicate to whom the forms were being faxed. However, the prescriptions were filled by Pharmacy. The form prescriptions lacked a section for the prescriber to indicate the specific number of items prescribed.

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23. On January 28, 2019, Inspector Flores received a completed Compounding Self-Assessment from Respondent, dated November 6, 2018.

24. After the November 2018 inspection, Inspector Flores also received a January 4, 2019 Certification of Environmental Compliance for Pharmacy's compounding room, issued by Controlled Environmental Regulatory Testing Services (CERTS).

March 19, 2019 Inspection

25. On March 19, 2019, Inspectors Flores and Yamada conducted an inspection of Pharmacy and were assisted by Respondent.

26. While standing near the front counter, the inspectors witnessed B.W., a non-licensed clerk/manager at Pharmacy, sign for a delivery of prescription drugs. Before the delivery driver left, Inspector Flores intervened and informed B.W., Respondent, and the delivery driver that only a pharmacist can sign for a prescription drug order delivery. Respondent informed the Board inspectors that B.W. sometimes signed for prescription drug orders. This is a violation of Business and Professions Code section 4059.5, subdivision (a). Inspector Flores instructed Respondent that, as the only pharmacist on duty, he must sign for the prescription drug order. Respondent then signed for the prescription drug order, and the delivery driver left the premises.

27. During the inspection, the Board inspectors discovered an unlocked drawer containing Schedule II medications. Inspector Flores had been informed Pharmacy did not dispense Schedule II substances and was awaiting reverse distribution of the medications for destruction. Inspector Flores asked Respondent to lock the drawer to secure the Schedule II medications. Respondent was unable to locate the key for the drawer, and he indicated he would have to ask Pharmacy's

manager, K.M. for the key. K.M. is not a licensed pharmacist or pharmacy technician. Her possession of a key to the Schedule II medication drawer is a violation of California Code of Regulations, title 16, section 1714, subdivision (d), as it relates to Title 21, Code of Federal Regulations, section 1301.75.

28. The Board inspectors also inspected a group of boxes left on a counter. The shipping boxes contained liquids, foams, and capsules under the company name Stop & Regrow Hair (SRH). Respondent informed the Board inspectors that Pharmacy had a contract with a Dr. Nettles to compound products for his line of oral and topical medications known as SRH. Respondent reported that Dr. Nettles' office supplied specific containers and labels, and the product orders came directly from Dr. Nettles' office. Pharmacy compounded the requested items per Dr. Nettles' instructions. Pharmacy shipped the orders directly to California patients. For non-California patients, Pharmacy sent the compounded medications to Dr. Nettles' office for shipping out-of-state, in violation of California Code of Regulations, title 16, section 1713, subdivision (a).

29. The shipping boxes for the completed SRH products included Pharmacy's prescription label on the inside lid of the shipping box. The actual medication bottles were labeled with SRH product labels provided by Dr. Nettles, and a small sticker with Pharmacy's prescription number, lot number, Beyond Use Date (BUD), date of preparation, and a telephone number to contact Dr. Nettles' office for refills. Failure to label the finished product, not just the shipping box lid, with Pharmacy's prescription label, was a violation of Business and Professions Code section 4076, subdivision (a).

30. The shipped SRH packages did not include a notice that consultation was available from a pharmacist at Pharmacy. This failure to provide any offer of consultation for compounded SRH prescription products mailed directly to patients

was a violation of California Code of Regulations, title 16, section 1707.2, subdivision (h)(2).

31. The Board inspectors also reviewed a December 12, 2018 Certificate of Analysis from a testing laboratory for Pharmacy's Lot Number K1309, a compounded Latanoprost/ Dutasteride 0.005%/ 0.1% Solution. The Certificate of Analysis documented the Dutasteride component of the product at 0.0167%, not 0.1%, thus failing to be within the required +/- 10% of the stated concentration. The Board inspectors asked Respondent what steps were taken when Pharmacy was notified the product had failed. Respondent stated he took no action based on the recommendation of Pharmacy's consultant, Eugene Braddy, a former California-licensed pharmacist who had previously surrendered his license. On Braddy's advice, Respondent believed the testing laboratory failed to properly shake the product prior to testing. The Board inspectors informed Respondent, if a product fails to pass a potency analysis, Respondent must quarantine the product (if any product remained in Pharmacy) and conduct a recall of any of the product dispensed to patients. Pharmacy could then decide whether to retest the product or dispose of it and send a new batch of product for testing. Respondent's and Pharmacy's dispensing of a known sub-potent compound labeled with the incorrect strength of the Dutasteride component was a violation of Business and Professions Code section 4169, subdivision (a)(3), as it relates to Health and Safety Code section 111440.

32. In the compounding room, the Board inspectors found a bulk container of Belladonna Extract USP Leaf Powdered, lot number C169524, with an expiration date of January 31, 2019, and a bulk container of Chrysin, lot number C183706, with an expiration date of February 28, 2019. The Board inspectors then reviewed the most recent compounding logs containing these ingredients and located the following

items: (a) a compounding log for Testosterone/Chrysin 10%/10%/ml PLO cream showing Chrysin, lot number C183706, expiration date of February 28, 2019, was used to compound the cream, and the final product was given an expiration date of July 10, 2019; (b) a compounding log for Testosterone/Chrysin 8%/10%/ml PLO cream showing Chrysin, lot number C183706, expiration date of February 28, 2019, was used to compound the cream, and the final product was given an expiration date of July 10, 2019; (c) a compounding log for Testosterone/Chrysin 15%/15%/ml PLO cream showing Chrysin, lot number C183706, expiration date of February 28, 2019, was used to compound the cream, and the final product was given an expiration date of July 10, 2019; (d) a compounding log for Ergotamine 0.6mg/Belladonna 0.2mg/Phenobarbital 20mg SR capsules showing Belladonna Extract, lot number C169524, expiration date of January 31, 2019, was used to compound the capsules, and the final product was given an expiration date of July 14, 2019; and (e) a compounding log for Ergotamine 0.6mg/Belladonna 0.2mg/Phenobarbital 40mg SR capsules showing Belladonna Extract, lot number C169524, expiration date of January 31, 2019, was used to compound the capsules, and the final product was given an expiration date of July 14, 2019. All five compounded medications were verified by Respondent. However, assigning a compounded medication a BUD/expiration date that exceeds any of the expiration dates of the ingredients used to compound the medication is a violation of California Code of Regulations, title 16, section 1735.2, subdivision (1)(1)(A), and Business and Professions Code section 4169, subdivision (a)(4).

33. The Board inspectors observed the cleanroom where hazardous drugs were compounded. They noted Pharmacy lacked a gauge for continuous monitoring to maintain negative pressure in the cleanroom.

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June 3, 2019 Inspection

34. In March 2019, the Board received an additional complaint claiming Pharmacy had sent L.M. medication that was not authorized by her or her physician. On June 3, 2019, Inspector Flores conducted another inspection of Pharmacy, assisted by Respondent, pharmacy technician S.R., and pharmacy clerk, B.W. When Inspector Flores requested L.M.'s patient profile, S.R. was unable to locate any patient profile for L.M. in Pharmacy's computer system. S.R. told Inspector Flores to check with B.W. regarding whether L.M.'s patient profile was kept in the other computer system used for the Pharmacy's diabetic supplies prescriptions. B.W. informed Inspector Flores the computer used to process the dispensing of diabetic supplies and topical creams had crashed on May 12, 2019, and the entire computer had been sent out for repair/recovery.

Eviction of Pharmacy and February 13, 2020 Inspection

35. On September 4, 2019, Pharmacy was evicted from its leased space for failure to pay rent.

36. Pharmacy never filed a Discontinuation of Business form or otherwise notified the Board it was closed for business.

37. On December 18, 2019, Respondent sent a letter to the Board informing the Board he was disassociating from Pharmacy as of September 4, 2019.

38. On January 23, 2020, the Board received notification that Pharmacy had been evicted from its lease space on September 4, 2019, for lack of payment. The notification came from A.M., the compliance officer representing Victor Valley Global Medical Center (VVGMC), the entity that leased space to Pharmacy. After Pharmacy's

eviction, VVGMC secured the premises where Pharmacy and Respondent, as PIC, had abandoned dangerous drugs, controlled substances, and patient records. A.M. had contacted the Board to determine what to do with the abandoned medications and records.

39. Inspector Ajayi visited Pharmacy on February 13, 2020, to determine the status of Pharmacy, and he found it was closed for business. A.M. and the VVGMC PIC, R.L., met Inspector Ajayi and informed him they had attempted several times to contact Pharmacy's owners and Respondent to arrange for disposition of the abandoned drugs and records. Pharmacy's owners never contacted them in response.

40. At one point, Respondent arranged to meet with A.M. and R.L. on a Saturday, but he was over an hour late, and A.M. and R.L. had to leave. Eventually, VVGMC personnel returned to Pharmacy's premises, logged all the medications with Board inspector approval, and returned them to distributors for appropriate disposal. Neither Pharmacy nor Respondent assisted in this process.

Respondent Evidence

41. In his testimony and in written statements, Respondent refused to accept full responsibility for his violations, but instead placed blame solely at the feet of Pharmacy and its owners. For example, in a statement, Respondent wrote, "It is these people who are directly responsible for ALL the accusations and allegations filed with the board. I, as PIC, am completely innocent, haven't done anything wrong whatsoever." (Exhibit A, p. B3.) Respondent maintained Pharmacy's financial mismanagement gave rise to the Board's disciplinary action, specifically noting, "There is only one single reason for this matter of accusations and complaints - financial indiscretion, financial hemorrhaging. and disputes caused by [Pharmacy]. To add insult

to injury, [Pharmacy] defrauded me! I was not paid my regular, hard earned wages totaling $85,000!!!" (Exhibit A, p. B1.) Respondent noted he never met the owners of Pharmacy, who operated the business remotely from Florida, and he only communicated with them via phone or email. Respondent further noted:

> This means that I am the only visible person to the board inspectors who can be blamed for everything that's wrong with [Pharmacy]. The inspectors don't [*sic*] see anyone from [Pharmacy] management, nor does he know them or his/her names. The only statement that the inspectors repeatedly make is, "you're the PIC. So you're responsible. We blame you. You fix everything." This is unfair to a PIC who is honest and with integrity. My name is written on the inspection report, not any of my superiors. They do wrong & get away with it. I get blamed for it because I am PIC. However, I am not the owner of the pharmacy.

(Exhibit A, p. B2.)

42. Respondent addressed each of the alleged violations, and he attempted the excuse each of his violations.

43. Regarding his failure to timely complete a pharmacy self-assessment (cause for discipline 19), Respondent asserted, "The reason I was unable to complete the self-assessment within 30 days was because I was originally hired to be PIC at Parkview Compounding Pharmacy in Rancho Cucamonga. I was not hired to be PIC at [Pharmacy]." (Exhibit A, p. B64.) This assertion is not persuasive, since Respondent

himself submitted a Change of PIC form to the Board indicating he was PIC at Pharmacy as of September 4, 2018.

44. Regarding Respondent's failure to complete the compounding self-assessment (cause for discipline 20), Respondent asserted, "I realize that the self-assessment was not completed, but I had a higher duty of ensuring the safety and protection of the public without interrupting the pharmacy operation due to a minor delay in completing an administrative requirement. I mitigated the circumstance after it was brought to my attention by inspector Flores." (Exhibit A, p. B69.) This assertion is not persuasive and does not excuse Respondent's violation.

45. Regarding Respondent allowing unlicensed pharmacy technician activity (cause for discipline 21), Respondent asserted S.R. was licensed. However, as noted above, S.R. was not licensed until October 2018, after engaging in compounding in September 2018, for which Respondent signed off.

46. Regarding Respondent's failure to complete a controlled substances inventory (cause for discipline 22), Respondent insisted he had done so, as set forth in Factual Findings 16 and 17. However, no completed inventory was produced to the Board inspector at the November 6, 2018 inspection, and Inspector Flores credibly testified the handwritten inventory did not fully comply with applicable laws and regulations. (See Factual Finding 18.)

47. Regarding Respondent's failure to maintain compounding equipment and certification (cause for discipline 23), Respondent asserted he had attempted to comply with the applicable requirements. He contended the transition of Pharmacy ownership was chaotic and coincided with his becoming PIC. He pointed to the September 19, 2018 CEPA report as evidence of his attempts to maintain

compounding equipment. However, the September 2018 CEPA report of substandard equipment had not been addressed by the time of the November 6, 2018 inspection. Consequently, Respondent's assertions are not persuasive and do not excuse Respondent's violation.

48. Regarding Respondent dispensing dangerous drugs and diabetic testing supplies pursuant to vague prescription forms (cause for discipline 24), Respondent asserted that he never issued invalid prescriptions and that he always called physicians to verify the authenticity of the pre-printed prescriptions. Respondent's generalized assertions of global compliance are not persuasive and do not excuse Respondent's violation.

49. Regarding Respondent allowing unlicensed pharmacy staff signing for dangerous drugs (cause for discipline 25), Respondent insisted he always signs for deliveries of dangerous drugs. Respondent maintained that, although the Board inspectors saw B.W. sign for a drug order, he did not see it because it occurred while the inspection was being conducted. Respondent's assertions are not credible and are contrary to his admission to Board inspectors during the March 2019 inspection that he sometimes allowed B.W. to sign for drug orders.

50. Regarding Respondent allowing unsecured controlled substances on the premises (cause for discipline 26), Respondent insisted he was not present when Pharmacy transitioned to new ownership, and he was not given a key to the controlled substances drawer. This assertion is not persuasive. At the March 2019 inspection, the Board inspectors found the drawer was unlocked and contained controlled substances. After Respondent became PIC, he could have obtained a key to the drawer to secure the controlled substances, but he had not done so prior to the March 2019 inspection. Additionally, Respondent contended he returned all controlled substances to a reverse

distributor for destruction. However, this did not occur until after the March 2019 inspection, when the unsecured controlled substances were discovered. Respondent's assertions do not excuse his violation.

51. Regarding Respondent's delivery of compounded prescriptions to Dr. Nettles' office for shipment to out- of-state patients (cause for discipline 27), Respondent denied the violation. He vaguely asserted, "As far as I know and have been informed, I have never dispensed a compounded prescription medication to a doctor's office out-of-state only to be given to a patient." (Exhibit A, pp. B21, B80.) Respondent's nebulous assertion is misleading since Respondent admitted to Board investigators orally and in his handwritten statement that he knew compounded medications were sent to Dr. Nettles' office to be shipped to out-of-state patients. (See Exhibit 7, p. A899.)

52. Regarding Respondent's failure to properly label compounded prescription products (cause for discipline 28), Respondent asserted, "With the exception of Dr. Nettle's compounded hair loss medications, all our medications including compounded & retail, had labels affixed to the prescription container [as required by statute]." (Exhibit A, pp. B21, B80-B81.) This assertion conveniently ignores, and attempts to dodge responsibility for, mislabeling Dr. Nettles' prescriptions which comprised a significant volume of products at Pharmacy.

Respondent explained the labeling violations occurred on advice of Pharmacy's consultant, Braddy. According to Respondent:

> [Braddy] advised us to follow a slightly different procedure because Dr. Nettles preferred to affix his proprietary label in addition to [Pharmacy's] label. We did not omit to affix the

> pharmacy label on the container. Due to lack of space and to make it convenient for the patient and less confusing, the doctor's label was affixed on the prescription container and the pharmacy label was affixed right on the inside flap of the box next to the prescription container. The patients seem to prefer it this way because it avoids crowding the prescription container with 2 labels, potentially confusing the patient with which directions to follow. This format seemed to be neat & patient friendly. We never received a customer complaint on account of this format.
>
> In any case, after this issue was brought to our attention by inspector Flores, we immediately thought of a viable solution which would both be patient friendly and in compliance with pharmacy law. We found a way to affix both labels on the prescription container.

(Exhibit A, p. B22.)

Respondent's assertions acknowledge he could have complied but did not. Consequently, Respondent's assertions are not persuasive and do not excuse his violation.

53. Regarding Respondent's failure to provide a notice/offer of consultation with prescriptions (cause for discipline 29), Respondent asserted he always provides consultation at Pharmacy. Respondent's generalized assertion is not persuasive. The violation specifically involved Respondent's failure to send notices/offers of consultation to the patients receiving Dr. Nettles' prescribed medications outside of

Pharmacy. Respondent further asserted, "I was never asked by the inspector about the consultation notice being shipped with compounded medications. There were plenty of such notices in the shipping department which were packaged with all compounded medications ready for shipping. The notice made consultation by the pharmacist available at all times. I personally packaged such notices in all shipments when I was shipping." (Exhibit A, p. B22.) This vague assertion is contrary to Respondent's statement, provided orally and in writing, to Board inspectors at the March 2019 inspection. Both Inspectors testified credibly at hearing about Respondent's admission, and Respondent's written statement specifically admitted "Dr. Nettles provided consultation – advised [patient] to call him for advice, questions. Pharmacy didn't send written notice to [patients]." (Exhibit 7, p. A899.) Respondent's assertions are not persuasive and do not excuse Respondent's violation.

54. Regarding Respondent dispensing sub-potent/misbranded medication (cause for discipline 30), Respondent pointed to purported laboratory error and to the advice of former pharmacist Braddy as excuses for his failure to quarantine and recall the subpotent compounded medication. However, Respondent's speculation that the laboratory did not shake the solution prior to testing was not established by the evidence. Moreover, contrary the Braddy's advice, until the medication was appropriately verified, Respondent had a duty to recall and retest the compounded mediation. Respondent additionally asserted that the Dutasteride was re-tested at 105.6 % of expected potency (Lot Number D1306, received by the laboratory May 9, 2019). (Exhibit H, p. B199.) However, that assertion is misleading. The Dutasteride deemed subpotent came from Pharmacy Lot Number K1309, and the evidence did not establish that lot was ever re-tested and determined to meet potency levels. Instead, the Dutasteride tested at 105.6% of expected potency came from a different lot

number, D1306. Respondent's assertions are not persuasive and do not excuse Respondent's violation.

55. Regarding Respondent dispensing compounded medications with incorrect beyond use dates (cause for discipline 31), Respondent asserted "I NEVER dispense expired medications." (Exhibit A pp. B35, B90.) However, Respondent's generalized denial is contradicted by credible evidence of his violations.

56. Regarding Respondent's failure to monitor and document a proper hazardous non-sterile compounding environment (cause for discipline 32), Respondent refused to admit any responsibility, but instead pointed to others as creating the violation. He noted that the compounding room eventually passed the CERTS testing, and he asserted he "took all necessary steps to correct what our predecessors omitted to accomplish. I did my due diligence as PIC to circumvent and mitigate this apparent anomaly." (Exhibit A, p. B39, B93.) Respondent did not address the failure to have any gauge to continuously monitor and maintain the negative pressure in the compounding room as noted at the March 2019 inspection. Respondent's assertions are not persuasive and do not excuse Respondent's violation.

57. Regarding Respondent's failure to timely notify the Board of ceasing to act as the PIC (cause for discipline 33), Respondent asserted, "This allegation is false. I had notified the board on December 18, 2019 that I was no longer PIC at [Pharmacy]." (Exhibit A, p. B95.) Respondent's assertion is not persuasive. Respondent's December 18, 2019 notice to the Board indicated he disassociated from Pharmacy as of September 4, 2019. Consequently, he should have notified the Board in writing he was no longer PIC within 30 days (i.e., by October 4, 2019). He failed to do so.

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58. Regarding Respondent's failure to maintain prescription documents as determined during the June 2019 inspection (cause for discipline 34), Respondent asserted at hearing that the patient records sought during the inspection were eventually sent to the Board by Pharmacy attorneys. However, patient records were not being properly maintained as of the June 2019 inspection, and only a single patient's prescription was eventually emailed to the Board.

59. Regarding Respondent's failure to notify the Board of the closure of Pharmacy (cause for discipline 35), Respondent again pointed to Pharmacy as the sole entity responsible for the violation. He asserted Pharmacy "FAILED to follow through with multiple reminders which I sent to them to fill [*sic*] a Discontinuance of Business Form with the Board." (Exhibit A, p. B44.) Respondent fails to acknowledge he has a duty, as PIC, to ensure full Pharmacy compliance with pharmacy laws and regulations. Respondent's attempt to divert blame is not persuasive and does not excuse Respondent's violation.

60. Regarding Respondent's failure to arrange for the maintenance of prescription records (cause for discipline 36), Respondent denied he was responsible for this violation, asserting "[Pharmacy] FAILED to arrange for the maintenance of records at [Pharmacy] after it was evicted for not paying rent to VVGMC (landlord). I DID NOT FAIL, [PHARMACY] FAILED." (EXBHIT A, p. B52.) Respondent fails to recognize he has a duty, as PIC, to ensure full Pharmacy compliance with pharmacy laws and regulations. Respondent's attempt to divert blame is not persuasive and does not excuse Respondent's violation.

61. Regarding Respondent's failure to arrange for disposition of drug stock (cause for discipline 37), Respondent denied any violation. He asserted he made his best efforts to work with A.M., R.L., and Inspector Ajayi. He once again pointed to

Pharmacy and its financial mismanagement as the reason for the failed disposition of drug stock. Although Respondent made some effort to be in contact with VVGMC and Inspector Ajayi about the disposition of drug stock, he did not follow up to ensure final disposition of the dangerous drugs and controlled substances. Respondent again fails to acknowledge he has a duty, as PIC, to ensure full Pharmacy compliance with pharmacy laws and regulations. Respondent's assertion of making his best efforts is not persuasive and does not excuse Respondent's violation.

62. Respondent has over 35 years of experience as a pharmacist, and during most of that time, he worked as a PIC. He held approximately five PIC positions prior to his employment at Pharmacy. After leaving Pharmacy, he worked as a PIC at Pure Science Pharmacy and later at Care Pharmacy. He currently works as a staff pharmacist at Quick RX Pharmacy, where he earns significantly less than he did as a PIC.

63. When asked if he took responsibility for any of his violations, Respondent testified, "the majority of responsibility for this is [Pharmacy's] because they did not cooperate with me to comply. So if a party is doing wrong things, and I am present, that does not make me the wrong party." Respondent insisted "it is a joint and cooperative responsibility," but "nothing was done per my advice and recommendations."

Costs

64. Complainant submitted, as evidence of the costs of prosecution of the Accusation, a Certification of Prosecution Costs/Declaration of Vinodhini Ramagopal, certifying that the Department of Justice, Office of the Attorney General billed the Board $28,640 for legal services provided through February 25, 2022.

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65. Complainant submitted, as evidence of the investigative costs for this matter, a certification of costs signed by Complainant, certifying that investigative costs totaled $36,416.50.

66. The evidence established that Complainant incurred total investigation and prosecution costs of $65,056.50, all of which are deemed reasonable.

LEGAL CONCLUSIONS

1. Business and Professions Code section 4301 requires the Board to impose discipline on any pharmacy licensee who is guilty of unprofessional conduct. Unprofessional conduct includes:

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

2. Business and Professions Code section 4113, subdivision (c), provides: "The pharmacist-in-charge shall be responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy."

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3. Nineteenth Cause for Discipline (Failure to Timely Complete Pharmacy Self-Assessment): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and Professions Code sections 4113, subdivision (c), and 4301, subdivision (o), for violating California Code of Regulations, title 16, section 1715, subdivision (b)(2) (PIC must complete self-assessment within 30 days of becoming new PIC), on the grounds that Respondent failed to timely complete Pharmacy's Self-Assessment within 30 days of becoming the PIC, as set forth in Factual Findings 3 through 63.

4. Twentieth Cause for Discipline (Failure to Complete the Compounding Self-Assessment Prior to Compounding): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and Professions Code sections 4113, subdivision (c), and 4301, subdivision (o), for violating California Code of Regulations, title 16, section 1735.2, subdivision (k) (PIC must complete compounding self-assessment within 30 days of becoming new PIC), on the grounds that Respondent failed to complete the Compounding Self-Assessment within 30 days of becoming new PIC and continued to engage in compounding activities, as set forth in Factual Findings 3 through 63.

5. Twenty-first Cause for Discipline (Unlicensed Pharmacy Technician Activity): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and Professions Code sections 4113, subdivision (c), and 4115, subdivisions (a) and (e) (pharmacy technician must be licensed by Board prior to performing non-discretionary tasks under pharmacist's supervision), in conjunction with California Code of Regulations, title 16, section 1793.2 (non-discretionary tasks include mixing/compounding pharmaceuticals), on the grounds that, while Respondent was PIC, a pharmacy staff member engaged in pharmacy technician compounding

activities prior to being licensed as a pharmacy technician by the Board, as set forth in Factual Findings 3 through 63.

6. Twenty-second Cause for Discipline (Failure to Complete a Controlled Substance Inventory): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and Professions Code sections 4113, subdivision (c), and 4301, subdivisions (j) and (o), in that Respondent violated Title 21, Code of Federal Regulations, section 1304.11, subdivision (a) ("The inventory may be taken either as of opening of business or as of the close of business on the inventory date and it shall be indicated on the inventory") by failing to complete a sufficient controlled substance inventory document, as set forth in Factual Findings 3 through 63.

7. Twenty-third Cause for Discipline (Failure to Maintain Compounding Equipment and Certification): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and Professions Code sections 4113, subdivision (c), and 4301, subdivisions (j) and (o), for violating California Code of Regulations, title 16, section 1735.6, subdivisions (a) and (e)(3)(B) (hazardous compounding must occur in externally-exhausted separate room with HEPA filter, and must be certified), on the grounds that Respondent failed to ensure Pharmacy's non-sterile compounding hood and compounding room were properly exhausted and certified, as set forth in Factual Findings 3 through 63.

8. Twenty-fourth Cause for Discipline (Dispensing Dangerous Drugs and Diabetic Testing Supplies Pursuant to Pre-Printed Prescription Forms): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and Professions Code sections 4113, subdivision (c), 4081, subdivision (d) (pharmacies must retain records of acquisition and sale of test devices and make available for inspection), and 4301, subdivisions (j) and (o), in conjunction with California Code of Regulations, title 16,

section 1717.3, subdivision (b) (prescriber must indicate on prescription form the number of drugs prescribed), on the grounds that while Respondent was PIC, Pharmacy dispensed hundreds of diabetic supplies pursuant to pre-printed prescription forms where the prescribers did not indicate the specific number of items prescribed, as set forth in Factual Findings 3 through 63.

9. Twenty-fifth Cause for Discipline (Unlicensed Pharmacy Staff Signing for Dangerous Drugs): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and Professions Code sections 4113, subdivision (c), 4059.5, subdivision (a) (delivery of dangerous drugs must be received and signed for by a pharmacist), and 4301, subdivisions (j) and (o), in that Respondent allowed an unlicensed pharmacy staff member to sign for an order of dangerous drugs, as set forth in Factual Findings 3 through 63.

10. Twenty-sixth Cause for Discipline (Unsecured Controlled Substances): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and Professions Code sections 4113, subdivision (c), and 4301, subdivisions (j) and (o), in conjunction with California Code of Regulations, title 16, section 1714, subdivision (d) (possession of key to where controlled substances are stored is restricted to pharmacist), and Title 21, Code of Federal Regulations, section 1301.75, subdivision (b) (controlled substances shall be stored in securely locked cabinet), on the grounds that, while Respondent was PIC, Pharmacy's Schedule II controlled substances were located in an unlocked drawer, and the key was in the possession of an unlicensed pharmacy manager, as set forth in Factual Findings 3 through 63.

11. Twenty-seventh Cause for Discipline (Delivery of Compounded Prescription Medications to Doctor's Office for Shipment to Out-of-State Patients): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and

Professions Code sections 4113, subdivision (c), and 4301, subdivisions (j) and (o), in conjunction with California Code of Regulations, title 16, section 1713, subdivision (a) ("no licensee shall participate in any arrangement or agreement, whereby prescription medications, may be accepted by, or delivered to any place not licensed as a retail pharmacy"), on the grounds that, while Respondent was PIC, Pharmacy sent compounded prescription medications to the original prescribing doctor's office for shipment to out-of-state patients, as set forth in Factual Findings 3 through 63.

12. Twenty-eighth Cause for Discipline (Failure to Properly Label Compounded Prescription Products): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and Professions Code sections 4113, subdivision (c), and 4076, subdivision (a), subsections (3) through (7) (prescriptions must be dispensed in correctly labeled containers), in that, while Respondent was PIC, Pharmacy failed to place Pharmacy's prescription labels on the compounded medication bottles, instead placing the doctor's product labels on the bottles, and Pharmacy's label on the shipping box, as set forth in Factual Findings 3 through 63.

13. Twenty-ninth Cause for Discipline (Failure to Provide Notice/Offer of Consultation): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and Professions Code sections 4113, subdivision (c), and 4301, subdivision (o), in conjunction with California Code of Regulations, title 16, section 1707.2, subdivision (b)(1) (when prescription is mailed, a pharmacy must ensure the patient receives written notice of right to request pharmacist consultation), on the grounds that, while Respondent was PIC, Pharmacy was not providing any notice or offer of consultation to patients who were shipped certain compounded prescription medications, as set forth in Factual Findings 3 through 63.

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14. Thirtieth Cause for Discipline (Dispensing of Sub-Potent/Misbranded Medications): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and Professions Code sections 4113, subdivision (c), 4301, subdivisions (j) and (o), and 4169, subdivision (a)(3) (no person may sell dangerous drugs that the person knew or reasonably should have known were misbranded), in conjunction with Health and Safety Code section 111440 ("It is unlawful for any person to manufacture, sell, deliver, hold, or offer for sale any drug or device that is misbranded"), on the grounds that, while Respondent was PIC, Pharmacy dispensed compounded Latanoprost-Dutasteride 0.005%/0.1% solution to patients when a component of that compounded medication, Dutasteride, failed to meet the required +/- 10 percent of the stated potency, as set forth in Factual Findings 3 through 63.

15. Thirty-first Cause for Discipline (Dispensing Compounded Medications with Incorrect Beyond Use Dates): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and Professions Code sections 4113, subdivision (c), 4301, subdivision (o), and 4169, subdivision (a)(4) (no dangerous drug may be sold after the beyond use date on the label), in conjunction with California Code of Regulations, title 16, section 1735.2, subdivision (i)(1)(A) (compounded drug shall be given beyond use date that does not exceed the shortest expiration date of any of its ingredients), on the grounds that, while Respondent was PIC, Pharmacy compounded medications and applied Beyond Use Dates that exceeded the expiration date of one of the components, as set forth in Factual Findings 3 through 63.

16. Thirty-second Cause for Discipline (Failure to Monitor and Document a Proper Hazardous Non-Sterile Compounding Environment): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and Professions Code sections 4113, subdivision (c), and 4301, subdivisions (j) and (o), in conjunction with California

Code of Regulations, title 16, section 1735.6, subdivision (e)(2) (hazardous drug compounding shall be completed in an externally exhausted physically separate room maintained at a specified negative pressure), on the grounds that, while Respondent was PIC, he failed to ensure Pharmacy had a gauge to continuously monitor and maintain the negative pressure in the compounding room, as set forth in Factual Findings 3 through 63.

17. Thirty-third Cause for Discipline (Failure to Timely Notify the Board of Ceasing to Act as the Pharmacist-In-Charge): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and Professions Code sections 4101, subdivision (a) (PIC who ceases to act as PIC shall notify Board in writing within 30 days of the date of that change in status), on the grounds that Respondent failed to timely notify the Board he was no longer PIC at Pharmacy, as set forth in Factual Findings 3 through 63.

18. Thirty-fourth Cause for Discipline (Failure to Maintain Prescription Documents): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and Professions Code sections 4113, subdivision (c), 4081, subdivision (a) (pharmacy must maintain all records of disposition of dangerous drugs), and 4105, subdivisions (a), (b), and (c) (documentation regarding disposition of dangerous drugs and dangerous devices shall be retained on the licensed premises in a readily retrievable form), on the grounds that, while Respondent was PIC, Pharmacy failed to properly maintain patient prescription records, as set forth in Factual Findings 3 through 63.

19. Thirty-fifth Cause for Discipline (Failure to Notify the Board of Closure): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and Professions Code sections 4113, subdivision (c), and 4301, subdivision (o), in

conjunction with California Code of Regulations, title 16, section 1708.2 (pharmacy shall contact the Board prior to transferring or selling any dangerous drugs or inventory as a result of termination of business), on the grounds that, while Respondent was PIC, he failed to notify the Board of the closure of Pharmacy prior to its discontinuance of business, as set forth in Factual Findings 3 through 63.

20. Thirty-sixth Cause for Discipline (Failure to Arrange for the Maintenance of Prescription Records): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and Professions Code sections 4113, subdivision (c), 4301, subdivision (o), and 4333, subdivision (a) (when a pharmacy discontinues business, prescription records shall be maintained in a Board-licensed facility for at least three years), on the grounds that, while Respondent was PIC, he failed to arrange for the storage or maintenance of Pharmacy's prescription records at a Board-licensed facility after Pharmacy was evicted from its location, as set forth in Factual Findings 3 through 63.

21. Thirty-seventh Cause for Discipline (Failure to Arrange for Disposition of Drug Stock): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and Professions Code sections 4113, subdivision (c), 4301, subdivisions (j) and (o), and 4312, subdivision (b) (within 10 days of notifying the Board of its intent to discontinue business, a pharmacy shall arrange for the transfer of all dangerous drugs and controlled substances to another licensee authorized to possess the dangerous drugs and controlled substances), on the grounds that, while Respondent was PIC, he failed to arrange for the transfer of Pharmacy's inventory of dangerous drugs and controlled substances to another licensed premises, as set forth in Factual Findings 3 through 63.

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22. Thirty-eighth Cause for Discipline (Unprofessional Conduct): Cause exists to discipline Respondent's pharmacist license, pursuant to Business and Professions Code sections 4113, subdivision (c), and 4306.5, on the grounds that, while Respondent was PIC, he failed to exercise professional judgment, training, and experience as a PIC, as set forth in Factual Findings 3 through 63.

23. Pursuant to Business and Professions Code section 125.3, Complainant is entitled to recover reasonable costs of investigation and enforcement of this matter in the amount of $65,056.50, as set forth in Factual Finding 66. However, to ensure that cost awards do not deter licentiates with potentially meritorious claims or defenses from exercising their right to a hearing, the Board must use its discretion to reduce or eliminate costs by considering the following factors: the licentiate's ability to obtain dismissal or reduction of the charges; the licentiate's subjective good faith belief in the merits of his or her position; whether the licentiate raised a colorable challenge to the proposed discipline; the licentiate's financial ability to pay; and whether the scope of the investigation was appropriate in light of the alleged misconduct. (*Zuckerman v. State Board of Chiropractic Examiners* (*Zuckerman*) (2002) 29 Cal.4th 32, 45.) In this case, Complainant established all causes for discipline against Respondent. Although half of the causes for discipline alleged in the Accusation pertained only to Pharmacy, those causes for discipline mirrored the causes for discipline against Respondent and the investigation and prosecution costs were not duplicative. However, given Respondent's decreased income, the costs will be reduced by 50 percent, and Respondent shall pay the Board the reasonable costs for investigation and enforcement totaling $32,532.75.

24. Pursuant to the Board's Disciplinary Guidelines, in determining the appropriate discipline in a case, factors such as the following should be considered: (1)

actual or potential harm to the public; (2) actual or potential harm to any consumer; (3) prior disciplinary record, including level of compliance with disciplinary order(s); (4) prior warning(s), including but not limited to citation(s) and fine(s), letter(s) of admonishment, and/or correction notice(s); (5) number and/or variety of current violations; (6) nature and severity of the act(s), offense(s) or crime(s) under consideration; (7) aggravating evidence; (8) mitigating evidence; (9) rehabilitation evidence; (10) compliance with terms of any criminal sentence, parole, or probation; (11) overall criminal record; (12) if applicable, evidence of proceedings for case being set aside and dismissed pursuant to Section 1203.4 of the Penal Code; (13) time passed since the act(s) or offense(s); (14) whether the conduct was intentional or negligent, demonstrated incompetence, or, if the respondent is being held to account for conduct committed by another, the respondent had knowledge of or knowingly participated in such conduct; (15) financial benefit to the respondent from the misconduct; and (16) other licenses held by the respondent and license history of those licenses.

25. Respondent has committed a significant number of varying violations which were recent in time. However, there was no evidence the violations resulted in harm to any patients or to the public. Additionally, the violations were not intentional flouting of the law but arose from Respondent's negligence in his duties as PIC to ensure Pharmacy's compliance with the applicable laws and regulations.

26. While Pharmacy created the circumstances that eventually led to the violations, Respondent as PIC was also responsible for Pharmacy's compliance. However, Respondent refuses to accept any responsibility for the violations, placing full blame on Pharmacy. Remorse for one's conduct and the acceptance of responsibility are the cornerstones of rehabilitation. (See *In the Matter of Brown* (1993)

2 Cal. State Bar Ct. Rptr. 309.) Fully acknowledging the wrongfulness of past actions is an essential step towards rehabilitation. (See *Seide v. Committee of Bar Examiners* (1989) 49 Cal.3d 933; *In the Matter of Brown, supra*.)

27. However, mere remorse does not demonstrate rehabilitation. A truer indication of rehabilitation is sustained conduct over an extended period of time. (*In re Menna* (1995) 11 Cal.4th 975, 991.) Since leaving Pharmacy's employment, and for many years prior to working at Pharmacy, Respondent was licensed as a pharmacist with no complaints of wrongdoing.

28. The statutes relating to licensing of professions generally are designed to protect the public from dishonest, untruthful, and disreputable licensees. (*Arneson v. Fox* (1980) 28 Cal.3d 440, 451.) Administrative actions regarding a state-issued license are not for the primary purpose of punishing an individual. (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 165.) Rather, in issuing and disciplining licenses, a state agency is primarily concerned with protection of the public, maintaining the integrity and high standards of the profession, and preserving public confidence in licensure. (*Ibid*; see also *Fahmy v. Medical Bd. of California* (1995) 38 Cal.App.4th 810, 817.)

29. Despite his lack of remorse, Respondent has a long history of compliance, and he presents a very low risk of recidivism, particularly as a staff pharmacist. Respondent's continued practice as a staff pharmacist under appropriate probationary terms will best protect the public without imposing overly harsh and punitive discipline on Respondent.

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ORDER

License number RPH 39954, issued to Respondent Ashok Popat, is revoked. However, the revocation is stayed, and Respondent is placed on probation for four years upon the following terms and conditions:

1. OBEY ALL LAWS

Respondent shall obey all state and federal laws and regulations.

Respondent shall report any of the following occurrences to the board, in writing, within seventy- two (72) hours of such occurrence:

(1) an arrest or issuance of a criminal complaint for violation of any provision of the Pharmacy Law, state and federal food and drug laws, or state and federal controlled substances laws

(2) a plea of guilty, or nolo contendere, no contest, or similar, in any state or federal criminal proceeding to any criminal complaint, information or indictment

(3) a conviction of any crime

(4) the filing of a disciplinary pleading, issuance of a citation, or initiation of another administrative action filed by any state or federal agency which involves respondent's license or which is related to the practice of pharmacy or the manufacturing, obtaining, handling, distributing, billing, or charging for any drug, device or controlled substance.

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

2. REPORT TO THE BOARD

Respondent shall report to the Board quarterly, on a schedule as directed by the Board or its designee. The report shall be made either in person or in writing, as directed. Among other requirements, Respondent shall state in each report under penalty of perjury whether there has been compliance with all the terms and conditions of probation.

Failure to submit timely reports in a form as directed shall be considered a violation of probation. Any period(s) of delinquency in submission of reports as directed may be added to the total period of probation. Moreover, if the final probation report is not made as directed, probation shall be automatically extended until such time as the final report is made and accepted by the Board.

3. INTERVIEW WITH THE BOARD

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

4. COOPERATE WITH BOARD STAFF

Respondent shall timely cooperate with the Board's inspection program and with the Board's monitoring and investigation of Respondent's compliance with the terms and conditions of his probation, including but not limited to: timely responses to requests for information by Board staff; timely compliance with directives from

Board staff regarding requirements of any term or condition of probation; and timely completion of documentation pertaining to a term or condition of probation. Failure to timely cooperate shall be considered a violation of probation.

5. CONTINUING EDUCATION

Respondent shall provide evidence of efforts to maintain skill and knowledge as a pharmacist as directed by the Board or its designee.

6. REPORTING OF EMPLOYMENT AND NOTICE TO EMPLOYERS

During the period of probation, Respondent shall notify all present and prospective employers of this Decision (Case number 7046; OAH number 2021070154) and the terms, conditions and restrictions imposed on Respondent by this Decision, as follows:

Within 30 days of the effective date of this Decision, and within 10 days of undertaking any new employment, Respondent shall report to the Board in writing the name, physical address, and mailing address of each of his employer(s), and the name(s) and telephone number(s) of all of his direct supervisor(s), as well as any pharmacist(s)-in-charge, designated representative(s)-in-charge, responsible manager, or other compliance supervisor(s) and the work schedule, if known. Respondent shall also include the reason(s) for leaving the prior employment. Respondent shall sign and return to the Board a written consent authorizing the Board or its designee to communicate with all of Respondent's employer(s) and supervisor(s), and authorizing those employer(s) or supervisor(s) to communicate with the Board or its designee, concerning Respondent's work status, performance, and monitoring. Failure to comply with the requirements or deadlines of this condition shall be considered a violation of probation.

Within 30 days of the effective date of this Decision, and within 15 days of Respondent undertaking any new employment, Respondent shall cause (a) his direct supervisor, (b) his pharmacist-in-charge, designated representative-in-charge, responsible manager, or other compliance supervisor, and (c) the owner or owner representative of his employer, to report to the Board in writing acknowledging that the listed individual(s) has/have read this Decision (Case number 7046; OAH number 2021070154), and the terms and conditions imposed thereby. If one person serves in more than one role described in (a), (b), or (c), the acknowledgment shall so state. It shall be the Respondent's responsibility to ensure that these acknowledgment(s) are timely submitted to the Board. In the event of a change in the person(s) serving the role(s) described in (a), (b), or (c) during the term of probation, Respondent shall cause the person(s) taking over the role(s) to report to the Board in writing within 15 days of the change acknowledging that he or she has read this Decision (Case number 7046; OAH number 2021070154), and the terms and conditions imposed thereby.

If Respondent works for or is employed by or through an employment service, Respondent must notify the person(s) described in (a), (b), and (c) above at every entity licensed by the Board of this Decision (Case number 7046; OAH number 2021070154), and the terms and conditions imposed thereby in advance of Respondent commencing work at such licensed entity. A record of this notification must be provided to the Board upon request.

Furthermore, within 30 days of the effective date of this Decision, and within 15 days of Respondent undertaking any new employment by or through an employment service, Respondent shall cause the person(s) described in (a), (b), and (c) above at the employment service to report to the Board in writing acknowledging that he or she has read this Decision (Case number 7046; OAH number 2021070154), and the terms

and conditions imposed thereby. It shall be Respondent's responsibility to ensure that these acknowledgment(s) are timely submitted to the Board.

Failure to timely notify present or prospective employer(s) or failure to cause the identified person(s) with that/those employer(s) to submit timely written acknowledgments to the Board shall be considered a violation of probation.

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

7. NOTIFICATION OF CHANGE(S) IN NAME, ADDRESS(ES), OR PHONE NUMBER(S)

Respondent shall further notify the board in writing within 10 days of any change in name, residence address, mailing address, e-mail address or phone number.

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

8. RESTRICTIONS ON SUPERVISION AND OVERSIGHT OF LICENSED FACILITIES

During the period of probation, Respondent shall not supervise any intern pharmacist, be the pharmacist-in-charge, designated representative-in-charge, responsible manager, or other compliance supervisor of any entity licensed by the Board, nor serve as a consultant.

Assumption of any such unauthorized supervision responsibilities shall be considered a violation of probation.

9. REIMBURSEMENT OF BOARD COSTS

As a condition precedent to successful completion of probation, Respondent shall pay to the Board its costs of investigation and prosecution in the amount of $32,532.75.

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

Failure to pay costs by the deadline(s) as directed shall be considered a violation of probation.

10. PROBATION MONITORING COSTS

Respondent shall pay any costs associated with probation monitoring as determined by the Board each year of probation. Such costs shall be payable to the Board on a schedule as directed by the Board or its designee. Failure to pay such costs by the deadline(s) as directed shall be considered a violation of probation.

11. STATUS OF LICENSE

Respondent shall, at all times while on probation, maintain an active, current pharmacist license with the Board, including any period during which suspension or probation is tolled.

Failure to maintain an active, current pharmacist license shall be considered a violation of probation.

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

12. LICENSE SURRENDER WHILE ON PROBATION/SUSPENSION

Following the effective date of this Decision, should Respondent cease practice due to retirement or health, or be otherwise unable to satisfy the terms and conditions of probation, Respondent may relinquish his license, including any indicia of licensure issued by the Board, along with a request to surrender the license. The Board or its designee shall have the discretion whether to accept the surrender or take any other action it deems appropriate and reasonable. Upon formal acceptance of the surrender of the license, Respondent will no longer be subject to the terms and conditions of probation. This surrender constitutes a record of discipline and shall become a part of the Respondent’s license history with the board.

Upon acceptance of the surrender, Respondent shall relinquish his pocket and/or wall license, including any indicia of licensure to the Board within 10 days of notification by the Board that the surrender is accepted if not already provided.

Respondent may not reapply for any license from the Board for three years from the effective date of the surrender. Respondent shall meet all requirements applicable to the license sought as of the date the application for that license is submitted to the Board, including any outstanding costs.

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13. PRACTICE REQUIREMENT – EXTENSION OF PROBATION

Except during periods of suspension, Respondent shall, at all times while on probation, be employed as a pharmacist in California for a minimum of 40 hours per calendar month. Any month during which this minimum is not met shall extend the period of probation by one month. During any such period of insufficient employment, Respondent must nonetheless comply with all terms and conditions of probation, unless Respondent receives a waiver in writing from the Board or its designee.

If Respondent does not practice as a pharmacist in California for the minimum number of hours in any calendar month, for any reason (including vacation), Respondent shall notify the Board in writing within 10 days of the conclusion of that calendar month. This notification shall include at least: the date(s), location(s), and hours of last practice; the reason(s) for the interruption or reduction in practice; and the anticipated date(s) on which Respondent will resume practice at the required level. Respondent shall further notify the Board in writing within 10 days following the next calendar month during which Respondent practices as a pharmacist in California for the minimum of hours. Any failure to timely provide such notification(s) shall be considered a violation of probation.

It is a violation of probation for Respondent's probation to be extended pursuant to the provisions of this condition for a total period, counting consecutive and non-consecutive months, exceeding 36 months. The Board or its designee may post a notice of the extended probation period on its website.

14. VIOLATION OF PROBATION

If Respondent has not complied with any term or condition of probation, the Board shall have continuing jurisdiction over Respondent, and the Board shall provide

notice to Respondent that probation shall automatically be extended, until all terms and conditions have been satisfied or the Board has taken other action as deemed appropriate to treat the failure to comply as a violation of probation, to terminate probation, and to impose the penalty that was stayed. The Board or its designee may post a notice of the extended probation period on its website.

If Respondent violates probation in any respect, the Board, after giving Respondent notice and an opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If a petition to revoke probation or an accusation is filed against Respondent during probation, or the preparation of an accusation or petition to revoke probation is requested from the Office of the Attorney General, the Board shall have continuing jurisdiction and the period of probation shall be automatically extended until the petition to revoke probation or accusation is heard and decided.

15. NO OWNERSHIP OR MANAGEMENT OF LICENSED PREMISES

Respondent shall not own, have any legal or beneficial interest in, nor serve as a manager, administrator, member, officer, director, trustee, associate, or partner of any business, firm, partnership, or corporation currently or hereinafter licensed by the Board. Respondent shall sell or transfer any legal or beneficial interest in any entity licensed by the Board within 90 days following the effective date of this Decision and shall immediately thereafter provide written proof thereof to the Board. Failure to timely divest any legal or beneficial interest(s) or provide documentation thereof shall be considered a violation of probation.

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16. COMPLETION OF PROBATION

Upon written notice by the Board or its designee indicating successful completion of probation, Respondent's license will be fully restored.

DATE: 05/10/2022

Julie Cabos-Owen

JULIE CABOS-OWEN

Administrative Law Judge

Office of Administrative Hearings

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

In the Matter of the Accusation Against**:** **SIX DEGREES, INC. DBA SIX DEGREES HEALTH DBA PRESCRIPTION SHOPPE, ANNA KARINA RUBIO, MARIANNE CHRISTIANE ANTONIO** **15247 Eleventh St., 1000A & 1000B** **Victorville, CA 92395** **Permit No. PHY 56833,** **and** **ASHOK POPAT** **630 Crestview Dr.** **Diamond Bar, CA 91765** **Pharmacist License No. RPH 39954,** Respondents.	Case No. 7046 **ACCUSATION**

PARTIES

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

2. On or about August 31, 2018, the Board of Pharmacy issued Permit Number PHY 56833 to Six Degrees, Inc. dba Six Degrees Health dba Prescription Shoppe, Anna Karina Rubio, Marianne Christiane Antonio (Respondent Prescription Shoppe). The Permit expired on August 1, 2020, and has not been renewed.

3. On or about March 18, 1986, the Board of Pharmacy issued Pharmacist License Number RPH 39954 to Ashok Popat (Respondent Popat). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2023, unless renewed.

JURISDICTION

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

5. Section 4300 of the Code states in pertinent part:

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

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(e) The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code, and the board shall have all the powers granted therein. The action shall be final, except that the propriety of the action is subject to review by the superior court pursuant to Section 1094.5 of the Code of Civil Procedure.

6. Section 4300.1 of the Code states:

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

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STATUTORY PROVISIONS

7. Section 4076 of the Code states in pertinent part:

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

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(3) The name of the patient or patients.

(4) The name of the prescriber or, if applicable, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(5) The date of issue.

(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.

(7) The strength of the drug or drugs dispensed.

8. Section 4081 of the Code states in relevant part:

(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, outsourcing facility, physician, dentist, podiatrist, veterinarian, laboratory, licensed correctional clinic, as defined in Section 4187, 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.

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(d) Pharmacies that dispense nonprescription diabetes test devices pursuant to prescriptions shall retain records of acquisition and sale of those nonprescription diabetes test devices for at least three years from the date of making. The records shall be at all times during business hours open to inspection by authorized officers of the law.

9. Section 4095.5, subdivision (a) of the Code states:

Except as otherwise provided in this chapter, dangerous drugs or dangerous devices may only be ordered by an entity licensed by the board and shall be delivered to the licensed premises and signed for and received by a pharmacist. Where a licensee is permitted to operate through a designated representative, or in the case of a reverse distributor a designated representative-reverse distributor, that individual shall sign for and receive the delivery.

10. Section 4101, subdivision (a) of the Code states:

A pharmacist may take charge of and act as the pharmacist-in-charge of a pharmacy upon application by the pharmacy and approval by the board. A pharmacist-in-charge who ceases to act as the pharmacist-in-charge of the pharmacy shall notify the board in writing within 30 days of the date of that change in status.

11. Section 4105 of the Code states in relevant part:

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

(b) The licensee may remove the original records or documentation from the licensed premises on a temporary basis for license-related purposes. However, a duplicate set of those records or other documentation shall be retained on the licensed premises.

(c) The records required by this section shall be retained on the licensed premises for a period of three years from the date of making.

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12. Section 4110 of the Code states in relevant part:

(a) No person shall conduct a pharmacy in the State of California unless he or she has obtained a license from the board. A license shall be required for each pharmacy owned or operated by a specific person. A separate license shall be required for each of the premises of any person operating a pharmacy in more than one location. The license shall be renewed annually. The board may, by regulation, determine the circumstances under which a license may be transferred.

13. Section 4113 of the Code states in pertinent part:

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(b) The proposed pharmacist-in-charge shall be subject to approval by the board. The board shall not issue or renew a pharmacy license without identification of an approved pharmacist-in-charge for the pharmacy.

(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.

14. Section 4115 of the Code 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.

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

15. Section 4169 of the Code states in pertinent part:

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

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(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.

(4) Purchase, trade, sell, or transfer dangerous drugs or dangerous devices after the beyond use date on the label.

16. Section 4301 of the Code states in relevant part:

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:

* * *

(j) The violation of any of the statutes of this state, or any other state, or of the United States regulating controlled substances and dangerous drugs.

* * *

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

17. 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.

18. Section 4307 of the Code states, in pertinent part:

(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.

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19. Section 4333 of the Code states in pertinent part:

(a) All prescriptions filled by a pharmacy and all other records required by Section 4081 shall be maintained on the premises and available for inspection by authorized officers of the law for a period of at least three years. In cases where the pharmacy discontinues business, these records shall be maintained in a board-licensed facility for at least three years.

20. Section 4312 of the Code states in pertinent part:

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(b) If the license of a wholesaler, third-party logistics provider, pharmacy, veterinary food-animal drug retailer, or outsourcing facility is canceled pursuant to subdivision (a) or revoked pursuant to Article 19 (commencing with Section 4300), or a wholesaler, third-party logistics provider, pharmacy, veterinary food-animal drug retailer, or outsourcing facility notifies the board of its intent to remain closed or to discontinue business, the licensee shall, within 10 days thereafter, arrange for the transfer of all dangerous drugs and controlled substances or dangerous devices to another licensee authorized to possess the dangerous drugs and controlled substances or dangerous devices. The licensee transferring the dangerous drugs and controlled substances or dangerous devices shall immediately confirm in writing to the board that the transfer has taken place.

21. Section 4402 of the Code states:

(a) 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.

(b)(1) Any pharmacist whose license is canceled pursuant to subdivision (a) may obtain a new license if he or she takes and passes the examination that is required for initial license with the board.

(2) The board may impose conditions on any license issued pursuant to this section, as it deems necessary.

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(c) A license that has been revoked by the board under former Section 4411 shall be deemed canceled three years after the board's revocation action, unless the board has acted to reinstate the license in the interim.

(d) This section shall not affect the authority of the board to proceed with any accusation that has been filed prior to the expiration of the three-year period.

(e) Any other license issued by the board may be canceled by the board if the license is not renewed within 60 days after its expiration. Any license canceled under this subdivision may not be reissued. Instead, a new application will be required.

22. Section 111440 of the Health and Safety Code states:

It is unlawful for any person to manufacture, sell, deliver, hold, or offer for sale any drug or device that is misbranded.

REGULATORY PROVISIONS

23. California Code of Regulations, title 16, section 1707.2 states:

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

(1) upon request;

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

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

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

(b)(1) When the patient or patient's agent is not present (including, but not limited to, a prescription drug that was shipped by mail or delivery), a pharmacy shall ensure that:

(A) the patient receives written notice of his or her right to request consultation;

(B) the patient receives written notice of the hours of availability and the telephone number from which the patient may obtain oral consultation from a pharmacist who has ready access to the patient's record; and

(C) a pharmacist shall be available (i) to speak to the patient or patient's agent during any regular hours of operation, within an average of ten (10) minutes or less, unless a return call is scheduled to occur within one business hour, (ii) for no less than six days per week, and (iii) for a minimum of 40 hours per week.

(2) A pharmacist is not required by this subsection to provide oral consultation to an inpatient of a health care facility licensed pursuant to section 1250 of the Health and Safety Code, or to an inmate of an adult correctional facility or a juvenile detention facility, except upon the patient's discharge. A pharmacist is not obligated to consult about discharge medications if a health facility licensed pursuant to subdivision (a) or (b) of Health and Safety Code Section 1250 has implemented a written policy about discharge medications which meets the requirements of Business and Professions Code Section 4074.

(c) When oral consultation is provided, it shall include at least the following:

(1) directions for use and storage and the importance of compliance with directions; and

(2) precautions and relevant warnings, including common severe side or adverse effects or interactions that may be encountered.

(d) Whenever a pharmacist deems it warranted in the exercise of his or her professional judgment, oral consultation shall also include:

(1) the name and description of the medication;

(2) the route of administration, dosage form, dosage, and duration of drug therapy;

(3) any special directions for use and storage;

(4) precautions for preparation and administration by the patient, including techniques for self-monitoring drug therapy;

(5) prescription refill information;

(6) therapeutic contraindications, avoidance of common severe side or adverse effects or known interactions, including serious potential interactions with known nonprescription medications and therapeutic contraindications and the action required if such side or adverse effects or interactions or therapeutic contraindications are present or occur;

(7) action to be taken in the event of a missed dose.

(e) Notwithstanding the requirements set forth in subsection (a) and (b), a pharmacist is not required to provide oral consultation when a patient or the patient's agent refuses such consultation.

24. California Code of Regulations, title 16, section 1708.2 states:

Any permit holder shall contact the board prior to transferring or selling any dangerous drugs, devices or hypodermics inventory as a result of termination of business or bankruptcy proceedings and shall follow official instructions given by the board applicable to the transaction.

25. California Code of Regulations, title 16, section 1713, subdivision (a), states:

Except as otherwise provided in this Division, no licensee shall participate in any arrangement or agreement, whereby prescriptions, or prescription medications, may be left at, picked up from, accepted by, or delivered to any place not licensed as a retail pharmacy.

26. California Code of Regulations, title 16, section 1715 states in relevant part:

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

(b) In addition to the self-assessment required in subdivision (a) of this section, the pharmacist-in-charge shall complete a self-assessment within 30 days whenever:

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(2) There is a change in the pharmacist-in-charge, and he or she becomes the new pharmacist-in-charge of a pharmacy.

27. California Code of Regulations, title 16, section 1717.3, subdivision (b), states:

A person may dispense a dangerous drug, that is not a controlled substance, pursuant to a preprinted multiple checkoff prescription blank and may dispense more than one dangerous drug, that is not a controlled substance, pursuant to such a blank if the prescriber has indicated on the blank the number of dangerous drugs he or she has prescribed.

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28. California Code of Regulations, title 16, section 1714, subdivision (d), states:

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

29. California Code of Regulations, title 16, section 1735.2, subdivision (i)(1)(A), states:

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(i) Every compounded drug preparation shall be given a beyond use date representing the date or date and time beyond which the compounded drug preparation should not be used, stored, transported or administered, and determined based on the professional judgment of the pharmacist performing or supervising the compounding.

(1) For non-sterile compounded drug preparation(s), the beyond use date shall not exceed any of the following:

(A) the shortest expiration date or beyond use date of any ingredient in the compounded drug preparation.

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(k) Prior to allowing any drug product preparation to be compounded in a pharmacy, the pharmacist-in-charge shall complete a self-assessment for compounding pharmacies developed by the board (Incorporated by reference is "Community Pharmacy & Hospital Outpatient Pharmacy Compounding Self-Assessment" Form 17M-39 Rev. 02/12.) as required by Section 1715 of Title 16, Division 17, of the California Code of Regulations. That form contains a first section applicable to all compounding, and a second section applicable to sterile injectable compounding. The first section must be completed by the pharmacist-in-charge before any compounding is performed in the pharmacy. The second section must be completed by the pharmacist-in-charge before any sterile compounding is performed in the pharmacy. The applicable sections of the self-assessment shall subsequently be completed before July 1 of each odd-numbered year, within 30 days of the start date of a new pharmacist-in-charge or change of location, and within 30 days of

the issuance of a new pharmacy license. The primary purpose of the self-assessment is to promote compliance through self-examination and education.

30. California Code of Regulations, title 16, section 1735.6 states in relevant part:

(a) Any pharmacy engaged in compounding shall maintain written documentation regarding the facilities and equipment necessary for safe and accurate compounding of compounded drug preparations. This shall include records of maintenance and cleaning of the facilities and equipment. Where applicable, this shall also include records of certification(s) of facilities or equipment.

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(e) Hazardous drug compounding shall be completed in an externally exhausted physically separate room with the following requirements:

(1) Minimum of 30 air changes per hour except that 12 air changes per hour are acceptable for segregated compounding areas with a BSC or CACI when products are assigned a BUD of 12 hours or less or when non sterile products are compounded; and

(2) Maintained at a negative pressure of 0.01 to 0.03 inches of water column relative to all adjacent spaces (rooms, above ceiling, and corridors); and

(3)

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(B) For nonsterile compounding, a BSC, a CACI, or other containment ventilated enclosure shall be used and shall either use a redundant-HEPA filter in series or be externally exhausted. For purposes of this paragraph, a containment ventilated enclosure means a full or partial enclosure that uses ventilation principles to capture, contain, and remove airborne contaminants through high-efficiency particulate air (HEPA) filtration and to prevent their release into the work environment.

31. California Code of Regulations, title 16, section 1793.2 states:

"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.

CODE OF FEDERAL REGULATIONS

32. Code of Federal Regulations, title 21, section 1301.75, subdivision (b) states:

Controlled substances listed in Schedules II, III, IV, and V shall be stored in a securely locked, substantially constructed cabinet. However, pharmacies and institutional practitioners may disperse such substances throughout the stock of noncontrolled substances in such a manner as to obstruct the theft or diversion of the controlled substances.

33. Code of Federal Regulations, title 21, section 1304.11, states in pertinent part:

(a) General requirements. Each inventory shall contain a complete and accurate record of all controlled substances on hand on the date the inventory is taken, and shall be maintained in written, typewritten, or printed form at the registered location. An inventory taken by use of an oral recording device must be promptly transcribed. Controlled substances shall be deemed to be "on hand" if they are in the possession of or under the control of the registrant, including substances returned by a customer, ordered by a customer but not yet invoiced, stored in a warehouse on behalf of the registrant, and substances in the possession of employees of the registrant and intended for distribution as complimentary samples. A separate inventory shall be made for each registered location and each independent activity registered, except as provided in paragraph (e)(4) of this section. In the event controlled substances in the possession or under the control of the registrant are stored at a location for which he/she is not registered, the substances shall be included in the inventory of the registered location to which they are subject to control or to which the person possessing the substance is responsible. The inventory may be taken either as of opening of business or as of the close of business on the inventory date and it shall be indicated on the inventory.

(b) Initial inventory date. Every person required to keep records shall take an inventory of all stocks of controlled substances on hand on the date he/she first engages in the manufacture, distribution, or dispensing of controlled substances, in accordance with paragraph (e) of this

section as applicable. In the event a person commences business with no controlled substances on hand, he/she shall record this fact as the initial inventory.

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

COST RECOVERY

34. Section 125.3 of the Code states, 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.

FACTUAL ALLEGATIONS

November 6, 2018 Inspection

35. On October 9, 2018 and on October 11, 2018, the Board received complaints from R.W. regarding Prescription Shoppe. Prescription Shoppe was originally licensed under owners L.L. and C.B. Owners, L.L. and C.B., sold Prescription Shoppe to Six Degrees, Inc. and Six Degrees Inc. dba Six Degrees Health dba Prescription Shoppe was issued a license by the Board on August 31, 2018.

36. The corporate members and directors of Six Degrees, Inc. hired R.W. on or about July 2018 and made him the Pharmacist-in-Charge (PIC) shortly thereafter in that same month. The new owners terminated R.W. at the end of August 2018. R.W. notified the Board via letter on October 21, 2018 that he had disassociated as the PIC of Prescription Shoppe on August 31, 2018.

37. A review of the Change of PIC application submitted to the Board by Prescription Shoppe showed a receipt date of November 13, 2018. The application indicated that R.W. was actually disassociated from Prescription Shoppe, effective September 4, 2018 and that Respondent Popat's effective date for being the new PIC at Prescription Shoppe was September 4, 2018. Respondent Popat was the only one that signed the Change of PIC application. Also,

Respondent Popat did not document that he reviewed and signed the Community Pharmacy Self-Assessment until October 7, 2018.

38. C.C., the pharmacy technician at Prescription Shoppe since June 1998 saw the new manager, K.M. onsite at Prescription Shoppe several months before the new change of ownership took place. On September 4, 2018, C.C. was terminated from Prescription Shoppe.

39. On November 6, 2018, the Board inspected Prescription Shoppe with the assistance of the PIC, Respondent Popat and pharmacy technician, S.R.

40. Respondent Popat informed the Board inspector that the pharmacy was mainly set up as a compounding pharmacy. Respondent Popat was unable to produce a completed/signed Compounding Self-Assessment upon the Board inspector's request. The Board inspector informed Respondent Popat that the Compounding Self-Assessment had to be completed before any compounding could take place. Respondent Popat thumbed through the Compounding Self-Assessment, placed it down on the pharmacy counter and then proceeded back into the pharmacy's compounding room and continued to engage in his compounding activities.

41. The Board inspector reviewed the pharmacy's Biennial Inventories for controlled substances, which was almost entirely blank with no quantities filled in, no documented time and date of the inventory, and no signatures.

42. Upon review of the compounding logs, the Board inspector discovered that S.R. had engaged in pharmacy technician compounding activities between June 2018 through September 2018 prior to being licensed as a pharmacy technician by the Board. In October 2018, S.R. was licensed by the Board as a pharmacy technician. A review of the training records for S.R. also showed an employee performance evaluation dated June 9, 2018, which was signed under the supervisor's signature area by K.M., the new manager of Prescription Shoppe.

43. In addition, Prescription Shoppe's non-sterile compounding hood and compounding room, where the pharmacy compounds National Institute for Occupational Safety and Health (NIOSH) classified hazardous medications, were not properly exhausted or certified. The hood in the compounding room was not functioning under negative pressure and the hood and ducting was in need of repair.

March 19, 2019 Inspection

44. On November 18, 2018, the Board received another complaint regarding Prescription Shoppe, which prompted an additional inspection of the pharmacy on March 19, 2019.

45. On January 28, 2019, the Board received a package from Prescription Shoppe containing prescription hard copies requested by the Board. These copies included examples of the prescription format utilized to acquire diabetic testing equipment and supplies.

46. Most of the prescription documents for the diabetic supplies were on a pre-formatted prescription form that listed a series of diabetic testing supplies that were being prescribed, with instructions on some of the prescription forms instructing the prescriber to cross out those items that were not being prescribed. The various ways in which the prescribers attempted to make their indications included crossing items out, circling certain item, or placing check marks next to certain items, thereby making the prescriptions ambiguous as to the prescriber's intent. Also, the prescription documents lacked an area for the prescriber to indicate the number of items prescribed or which topical cream was to be chosen from multiple topical creams. Additionally, the majority of the prescription documents did not indicate where the documents were to be faxed to or include the prescription numbers or back tags to document which items Prescription Shoppe filled.

47. On March 19, 2019, the Board conducted an inspection of Prescription Shoppe. Respondent Popat, the PIC, assisted with the inspection.

48. While standing near the front counter of the pharmacy, the Board inspectors witnessed B.W., a non-licensed clerk/manager at Prescription Shoppe, sign for a prescription drug order. Respondent Popat informed the Board inspector that B.W. sometimes signed for prescription drug orders.

49. During the inspection, the Board inspectors discovered that the drawer containing Schedule II medications was unlocked. Respondent Popat was unable to locate the key for the drawer and he indicated that he would have to ask Prescription Shoppe's manager, K.M. Manager K.M. is not a licensed pharmacist or pharmacy technician.

50. The Board inspectors then reviewed a series of boxes that were on top of a counter. The shipping boxes contained liquids, foams, and capsules under the company name of Stop & Regrow Hair. Respondent Popat informed the Board inspectors that Prescription Shoppe acquired a contract from the office of a Dr. Nettles to compound specific products for a line of oral and topical medications known as SRH. The doctor's office supplies specific containers and labels and the orders come directly from Dr. Nettles' office. Prescription Shoppe compounds the requested items and then either ships the orders directly to the patient or the doctor's office.

51. The shipping boxes for the completed product include Prescription Shoppe's prescription label on the inside lid of the shipping box. The vials/bottles of medications are labeled with an SRH product line label and a small sticker with Prescription Shoppe's prescription number, lot number, Beyond Use Date (BUD), date of preparation, and a number for Dr. Nettles' office for refills. The packages do not include a notice that consultation is available from the pharmacist at Prescription Shoppe.

52. Prescriptions for patients located in states other than California are shipped from Prescription Shoppe to Dr. Nettles' office and prescriptions for patients located in California were shipped directly to the patient.

53. The Board inspectors found that Prescription Shoppe had dispensed a compounded medication, Latanoporst-Dutasteride 0.005%/0.1% solution to patients. A review of a Certificate of Analysis document for this SRH product indicated that the Dutasteride component of the combination product failed to be with +/- 10% of the stated concentration. Respondent Popat informed the Board inspectors that they did not do anything when Prescription Shoppe was notified that the product had failed. Prescription Shoppe did not do anything based on the recommendation of their consultant pharmacist who believed that the testing lab failed to properly shake the product well before testing.

54. A review of the compounding logs revealed:

(a) Compounding log for Testosterone/Chrysin 10%/10%/ml PLO Cream showing Chrysin, lot number C183706, expiration date of February 28, 2019, was utilized to compound the cream

and the final product was given an expiration date of July 10, 2019; the product was verified by Respondent Popat.

(b) Compounding log for Testosterone/Chrysin 8%/10%/ml PLO Cream showing Chrysin, lot number C183706, expiration date of February 28, 2019, was utilized to compound the cream and the final product was given an expiration date of July 10, 2019; the product was verified by Respondent Popat.

(c) Compounding log for Testosterone/Chrysin 15%/15%/ml PLO Cream showing Chrysin, lot number C183706, expiration date of 2/28/2019, was utilized to compound the cream and the final product was given an expiration date of 7/10/2019; the product was verified by Respondent Popat.

(d) Compounding log for Ergotamine 0.6mg/Belladonna 0.2mg/Phenobarbital 20mg SR capsules showing Belladonna Extract, lot number C169524, expiration date of January 31, 2019, was utilized to compound the capsules and the final product was given an expiration date of July 14, 2019; the product was verified by Respondent Popat.

(e) Compounding log for Ergotamine 0.6mg/Belladonna 0.2mg/Phenobarbital 40mg SR capsules showing Belladonna Extract, lot number C169524, expiration date of January 31, 2019, was utilized to compound the capsules and the final product was given an expiration date of July 14, 2019; the product was verified by Respondent Popat.

55. A review of the non-sterile compounding hood and cleanroom where hazardous drugs are compounded revealed the lack of continuous monitoring to maintain negative pressure in the cleanroom. Prescription Shoppe does not have a gauge to monitor negative pressure and has two trash cans for hazardous disposal, that are not labeled and are disposed of in the building trash dumpsters.

56. Finally, Prescription Shoppe was evicted from its leased space on or about September 4, 2019. On December 18, 2019, Respondent Popat sent a letter to the Board informing the Board that he was no longer the PIC at Prescription Shoppe.

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June 3, 2019 Inspection

57. The Board received an additional complaint claiming that Prescriptions Shoppe had sent L.M. some dermatology medication that was not authorized by her or her physician. During the inspection on June 3, 2019, Respondent Popat, S.R, the pharmacy technician, and the pharmacy clerk, B.W., assisted the Board inspector.

58. S.R. was unable to locate any patient profile for L.M. in their computer system. B.W. informed the inspector that the computer that processed and dispensed diabetic supplies and topical creams crashed on May 12 2019 and that the entire computer had been sent off for repair/recovery.

February 13, 2020 Inspection

59. On January 23, 2020, the Board received notification that Prescription Shoppe had been evicted from its lease space on September 4, 2019 for lack of payment. The notification came from A.M., the compliance/privacy officer representing Victor Valley Global Medical Center (VVGMC), the entity that leased space to Prescription Shoppe.

60. Prescription Shoppe and the PIC, Respondent Popat, left behind and abandoned prescription records, dangerous drugs and controlled substance inventory, and patient records after Prescription Shoppe was evicted from the premises.

61. The Board visited Prescription Shoppe on February 13, 2020 to determine the status of the pharmacy and found that Prescription Shoppe was closed for business. The Board inspectors met with A.M. and R.L., PIC at VVGMC, during their visit. A.M. and R.L. informed the Board inspectors that they had made multiple attempts to contact the owners of Prescription Shoppe and Respondent Popat to arrange for the pharmacy to handle the abandoned drugs and patient records.

62. A review of the Board's records showed that Prescription Shoppe had failed to file a Discontinuous of Business form or otherwise notify the Board that the pharmacy was closed. Respondent Popat, as the PIC of Prescription Shoppe, notified the Board on December 18, 2019 that he was disassociating from Prescription Shoppe. Respondent Popat later emailed the Board on February 12, 2020 stating that his disassociation date should be September 4, 2019.

PRESCRIPTION SHOPPE

FIRST CAUSE FOR DISCIPLINE

(Failure to Complete a Controlled Substance Inventory)

63. Respondent Prescription Shoppe is subject to disciplinary action pursuant to section 4301, subdivisions (j) and (o), in that Respondent Prescription Shoppe violated Code of Federal Regulations section 1304.11, subdivisions (a), (b), and (c). The circumstances are that during the inspection of Prescription Shoppe on November 6, 2018, it was discovered that Prescription Shoppe had no controlled substance inventory records available for review and provided a blank inventory document as to the pharmacy's controlled substance inventory, as set forth more particularly in paragraphs 35-43.

SECOND CAUSE FOR DISCIPLINE

(Failure to Timely Notify the Board of a Change in Pharmacist-In-Charge)

64. Respondent Prescription Shoppe is subject to disciplinary action pursuant to Code section 4113, subdivision (d) in that a Change of PIC application received by the Board on November 13, 2018, documented that there was a change of PIC at Prescription Shoppe on September 4, 2018. The notification to the Board about the change in PIC surpassed the 30-day notification requirement, as set forth more particularly in paragraph 37.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Compounding Equipment and Certification)

65. Respondent Prescription Shoppe is subject to disciplinary action under section 4301, subdivision (j) and (o) for violating California Code of Regulations, title 16, sections 1735.6, subdivisions (a) and (e)(3)(B) in that the pharmacy's non-sterile compounding hood and compounding room, where the pharmacy engaged in the compounding of NIOSH classified hazardous medications, were not properly exhausted or certified, as set forth more particularly in paragraph 43.

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FOURTH CAUSE FOR DISCIPLINE

(Unlicensed Activity)

66. Respondent Prescription Shoppe is subject to disciplinary action pursuant to Code section 4110, subdivision (a) in that while Prescription Shoppe was still licensed under L.L. and C.B., the corporate members and directors of Six Degrees, Inc. entered into a purchase agreement, instilled their own operating managers, signed off on pharmacy technician training documents, and hired a new PIC in July 2018, all prior to Six Degrees, Inc. being approved for licensure by the Board on August 31, 2018, as set forth more particularly in paragraphs 35-43.

FIFTH CAUSE FOR DISCIPLINE

(Unlicensed Pharmacy Technician Activity)

67. Respondent Prescription Shoppe is subject to disciplinary action pursuant to Code section 4115, subdivisions (a) and (e) in conjunction with California Code of Regulations, title 16, sections 1793.2 in that a review of the compounding logs revealed that a pharmacy staff member had engaged in pharmacy technician compounding activities prior to being licensed as a pharmacy technician by the Board, as set forth more particularly in paragraph 42.

SIXTH CAUSE FOR DISCIPLINE

(Dispensing Dangerous Drugs and Diabetic Testing Supplies Pursuant to Pre-Printed Multiple Checkoff Prescription Forms)

68. Respondent Prescription Shoppe is subject to disciplinary action under sections 4081, subdivision (d) and 4301, subdivisions (j) and (o) in conjunction with California Code of Regulations, title 16, sections 1717.3, subdivision (b) in that from May 2018 through June 2019, Prescription Shoppe engaged in dispensing hundreds of non-controlled dangerous drugs and diabetic supplies from pre-printed multiple checkoff prescription forms where the prescriber did not indicate the number of dangerous drugs prescribed and could not provide specific patient details related to the dispensing of the non-prescription diabetic test devices, as set forth more particularly in paragraphs 44-46.

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SEVENTH CAUSE FOR DISCIPLINE

(Unlicensed Pharmacy Staff Signing for Dangerous Drugs)

69. Respondent Prescription Shoppe is subject to disciplinary action under sections 4059, subdivision (a) and 4301, subdivisions (j) and (o) in that on March 19, 2019, unlicensed pharmacy staff member, B.W., was witnessed signing for an order of dangerous drugs, as set forth more particularly in paragraphs 47-48.

EIGHTH CAUSE FOR DISCIPLINE

(Unsecured Controlled Substances)

70. Respondent Prescription Shoppe is subject to disciplinary action under section 4301, subdivisions (j) and (o) in conjunction with California Code of Regulations, title 16, section 1714, subdivision (d) and Code of Federal Regulations section 1301.75, subdivision (b) in that Prescription Shoppe's Schedule II medications were located in an unlocked drawer. When the PIC was asked to lock the drawer, the PIC was unable to locate the key for the drawer and informed the Board inspector that the key may be in the possession of an unlicensed pharmacy manger, as set forth more particularly in paragraph 49.

NINTH CAUSE FOR DISCIPLINE

(Delivery of Compounded Prescription Medications to Doctor's Office for Shipment to Out-of-State Patients)

71. Respondent Prescription Shoppe is subject to disciplinary action under section 4301, subdivisions (j) and (o) in conjunction with California Code of Regulations, title 16, section 1713, subdivision (a) in that compounded prescription medications for patients residing outside of California were being sent to the original prescribing doctor's office for the eventual shipment of the prescriptions to the out-of-state patients, as set forth more particularly in paragraphs 50-52.

TENTH CAUSE FOR DISCIPLINE

(Failure to Properly Label Compounded Prescription Products)

72. Respondent Prescription Shoppe is subject to disciplinary action pursuant to section 4076, subdivision (a), subsections (3) through (7) because the actual physical containers of compounded prescription medications were being labeled with a doctor's 'product line label' and

the pharmacy's prescription label was only being applied to the shipping box, as set forth more particularly in paragraphs 50-51.

ELEVENTH CAUSE FOR DISCIPLINE

(Failure to Provide Notice/Offer of Consultation)

73. Respondent Prescription Shoppe is subject to disciplinary action under section 4301, subdivision (o) in conjunction with California Code of Regulations, title 16, section 1707.2, subdivision (b)(2) in that Prescription Shoppe was not providing any notice or offer of consultation to patients that were being shipped compounded prescription medications, as set forth more particularly in paragraphs 50-51.

TWELFTH CAUSE FOR DISCIPLINE

(Dispensing of Sub-Potent/Misbranded Medications)

74. Respondent Prescription Shoppe is subject to disciplinary action under sections 4301, subdivisions (j) and (o) and 4169, subdivision (a)(3) in conjunction with Health and Safety Code section 111440 in that Prescription Shoppe sent a compounded prescription medication, Latanoprost-Dutasteride 0.005%/0.1% solution, for end-product testing that failed to meet the +/- 10% of the stated potency (sub-potent) of the compounded medication for the Dutasteride component; and Prescription Shoppe proceeded to dispense the compounded medication to patients, as set forth more particularly in paragraph 53.

THIRTEENTH CAUSE FOR DISCIPLINE

(Dispensing Compounded Medications with Incorrect Beyond Use Dates)

75. Respondent Prescription Shoppe is subject to disciplinary action under sections 4301, subdivisions (j) and (o) and 4169, subdivision (a)(4) in conjunction with California Code of Regulations, title 16, section 1735.2, subdivision (i)(1)(A) in that Prescription Shoppe had compounded multiple medications with medications and/or components that were labeled by the manufacturer to expire before the BUD date applied to the finished compounded medication, as set forth more particularly in paragraph 54.

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FOURTEENTH CAUSE FOR DISCIPLINE

(Failure to Monitor and Document a Proper Hazardous Non-Sterile Compounding Environment)

76. Respondent Prescription Shoppe is subject to disciplinary action under section 4301, subdivision (o) in conjunction with California Code of Regulations, title 16, section 1735.6, subdivision (e)(2) for failing to obtain a negative pressure certification for the hazardous non-sterile compounding room and for not equipping the room with a pressure gauge to continuously monitor the pressure differential between the hazardous non-sterile compounding room and the adjacent spaces, as set forth more particularly in paragraph 55.

FIFTEENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Prescription Documents)

77. Respondent Prescription Shoppe is subject to disciplinary action under sections 4081, subdivision (a) and 4105, subdivisions (a), (b), and (c) in that during the June 3, 2019 inspection, staff members of Prescription Shoppe claimed the computer system holding patient profile information and electronic prescription records had crashed and was not available; Prescription Shoppe never provided the requested patient prescription records to the Board, as set forth more particularly in paragraphs 57-58.

SIXTEENTH CAUSE FOR DISCIPLINE

(Failure to Notify the Board of Closure)

78. Respondent Prescription Shoppe is subject to disciplinary action under sections 4301, subdivision (o) in conjunction with California Code of Regulations, title 16, section 1708.2 for failing to notify the Board of its closure prior to the discontinuance of business. On January 23, 2020, the Board received notification that Prescription Shoppe had been evicted from its lease space on September 4, 2019 from A.M., the compliance/privacy officer representing VVGMC, the entity that leased space to Prescription Shoppe, as set forth more particularly in paragraphs 59-62.

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SEVENTEENTH CAUSE FOR DISCIPLINE

(Failure to Arrange for the Maintenance of Prescription Records)

79. Respondent Prescription Shoppe is subject to disciplinary action under sections 4301, subdivision (o) and 4333, subdivision (a) for failing to arrange for the storage or maintenance of its prescription records at a Board-licensed facility after it was evicted from its location for non-payment of rent; instead, the prescription records were abandoned at Prescription Shoppe's location, as set forth more particularly in paragraphs 59-62.

EIGHTEENTH CAUSE FOR DISCIPLINE

(Failure to Arrange for Disposition of Drug Stock)

80. Respondent Prescription Shoppe is subject to disciplinary action under sections 4301, subdivisions (j) and (o) and 4312, subdivision (b) for failing to arrange for the transfer of all its dangerous drugs and controlled substances inventory to another licensee; and instead, abandoning the dangerous drugs and controlled substances at Prescription Shoppe's location after it discontinued its business, as set forth more particularly in paragraphs 59-62.

ASHOK POPAT

NINETEENTH CAUSE FOR DISCIPLINE

(Failure to Timely Complete Pharmacy Self-Assessment)

81. Respondent Popat is subject to disciplinary action under sections 4113, subdivision (c) and 4301, subdivision (o) for violating California Code of Regulations, title 16, section 1715(b)(2) for failing to timely complete the pharmacy's Self-Assessment within 30 days of becoming the PIC, as set forth more particularly in paragraph 37.

TWENTIETH CAUSE FOR DISCIPLINE

(Failure to Complete the Compounding Self-Assessment Prior to Compounding)

82. Respondent Popat is subject to disciplinary action under sections 4113, subdivision (c) and 4301, subdivision (o) for violating California Code of Regulations, title 16, section 1735.2(k) for failing to complete the Compounding Self-Assessment prior to engaging in compounding activities, as set forth more particularly in paragraph 40.

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TWENTY-FIRST CAUSE FOR DISCIPLINE

(Unlicensed Pharmacy Technician Activity)

83. Respondent Popat is subject to disciplinary action pursuant to Code sections 4113, subdivision (c) and 4115, subdivisions (a) and (e) in conjunction with California Code of Regulations, title 16, sections 1793.2 in that during the November 16, 2018 inspection, a review of the compounding logs revealed that while Respondent Popat served as the PIC, a pharmacy staff member had engaged in pharmacy technician compounding activities prior to being licensed as a pharmacy technician by the Board, as set forth more particularly in paragraph 42.

TWENTY-SECOND CAUSE FOR DISCIPLINE

(Failure to Complete a Controlled Substance Inventory)

84. Respondent Popat is subject to disciplinary action pursuant to disciplinary action under sections 4113, subdivision (c) and 4301, subdivisions (j) and (o), in that Respondent Popat violated Code of Federal Regulations section 1304.11, subdivisions (a), (b), and (c). The circumstances are that during the inspection of Prescription Shoppe on November 6, 2018, it was discovered that Prescription Shoppe had no controlled substance inventory records available for review and provided a blank inventory document as to the pharmacy's controlled substance inventory, as set forth more particularly in paragraphs 35-43.

TWENTY-THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Compounding Equipment and Certification)

85. Respondent Popat is subject to disciplinary action pursuant to disciplinary action under sections 4113, subdivision (c) and 4301, subdivisions (j) and (o), for violating California Code of Regulations, title 16, sections 1735.6, subdivisions (a) and (e)(3)(B) in that the pharmacy's non-sterile compounding hood and compounding room, where the pharmacy engaged in the compounding of NIOSH classified hazardous medications, were not properly exhausted or certified, as set forth more particularly in paragraph 43.

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TWENTY-FOURTH CAUSE FOR DISCIPLINE

(Dispensing Dangerous Drugs and Diabetic Testing Supplies Pursuant to Pre-Printed Multiple Checkoff Prescription Forms)

86. Respondent Popat is subject to disciplinary action under sections 4113, subdivision (c); 4081, subdivision (d), and 4301, subdivision (j) and (o) in conjunction with California Code of Regulations, title 16, sections 1717.3, subdivision (b) in that while Respondent was the PIC, Prescription Shoppe engaged in dispensing hundreds of non-controlled dangerous drugs and diabetic supplies from pre-printed multiple checkoff prescription forms where the prescriber did not indicate the number of dangerous drugs prescribed and could not provide specific patient details related to the dispensing of the non-prescription diabetic test devices, as set forth more particularly in paragraphs 44-46.

TWENTY-FIFTH CAUSE FOR DISCIPLINE

(Unlicensed Pharmacy Staff Signing for Dangerous Drugs)

87. Respondent Popat is subject to disciplinary action under sections 4113, subdivision (c); 4059, subdivision (a), and 4301, subdivision (j) and (o) in that on March 19, 2019, unlicensed pharmacy staff member, B.W., was witnessed signing for an order of dangerous drugs, as set forth more particularly in paragraphs 47-48.

TWENTY-SIXTH CAUSE FOR DISCIPLINE

(Unsecured Controlled Substances)

88. Respondent Popat is subject to disciplinary action under sections 4113, subdivision (c), 4301, subdivisions (j) and (o) in conjunction with California Code of Regulations, title 16, section 1714, subdivision (d) and Code of Federal Regulations section 1301.75, subdivision (b) in that Prescription Shoppe's Schedule II medications were located in an unlocked drawer. When Respondent Popat was asked to lock the drawer, he was unable to locate the key for the drawer and informed the Board inspector that the key may be in the possession of an unlicensed pharmacy manger, as set forth more particularly in paragraph 49.

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TWENTY-SEVENTH CAUSE FOR DISCIPLINE

(Delivery of Compounded Prescription Medications to Doctor's Office for Shipment to Out-of-State Patients)

89. Respondent Popat is subject to disciplinary action under sections 4113, subdivision (c), 4301, subdivisions (j) and (o) in conjunction with California Code of Regulations, title 16, section 1713, subdivision (a) in that compounded prescription medications for patients residing outside of California were being sent to the original prescribing doctor's office for the eventual shipment of the prescriptions to the out-of-state patients, as set forth more particularly in paragraphs 50-52.

TWENTY-EIGHTH CAUSE FOR DISCIPLINE

(Failure to Properly Label Compounded Prescription Products)

90. Respondent Popat is subject to disciplinary action under sections 4113, subdivision (c), section 4076, subdivision (a), subsections (3) through (7) because the actual physical containers of compounded prescription medications were being labeled with a doctor's 'product line label' and the pharmacy's prescription label was only being applied to the shipping box, as set forth more particularly in paragraphs 50-51.

TWENTY-NINTH CAUSE FOR DISCIPLINE

(Failure to Provide Notice/Offer of Consultation)

91. Respondent Popat is subject to disciplinary action under sections 4113, subdivision (c) and 4301, subdivision (o) in conjunction with California Code of Regulations, title 16, section 1707.2, subdivision (b)(2) in that Prescription Shoppe was not providing any notice or offer of consultation to patients that were being shipped compounded prescription medications, as set forth more particularly in paragraphs 50-51.

THIRTIETH CAUSE FOR DISCIPLINE

(Dispensing of Sub-Potent/Misbranded Medications)

92. Respondent Popat is subject to disciplinary action under sections 4113, subdivision (c); 4301, subdivisions (j) and (o), and 4169, subdivision (a)(3) in conjunction with Health and Safety Code section 111440 in that Prescription Shoppe sent a compounded prescription

medication, Latanoprost-Dutasteride 0.005%/0.1% solution, for end-product testing that failed to meet the +/- 10% of the stated potency (sub-potent) of the compounded medication for the Dutasteride component; and Prescription Shoppe proceeded to dispense the compounded medication to patients, as set forth more particularly in paragraph 53.

THIRTY-FIRST CAUSE FOR DISCIPLINE

(Dispensing Compounded Medications with Incorrect Beyond Use Dates)

93. Respondent Popat is subject to disciplinary action under sections 4113, subdivision (c); 4301, subdivisions (j) and (o), and 4169, subdivision (a)(4) in conjunction with California Code of Regulations, title 16, section 1735.2, subdivision (i)(1)(A) in that Prescription Shoppe had compounded multiple medications with medications and/or components that were labeled by the manufacturer to expire before the BUD date applied to the finished compounded medication, as set forth more particularly in paragraph 54.

THIRTY-SECOND CAUSE FOR DISCIPLINE

(Failure to Monitor and Document a Proper Hazardous Non-Sterile Compounding Environment)

94. Respondent Popat is subject to disciplinary action under sections 4113, subdivision (c) and 4301, subdivision (o) in conjunction with California Code of Regulations, title 16, section 1735.6, subdivision (e)(2) for failing to obtain a negative pressure certification for the hazardous non-sterile compounding room and for not equipping the room with a pressure gauge to continuously monitor the pressure differential between the hazardous non-sterile compounding room and the adjacent spaces, as set forth more particularly in paragraph 55.

THIRTY-THIRD CAUSE FOR DISCIPLINE

(Failure to Timely Notify the Board of Ceasing to Act as the Pharmacist-In-Charge)

95. Respondent Popat is subject to disciplinary action pursuant to Code section 4101, subdivision (a) in that on or about December 18, 2019, Respondent Popat notified the Board that he was no longer the PIC at Prescription Shoppe. Prescription Shoppe had been evicted from its leased space on or about September 4, 2019, which made Respondent Popat's December 18, 2019

notice beyond the 30-day notification requirement. The facts in support of this cause for discipline are set forth more particularly in paragraph 56.

THIRTY-FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Prescription Documents)

96. Respondent Popat is subject to disciplinary action under sections 4113, subdivision (c); 4081, subdivision (a) and 4105, subdivisions (a), (b), and (c) in that during the June 3, 2019 inspection, staff members of Prescription Shoppe claimed the computer system holding patient profile information and electronic prescription records had crashed and was not available; Prescription Shoppe never provided the requested patient prescription records to the Board, as set forth more particularly in paragraphs 57-58.

THIRTY-FIFTH CAUSE FOR DISCIPLINE

(Failure to Notify the Board of Closure)

97. Respondent Popat is subject to disciplinary action under sections 4113, subdivision (c) and 4301, subdivision (o) in conjunction with California Code of Regulations, title 16, section 1708.2 for failing to notify the Board of its closure prior to the discontinuance of business. On January 23, 2020, the Board received notification that Prescription Shoppe had been evicted from its lease space on September 4, 2019 from A.M., the compliance/privacy officer representing VVGMC, the entity that leased space to Prescription Shoppe, as set forth more particularly in paragraphs 59-62.

THIRTY-SIXTH CAUSE FOR DISCIPLINE

(Failure to Arrange for the Maintenance of Prescription Records)

98. Respondent Popat is subject to disciplinary action under sections 4113, subdivision (c); 4301, subdivision (o), and 4333, subdivision (a) for failing to arrange for the storage or maintenance of its prescription records at a Board-licensed facility after Prescription Shoppe was evicted from its location for non-payment of rent; instead, the prescription records were abandoned at Prescription Shoppe's location, as set forth more particularly in paragraphs 59-62.

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THIRTY-SEVENTH CAUSE FOR DISCIPLINE

(Failure to Arrange for Disposition of Drug Stock)

99. Respondent Popat is subject to disciplinary action under sections 4113, subdivision (c), section 4301, subdivisions (j) and (o) and 4312, subdivision (b) for failing to arrange for the transfer of all of Prescription Shoppe's dangerous drugs and controlled substances inventory to another licensee; and instead, abandoned the dangerous drugs and controlled substances at Prescription Shoppe's location after it discontinued its business, as set forth more particularly in paragraphs 59-62.

THIRTY-EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

100. Respondent Popat is subject to disciplinary action under sections 4113, subdivision (c) and 4306.5 for failing to exercise professional judgment, training, and experience as a PIC when he failed to arrange for the storage of prescription drugs and records after Prescription Shoppe was evicted; instead abandoning the prescription drugs and records. Further, Respondent Popat only notified the Board on December 18, 2019 that he was disassociating from Prescription Shoppe even though he had disassociated on September 4, 2019. The facts in support of this cause for discipline are set forth more particularly in paragraphs 59-62.

OTHER MATTERS

101. Pursuant to Code section 4307, if discipline is imposed on Permit Number PHY 56833 issued to Six Degrees, Inc. dba Six Degrees Health dba Prescription Shoppe, Anna Karina Rubio, Marianne Christiane Antonio, then they shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for 5 years if Permit Number PHY 56833 is placed on probation or until Permit Number PHY 56833 is reinstated if it is revoked.

102. Pursuant to Code section 4307, if discipline is imposed on Permit Number PHY 56833 issued to Six Degrees, Inc. dba Six Degrees Health dba Prescription Shoppe while Anna Karina Rubio has been an officer and owner and had knowledge of or knowingly participated in any conduct for which the licensee is disciplined, Anna Karina Rubio shall be prohibited from

serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for 5 years if Permit Number PHY 56833 is placed on probation or until Permit Number PHY 56833 is reinstated if revoked.

103. Pursuant to Code section 4307, if discipline is imposed on Permit Number PHY 56833 issued to Six Degrees, Inc. dba Six Degrees Health dba Prescription Shoppe while Marianne Christiane Antonio has been an officer and owner and had knowledge of or knowingly participated in any conduct for which the licensee is disciplined, Marianne Christiane Antonio shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for 5 years if Permit Number PHY 56833 is placed on probation or until Permit Number PHY 56833 is reinstated if revoked.

104. Pursuant to Code section 4307, if discipline is imposed on Pharmacist License Number RPH 39954 issued to Ashok Popat, then he 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 for 5 years if Pharmacist License Number RPH 39954 is placed on probation or until Pharmacist License Number RPH 39954 is reinstated if 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 56833, issued to Six Degrees, Inc. dba Six Degrees Health dba Prescription Shoppe, Anna Karina Rubio, Marianne Christiane Antonio;

2. Revoking or suspending Pharmacist License Number RPH 39954, issued to Ashok Popat;

3. Ordering Prescription Shoppe and Ashok Popat 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;

4. Prohibiting Anna Karina Rubio from serving as a manager, administrator, owner member, officer, director, associate, or partner of a license for 5 years if Permit Number PHY

56833 is placed on probation or until Permit Number PHY 56833 is reinstated if Permit Number PHY 56833 issued to Six Degrees, Inc. dba Six Degrees Health dba Prescription Shoppe is revoked;

5. Prohibiting Marianne Christiane Antonio from serving as a manager, administrator, owner member, officer, director, associate, or partner of a license for 5 years if Permit Number PHY 56833 is placed on probation or until Permit Number PHY 56833 is reinstated if Permit Number PHY 56833 issued to Six Degrees, Inc. dba Six Degrees Health dba Prescription Shoppe is revoked;

6. Prohibiting Ashok Popat from serving as a manager, administrator, owner member, officer, director, associate, or partner of a license for 5 years if Pharmacist License Number RPH 39954 is placed on probation or until Pharmacist License Number RPH 39954 is reinstated if Pharmacist License Number RPH 39954 issued to Ashok Popat is revoked;

and,

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

DATED: 5/4/2021

Signature on File

ANNE SODERGREN
Executive Officer
Board of Pharmacy
Department of Consumer Affairs
State of California
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