IN THE MATTER OF	*	**BEFORE THE**
PAMELA ARREY, P.D.	*	**STATE BOARD**
License No.: 11345	*	**OF**
Respondent	*	**PHARMACY**

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ORDER FOR SUMMARY SUSPENSION

Pursuant to Md. State Govt. Code Ann. ' 10-226 (c)(2004 Repl. Vol. and 2007 Supp.), the State Board of Pharmacy (the "Board") hereby suspends the license to practice pharmacy in Maryland issued to Pamela Arrey, P.D., (the "Respondent"), under the Maryland Pharmacy Act (the "Act"), Md. Health Occ. Code Ann. § 12-101, et seq., (2005 Repl. Vol. and 2007 Supp.). This Order is based on the following investigative findings, which the Board has reason to believe are true:

BACKGROUND

1. At all times relevant hereto, the Respondent was licensed to practice pharmacy in Maryland. The Respondent was first licensed on April 20, 1988. The Respondent=s license expires on December 31, 2009.

2. At all times relevant hereto, the Respondent owned two Medicine Shoppe pharmacies: one is located at the Milford Mill Shopping Center on Liberty Road ("Liberty Shoppe") in Baltimore County, Maryland, and one in the 5900 block of Reisterstown Road, ("Reisterstown Shoppe") in Baltimore City, Maryland.[1]

3. On February 1, 2002, the Board issued an unexecuted Summary Suspension

1 The Respondent closed the Annapolis Medicine Shoppe, which was the action of a prior Board suspension and Order in 2002.

Order and on September 15, 2002, the Board issued charges. On November 22, 2002, the Respondent signed a Consent Order based upon the following Findings of Fact found in the Summary Suspension and Charges:[2]

A. With regard to the Liberty Shoppe:

1. On June 22, 2001, at approximately 9:00 a.m., Larry Friedman, Division of Drug Control (D.D.C) Inspector, observed pharmacist Oluwatosin Adekoya open the store. Mr. Friedman entered the pharmacy where he conducted an inspection, which disclosed, among other things, a number of faxed prescriptions for Schedule II Controlled Dangerous Substances (CDS) without a corresponding hard copy of the original. Mr. Friedman took twenty-two of these to D.D.C.

2. On January 4, 2002, Deitra Gale, Compliance Specialist, arrived at the Liberty Medicine Shoppe at approximately 2:15 p.m., finding the store unlocked and open for business. There was no pharmacist on duty at that time--only a technician. Ms. Gale was told that the pharmacist would be "right back." Approximately 10 minutes lapsed, at which time the Respondent arrived and explained that she had entrusted the technician to "lock the door." Ms. Gale explained to the Respondent that a technician could not be left alone in the pharmacy area, regardless of whether or not it was locked. The technician stated, under oath, that the other technician, "Emmanuel," had a key to the store.

3. The Respondent allowed unlicensed individuals to be in the pharmacy when no licensed pharmacist was present and allowed an unlicensed individual access to the pharmacy by giving him the key.

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[2]For purposes of this Summary Suspension Order, only those Findings relevant to the Liberty and Reisterstown pharmacies will be referred to, inasmuch as the Respondent sold the Annapolis pharmacy which was also the subject of the Consent Order.

4. The work schedule provided to the Board by the Respondent listed pharmacist Bonnie Enwezor as the pharmacist on duty for October 5 and November 16, 2001. Ms. Enwezor stated under oath that she did not, in fact, work at the Medicine Shoppes on those dates. Therefore, according to the records supplied to the Board by the Respondent, the Liberty Medicine Shoppe did not have a pharmacist on duty during those dates, as required, or the Respondent provided false information to the Board during its investigation.

B. With regard to the Reisterstown Shoppe:

5. On June 22, 2001, Jack Freedman and Cathy Putz of the D.D.C., and Ms. Andoll, Pharmacist Compliance Officer, arrived at the Reisterstown Medicine Shoppe at 10:00 a.m., the posted opening time. At approximately 10:15 am. they observed a person unlocking the pharmacy door and entering the premises, who later identified herself as Bertha Mbuh, a technician. Ms. Mbuh stated that a pharmacist was on the way and contacted someone by telephone. Ms. Mbuh stated that she would dispense a prescription which had been checked by the pharmacist when the pharmacist was not on duty, but would not take new prescriptions by telephone.

6. When the Respondent arrived at 10:30 a.m., she stated that she had been delayed due to having to stop at the Liberty Medicine Shoppe that morning to deal with computer problems. However, as per the above, Inspector Friedman was at the Liberty Medicine Shoppe that morning and only pharmacist Adekoya was there. The Respondent was not there when the pharmacy opened. In addition, there was no evidence of computer problems at that location that morning.

7. The inspectors found the pharmacy to be in disarray, with the dispensing counter dirty and disorganized. Drinks were kept in the refrigerator used for drugs. Purchasing invoices for Schedules III and IV were not being signed consistently. Some contained a signature the Respondent later identified to be that of the Respondent's 7-year old daughter. There were also incomplete DEA 222 forms, as well as faxed prescriptions for Schedule I Is without corresponding hard copies. In addition, there were discrepancies for OxyContin tablets, which differed from that claimed in the May 16, 2001 inventory. The Respondent failed to timely deliver a biennial audit to the Board, as promised.

8. On January 4, 2002, at approximately 2 p.m., Ms. Putz returned to the Reisterstown location to follow up on the problems identified in June 2001. When Ms. Putz arrived, two unlicensed individuals, Ms. Mbuh and Adolph Schwartz, were in the pharmacy and customers were in store. Ms. Putz was informed that the Respondent had been in the pharmacy, but had to leave. Thereupon, Ms. Putz instructed Ms Mbuh and Mr. Schwartz to close the pharmacy. Mr. Schwartz locked the pharmacy and they waited outside until Ms. Enwezor arrived from the Liberty Road store.

9. The Respondent allowed unlicensed persons in the pharmacy when no licensed pharmacist was present. In addition, the Respondent allowed an unlicensed person to have access to the pharmacy by giving him the key.

C. With regard to other Findings:

Other Discrepancies

10. Due to the Board's concerns about adequate pharmacist coverage for all

three of the Respondent's pharmacies, the Board requested that the Respondent supply to the Board an accounting of the licensed pharmacists who worked at each store and the hours that they worked at each store, for October, November and December, 2001. The Respondent belatedly supplied schedules, purporting to show that each of the above pharmacies was, in fact, staffed by Maryland licensed pharmacists during that time period. Based upon interviews with the pharmacists, the following discrepancies were disclosed between the Respondent's lists and the actual work schedules of the pharmacists:

A. Pharmacist Lawrence Ekaney was listed by the Respondent as having worked on October 6, 2001 at Reisterstown; and, December 28, 2001 at Reisterstown. Mr. Ekaney stated under oath that he did not work on these dates for the Medicine Shoppes. Thus, for those dates at those locations, there was either no pharmacist on duty, as required, or the Respondent provided false information to the Board regarding coverage.

B. Two employees listed on the January 14, 2002 employee list submitted to the Board by the Respondent, namely, Grace Bogunjoko and Olujjmi Odusanya, who stated under oath that they were recent hires, have only worked one or two dates for the Respondent, and were not the pharmacists on duty for the week of January 14, 2002, as listed. Therefore, it appears that no pharmacist was on duty on those dates on which their names appeared at those locations, as required, or the Respondent provided false information to the Board in its investigations of coverage.

C. In addition, the Respondent listed Oluyinka Agboola as the pharmacist on duty on several occasions. Ms. Agboola worked on only one day between April 9, 2000 to

April 22, 2000, and relocated to Florida in May 2000, where she has been working for Eckerd Corp since June 12, 2000. Either the Respondent failed to have coverage on the dates that she listed Ms. Agboola as the pharmacist on duty, or the Respondent provided the Board with false information regarding coverage.

11. The Respondent submitted false documentation claiming that pharmacists were on duty when, in fact, none was on duty at the pharmacies, as claimed on several occasions from June 2001 through January 14, 2002.

12. During the aforecited times and dates, at each of the pharmacies, several unlicensed persons were either opening or closing pharmacies, or were alone in the pharmacy without a licensed pharmacist on the premises. As set forth in the regulations governing the practice of pharmacy in Maryland, only licensed pharmacists may have access, e.g., the keys or security code, to the pharmacy area. As set forth above, the Respondent allowed her minor daughter to sign for pharmaceutical supplies-something which only a licensed pharmacist should do. One employee dispensed already filled prescriptions while the pharmacist was absent and another took inventory while no pharmacist was present. At each of the pharmacies, serious discrepancies were disclosed by the D.D.C. personnel on more than one occasion, including the dispensing of drugs by fax without a hard copy, a technician's dispensing prescriptions, and unaccounted for Schedule IIs.

13. As a result of the above Findings, the Respondent's license was Suspended for one year, with all but 12 months Stayed, and it was further Ordered that the Respondent be placed on Probation for one year, subject to the following

conditions:

A. The Respondent shall take and pass the Multistate Pharmacy Jurisprudence Examination (MPJE), with a score of at least 75%.

B. The Respondent shall submit timesheets of her pharmacist employees to the Board on a monthly basis.

C. The Respondent shall submit the name (s) and credentials of a pharmacist who agrees to serve as her mentor, for approval by the Board. If the Board approves said individual, the Mentor shall provide guidance to the Respondent for ten (10) hours per month regarding compliance with the laws governing record-keeping for controlled dangerous substances (CDS), and other relevant laws. The Respondent shall ensure that the Mentor files quarterly progress reports with the Board.

D. The Respondent shall have the sole responsibility for paying for the above requirements on a timely basis.

E. The Respondent shall develop and submit to the Board, within three months of the date of the Consent Order, policies and procedures regarding:

(1) scheduling of pharmacist coverage;

(2) lapses in pharmacist coverage;

(3) duties of unlicensed personnel and restrictions; and,

(4) pharmacy security.

CURRENT INVESTIGATION

14. On July 7, 2008, an inspection of the Liberty Shoppe was performed by Ann Taylor, Pharmacist Compliance Officer. During the inspection, Ms. Taylor noted the following:

A. The pharmacy was unkempt, to the point where, in the backroom, there was nowhere for the staff to walk. The rear exit was completely obstructed by delivery totes, boxes and barrels;

B. Medications were stored everywhere, including the bathroom, which was unsanitary;

C. An inspection of the totes, barrels and shelves disclosed expired medication in manufacturers' bottles, which had expiration dates removed either chemically or by cutting. The imprints of the dates were visible on many bottles where the expiration dates were chemically removed. Several of these bottles had stickers that had the lot number and a new expiration date covering the location where the manufacturer's imprint had been. Many of these medications were in a bag with a page of labels which would, apparently, be later affixed to the medication bottles. A total of 283 bottles of various expired medications were identified, of which 107 bottles did not have expiration dates on the bottles;

D. There were eleven bulk barrels in the pharmacy containing large

quantities of loose tablets (approximately 20,000 to 30,000 tablets per container). The label of the containers identified the tablets inside as Glucophage 500ER (30,720 caplets), Glucovance 125mg/500mg (20,280 tablets), diclofenac 50mg (20,000 tablets), metoprolol 50mg (20,280 caplets), Nifedipine 30mg (20,000 tablets), Gabapentin 100mg (24,000 tablets), Gabapentin 400mg (24,000 capsules), "Cabapentin 300mg" (20,000 tablets), lisinopril 20mg (20,000 tablets) and "Guaifenesin/Dextromethorphane HBR" (20,000 tablets). A pair of Latex gloves were found in several of the open containers. All of the barrels were labeled with a drug name, manufacturer's name, strength, lot number, National Drug Code (NDC) number, expiration date and quantity. All manufacturers that were identified were subsequently contacted to determine if the NDC number on the labels matched the NDC number for their products. All manufacturers indicated that the NDC numbers did not match the NDC numbers for their products;

E. When the Respondent was asked where these medications came from, she provided documentation that shows that she received the medication in the bulk barrels from a company named e-Meditech. This company is operated by Mr. Frank Egbe, but is not a licensed distributor in the State of Maryland. She stated that the medication comes from Catholic Charities Medical Missions (CCMMB) Board

by way of Mr. Egbe and she pays the donation fees. There were medications in the pharmacy that had the Catholic Charities labeling, however, most (but not all) were within date; and all of them had the appropriate NDC numbers.

F. The Respondent could not provide a copy of an invoice, however, she was able to provide a printout of the medication list that she stated she used to select the medications that she needed. She also provided a document that demonstrated payment to Mr. Egbe for the medication;

G. Bulk medication bottles were reused by relabeling and filling with different medication than that intended by the manufacturers. These bulk bottles were on the pharmacy shelves. The new labels covered the manufacturer labels. The handwritten or typed labels identified the medication with the same information as on the bulk barrels and also indicated the (real) NDC numbers of the same medication.

H. Many times the medication previously in the bottles were not the same as what was previously in the bottle (i.e. Manufacturer label for Roxicet, handwritten or typed label covering the manufacturer's label indicates Gabapentin 400mg). Some bottles, however, were refilled with the medication from the bulk containers and relabeled as such;

I. Medication repackaged in blister cards were found in some of the delivery totes. Many of the medications were the same as the medications that were identified as expired and in the bulk barrels;

J. The label on the blister card included the pharmacy address; a DEA number that did not have the appropriate number and type of digits; a prescription number; the name "Dr. P. Arrey"; the term "Med-Shoppe Cameroon", with the address and a foreign phone number; directions for use; manufacturer name; medication name; medication quantity; initials; date prescription written; original fill date; dispensing date; and discard date;

K. The Respondent was unable to provide a prescription for any of the prescription numbers on the blister cards. There was no patient name associated with the medications prepared in the blister cards. The Respondent could not produce a record or log for the 114 repackaged medications cards (total of 7972 doses of medication). There were no cautionary labels on the blister cards;

L. The Respondent did not have an exporter's permit or license. When asked for her license, she presented the inspector with a document entitled "SGS Government & Institutions Services";

M. The Respondent was unable to locate any policy and procedures for the operations for the pharmacy;

N. The Respondent was unable to provide a biennial inventory of the

CDS in the pharmacy and a perpetual inventory was not used. The Schedule II prescriptions were not filed and hard copy prescription files were not readily retrievable. Many of the Schedule II prescriptions did not bear the name of a prescriber;

O. On or around July 11, 2008 the DDC ordered and undertook an impoundment of the relabeled prescription and non-prescription drugs, expired prescription and non-prescription drugs, and the barrels of prescription drugs that originated from the CCMMB.

15. As a result of the findings at the Liberty Shoppe, on July 21, 2008, an inspection of the Medicine Shoppe on Reisterstown Road was performed by Ann Taylor, Pharmacist Compliance Officer, and Jeanelle McKnight, Pharmacy Inspector.

A. During the inspection, Ms. Taylor noted that the pharmacy was filled with many large capacity boxes and delivery totes which blocked the rear exit of the pharmacy. These boxes were taped and shrink-wrapped;

B. The staff informed the inspectors that they did not know why the boxes and totes were stored in the pharmacy. The staff contacted the Respondent, by telephone to have her explain why the boxes were stored in the pharmacy. She explained that the boxes were in the pharmacy as storage and when the in-store supply was expended, she would use the items in the boxes to restock the store. The boxes were labeled with names of sundry items (i.e. plates, knives); food

items (i.e., Hershey Hot Cocoa), and, medications. None of the items were currently on the shelves in the pharmacy. Eight boxes were opened and examined to identify the contents. The contents of the boxes matched the labeling on the exterior of the boxes;

C. There were two delivery totes labeled with drug names.

(1) In Tote #1, the contents were as follows:

(a) 18 bottles of Amoxicillin Oral Suspension 250mg/5ml-150ml with the manufacturer's lot# 5K08084; manufacturer's expiration dates were removed;

(b) Seven bottles of Amoxicillin Oral Suspension 250mg/5ml-80ml with the manufacturer's Lot# 5G01500; manufacturer's expiration fates were removed;

(c) 17 bottles of Amoxicillin Oral Suspension 250mg/5ml-150ml with the manufacturer's Lot# 5G04874; manufacturer's expiration dates were removed;

(2) In Tote #2, the contents were as follows: 66 bottles of Amoxicillin with Clavulanate Potassium Oral Suspension 200mg/5ml-100ml, manufacturer's expiration date and lot numbers were removed. [3]

D. In light of the recent impoundment by the DDC of similar misbranded medications at the Respondent's Liberty Shoppe, the totes were sealed as follows: Tote #1 - green seal serial number

3 Amoxicillin Oral Suspension and Amoxicillin with Clavulanate Potassium Oral Suspension are antibiotic medications typically used to treat infections in children.

1429871 and, Tote #2 - green seal serial number 1429861. Seals were provided by staff at the pharmacy. They were asked not to break the seals or remove the containers from the pharmacy;

E. A memo was sent to the DDC to inform it of the occurrence and the location of the misbranded medications;

F. The staff on duty (pharmacist and technician) were unable to provide signed and dated records of receipts of controlled substances entered into the pharmacy inventory;

G. The Schedule II invoices and DEA 222 forms were incomplete and unsigned;

H. The prescriptions for controlled substances did not contain the Federal caution labels. Several of the CDS prescriptions did not bear prescriber's DEA number;

I. The staff were unable to produce a current inventory of the quantity of Fentanyl 50mcg/hr, Duragesic 25mcg/hr, Hydromorphone 4mg; Morphine Sulfate IR 15mg; Oxycodone with Acetaminophen 7.5mg/500mg. A return request for expired medications for these medications was identified, however, no total inventory quantity could be provided;

J. A review of the CDS revealed the following discrepancies: shortage of 100 of methadone, 10mg unaccounted for, and, shortage of 102 morphine sulfate 30 mg unaccounted for.

K. The inspector observed that the pharmacist on duty, Tamer Fandy, allowed the pharmacy technician to have unsupervised access to the safe that contained the controlled dangerous substances;

L. There were no policies and procedures to specify duties that may be performed by ancillary personnel under the supervision of a licensed pharmacist, as required. Nor did the Respondent have documentation for training for all unlicensed personnel who perform tasks in the pharmacy, as required by law;

M. The pharmacy area was not neat, clean and organized and lacked the current edition of the Act and regulations thereunder;

N. The required cautionary statements or auxiliary labels were missing, in non-compliance with the Act;

O. The expiration date was not indicated in some instances and the original prescriptions were dispensed more than 120 days after the issue date;

P. There were no written procedures to follow when reporting a suspected medication error to the permit holder, pharmacist, health care facility , or other health care provider, as required;

Q. The pharmacy failed to maintain a minimum of two continuous years of records clearly demonstrating the content of annual educational training provided to each member of the pharmacy staff involved in the medication delivery system regarding the role

and responsibility of the pharmacy staff in preventing medication errors;

R. The Respondent failed to maintain invoices as required by law for accurate control and accountability of all pharmaceuticals;

S. The Respondent lacked written policies and procedures for the safe handling of drug recalls; nor did it maintain records of all recalls;

T. The Respondent failed to keep records of all receipts of controlled substances entered into the pharmacy inventory, as required;

U. The prescription label for controlled drugs failed to include the following warning: "CAUTION: *Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed."* In 6-point type or an auxiliary label that contains this warning, as required;

V. All controlled substances prescriptions failed to bear the name and address of the prescriber and patient, as required;

W. The Respondent failed to have written policies and procedures for investigating discrepancies and reporting of theft or loss, as required;

X. The Respondent failed to ensure that all Schedules III-V invoices were signed and dated or that Schedule II invoices and DEA 222 forms were completed;

Y. Prescription #6025281 for Albuterol Inhaler appeared to have been altered in the date area;

Z. Prescription # 4002613 had no original form, but only a faxed copy with no DEA # for the prescriber;

AA. There were also no DEA numbers for 16 more prescriptions;

BB. Staff was unable to produce current inventory numbers/quantities for Fentanyl 50 mg; Duragesis 25 mg; Hydromorphial 4 mg; Morphine Sulfate; Oxycodone with Acetaminophen 7.5/500 mg;

CC. In addition, there were no expiration dates on 18 bottles of Amoxicillin Oral Suspension ("Susp."). 250 mg/5ml-150 ml; seven bottles of Amoxicillin Oral Susp. 250 mg/5 ml-80 ml; 17 bottles of Amoxicillin Oral Susp. 250 mg/5 ml-150 ml; and, 66 bottles Amoxicillin/Clavulanate Potassium Oral Susp. 200 mg/5ml-100ml—the latter of which had no lot number. These were all sealed for DDC to pick up. The expiration dates and lot numbers appear to have been removed.

DD. On 8/1/08, DDC signed an impoundment Order for those drugs with removed expiration dates.

16. A follow-up consultation occurred with Matthew Rosenberg at the Food and Drug Administration (FDA). Ms. Taylor was informed that the FDA had taken samples of the medication in the bulk barrels impounded from the Liberty Shoppe and was performing chemical assays to determine the chemicals/ drugs in each of the tablet

samples.

17. The DDC also reported that the dumpsters connected to the building where the Liberty Shoppe is located were emptied and the FDA found other misbranded medication consistent with that found in the store in the dumpster.

18. Mathew Rosenberg reported that a search warrant was executed on August 6, 2008 for the Liberty and Reisterstown Shoppe's, as well as in the Respondent's home, where similar expired and relabeled medications were retrieved.

19. The Respondent was subsequently arrested and charged with altering labels of drugs, removing the expiration dates from the labels of drugs, and placing the labels on stock bottles of drugs that were did not match the NDC numbers on the bulk drums, in violation of Federal Law.

FINDINGS OF FACT

1. As set forth above, the Respondent's possession of hundreds of expired, re-labeled and/or misbranded drugs, and her failure to adhere to policies to protect the public safety and the safety of her employees, is a threat to the public health, safety or welfare.

2. The above actions also constitute violations of the Act. Specifically, the Respondent violated the following provisions of §12-313:

> (b) Subject to the hearing provisions of § 12-315 of this subtitle, the Board, on the affirmative vote of a majority of its members then serving, may deny a license to any applicant, reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the applicant or licensee:

(2) Fraudulently or deceptively uses a license;

(7) Willfully makes or files a false report or record as part of practicing pharmacy;

(8) Willfully fails to file or record any report that is required by law;

(15) Dispenses any drug, device, or diagnostic for which a prescription is required without a written, oral, or electronically transmitted prescription from an authorized prescriber;

(17) Violates any provision of § 12-503 of this title, which concerns the labeling requirements for prescriptions for drugs, devices, or diagnostics;

(21) Is professionally, physically, or mentally incompetent;

(25) Violates any rule or regulation adopted by the Board;

The Respondent also violated §12–503 of the Act:

(a) An authorized prescriber who issues a prescription shall indicate on the prescription the date of its issuance.

(b) Unless otherwise instructed by the authorized prescriber who issues the prescription, a pharmacist may not dispense any drug or device on a prescription presented more than 120 days after the date the prescription was issued.

The Respondent also violated §12–505 of the Act:

(a) Except for a drug or device dispensed to an inpatient in a hospital or related institution, each container of a drug or device dispensed shall be labeled in accordance with this section.

(b) In addition to any other information required by law, the label shall include:

(1) The date the prescription is filled; and

(2) Unless otherwise required by the prescriber:

(i) An expiration date of the drugs or devices which shall be the lesser of:

1. 1 year from the date of dispensing;
2. The month and year when the drugs or devices expire;
3. The appropriate expiration date for repackaged drugs or devices; or
4. A shorter period as determined by the pharmacist;

(ii) Any appropriate special handling instructions regarding proper storage of the drugs or devices; and

(iii) Subject to the provisions of subsection (c) of this section, the name and strength of the drugs or devices.

(c) (1) Except as provided in paragraph (2) of this subsection, the label shall indicate the same name for the drug or device as that used by the authorized prescriber.

(2) If, under § 12-504 of this subtitle, the pharmacist substitutes a drug or device product for that named by the authorized prescriber, the label shall indicate both the name of the drug or device product and the name of the manufacturer or distributor of the drug or device dispensed.

(d) (1) Except as provided in this subsection, if an authorized prescriber dispenses a drug or device, the prescriber shall label each container of the drug or device.

(2) In addition to any other information required by law, the authorized prescriber shall include on the label:

(i) The name and strength of the drug or device;

(ii) The date the prescription is dispensed;

(iii) An expiration date of the drug or device which shall be the lesser of:

1. 1 year from the date of dispensing;
2. The month and year when the drug or device expires; or
3. A shorter period as determined by the authorized prescriber; and

(iv) Any appropriate special handling instructions regarding proper storage of the drug or device.

(3) The labeling requirements of this subsection do not apply if the authorized prescriber dispenses the drug or device:

(i) To an inpatient in a hospital or related institution;

(ii) In an emergency situation; or

(iii) As a sample drug or device dispensed in the regular course of the authorized prescriber's practice.

(e) So long as any of the original contents remain in the container, a person may not alter, deface, or remove any label required by this section.

The Respondent further violated the Pharmacists Code of Conduct, Code Md. Regs. tit. 10. § 34.10 (July 12, 1999):

.01 Patient Safety and Welfare.

A. A pharmacist shall:

(1) Abide by all federal and State laws relating to the practice of pharmacy and the dispensing, distribution, storage, and labeling of drugs and devices, including but not limited to:

(a) United States Code, Title 21,

(b) Health-General Article, Titles 21 and 22, Annotated Code of Maryland,

(c) Health Occupations Article, Title 12, Annotated Code of Maryland,

(d) Criminal Law Article, Title 5, Annotated Code of Maryland, and

(e) COMAR 10.19.03;

(2) Verify the accuracy of the prescription before dispensing the drug or device if the pharmacist has reason to believe that the prescription contains an error; and

(3) Maintain proper sanitation, hygiene, biohazard precautions, and infection control when performing tasks in the prescription process.

B. A pharmacist may not:

(1) Engage in conduct which departs from the standard of care ordinarily exercised by a pharmacist;

(2) Practice pharmacy under circumstances or conditions which prevent the proper exercise of professional judgment; or

(3) Engage in unprofessional conduct.

CONCLUSIONS OF LAW

Based on the foregoing, the Board finds that the public health, safety or welfare imperatively requires emergency action, pursuant to Md. St. Gov't. Code Ann. ' 10-226(c)(2) (2004 Repl. Vol.).

ORDER

Based on the foregoing, it is therefore this 15th day of **August 2008**, by a majority vote of a quorum of the State Board of Pharmacy, by authority granted by the Board by Md. St. Govt. Code Ann. ' 10-226(c)(2) (2004 Repl. Vol.), the license held by the

Respondent to practice pharmacy in Maryland, License No. 11345, is hereby **SUMMARILY SUSPENDED;** and be it further

ORDERED, that upon the Board's receipt of a written request from the Respondent, a Show Cause Hearing shall be scheduled within thirty days of said request, at which the Respondent will be given an opportunity to be heard as to whether the Summary Suspension should be continued, regarding the Respondent's fitness to practice pharmacy and the danger to the public; and be it further

ORDERED, that the Respondent shall immediately turn over to the Board her wall certificate and wallet-sized license to practice pharmacy issued by the Board; and be it further

ORDERED, that this document constitutes a final Order of the Board and is therefore a public document for purposes of public disclosure, as required by Md. State Gov't Code Ann. §10-617(h) (2004 Repl. Vol.).

LaVerne Naesea, Executive Director
Board of Pharmacy

NOTICE OF HEARING

A Show Cause hearing to determine whether the Summary Suspension shall be continued will be held before the Board at 4201 Patterson Avenue, Baltimore, 21215 following a written request by the Respondent for same.