

**IN THE MATTER OF**

\*

**BEFORE THE**

**BEST PHARMACY**

\*

**MARYLAND STATE**

**Permit No. P07954**

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**BOARD OF PHARMACY**

\*

**Respondent-Pharmacy**

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**Case No. 24-001**

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**INTERIM ORDER OF STAYED SUMMARY SUSPENSION**  
**SUBJECT TO CERTAIN CONDITIONS**

On October 31, 2023, the Maryland State Board of Pharmacy (the “Board”) notified BEST PHARMACY (the “Respondent-Pharmacy”), Permit Number P07954, of the Board’s intent to summarily suspend the Respondent-Pharmacy’s permit to operate as a pharmacy in the State of Maryland. On November 15, 2023, the Board held a pre-deprivation show cause hearing to consider whether to summarily suspend the Respondent-Pharmacy’s permit. At the conclusion of the pre-deprivation show cause hearing, the Board voted to issue this Interim Order pursuant to its authority under Md. Code Ann., State Gov’t § 10-226(c)(2) and COMAR 10.34.01.12, concluding that the public health, safety or welfare imperatively requires emergency action. This Order is based on the following preliminary findings, which the Board has reason to believe are true:

**Preliminary Findings**

**BACKGROUND**

1. At all times relevant hereto, the Respondent-Pharmacy was permitted to operate as a pharmacy in the State of Maryland. The Respondent-Pharmacy was originally

issued a permit to operate as a pharmacy in Maryland on October 18, 2018, under Permit Number P07954. The Respondent-Pharmacy's permit is scheduled to expire on May 31, 2024.

2. The Respondent-Pharmacy is located in Hyattsville, Maryland.

3. At all times relevant hereto, the Respondent-Pharmacy was owned by an individual (the "Owner")<sup>1</sup>, who was not licensed as a pharmacist in Maryland.

4. At all times relevant hereto, the Owner employed a pharmacist ("Pharmacist 1") licensed to practice pharmacy in Maryland to provide pharmacy services.

## **THE COMPLAINT**

5. On or about July 6, 2023, the Board received a referral from the Maryland Office of Controlled Substances Administration ("OCSA") regarding regulatory inspections it conducted of the Respondent-Pharmacy on June 8, 2023, and July 5, 2023.

6. At the June 8, 2023, inspection, an OCSA inspector met with Pharmacist 1 and spoke with the Owner by telephone. During the inspection, the OCSA inspector discovered the following deficiencies: major discrepancy between the actual count of Schedule II Controlled Dangerous Substances ("CDS") compared to the Respondent-Pharmacy's records; Pharmacist 1 could not produce Schedule II CDS invoices prior to October 2021; and the Respondent-Pharmacy's dispensing records indicated no dispensing of Schedule II CDS since May 23, 2019, even though the Respondent-Pharmacy consistently ordered large

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<sup>1</sup> In order to maintain confidentiality, names of individuals and facilities involved in this matter will not be used in this document but will be provided to the Respondent-Pharmacy upon request.

quantities of Schedule II CDS after May 23, 2019. Moreover, the Owner stated that the Respondent-Pharmacy had not ordered Schedule II CDS since October of 2021, even though records indicated that large quantities of oxycodone were ordered in January of 2022. Finally, the Owner stated that large quantities of Schedule II CDS were stolen during a break-in a couple of months ago, but he could not produce a police report nor a DEA 106 Form. The OCSA inspector gave the Respondent-Pharmacy two weeks to produce documents to reconcile the significant discrepancies.

7. On or about July 5, 2023, OCSA inspectors conducted a follow-up inspection of the Respondent-Pharmacy. During the inspection, OCSA inspectors noted the following deficiencies: even though Pharmacist 1 produced Schedule II CDS invoices from 2019 to 2022, many invoices were missing; Pharmacist 1 was unable to open the Schedule II CDS safe to perform a drug count due to battery problems; and the Owner reporting that he had transferred Schedule II CDS inventory from the Respondent-Pharmacy to a new pharmacy ("Pharmacy 1") he planned to open in Takoma Park, Maryland, even though Pharmacy 1 did not have a CDS or DEA registration. OCSA inspectors then traveled to Pharmacy 1 in Takoma Park, Maryland with the Owner, intending to conduct an inspection of Pharmacy 1. The Owner, however, was unable to open the padlock to the door, stating that the "delivery person" had the key.

8. After receiving the referral from OCSA, the Board initiated an investigation of the Respondent-Pharmacy.

### **BOARD INVESTIGATION**

9. The Board's investigation included but was not limited to: subpoenaing pharmacy records from the Respondent-Pharmacy; reviewing the Automation of Reports and Consolidated Orders System ("ARCOS") report regarding CDS purchased by the Respondent-Pharmacy; reviewing the Prescription Drug Monitoring Program ("PDMP") report regarding CDS the Respondent-Pharmacy dispensed; onsite inspections and audits of the Respondent-Pharmacy and Pharmacy 1 on or about July 7, 2023, and August 2, 2023.

10. On or about July 7, 2023, Board inspectors conducted an onsite inspection of the Respondent-Pharmacy. Based on the ARCOS report, which detailed CDS the Respondent-Pharmacy purchased, as reported by the drug wholesalers, and the PDMP report, which detailed all CDS the Respondent-Pharmacy dispensed, the Respondent-Pharmacy was unable to account for large quantities of CDS. The major discrepancies included but were not limited to the following number of CDS tablets being unaccounted for: 32,710 tablets of oxycodone 30 mg; 17,691 tablets of oxycodone 20 mg; 21,904 tablets of oxycodone 15 mg; 5,610 tablets of amphetamine salts 30 mg; and 3,500 tablets of hydrocodone/acetaminophen 10/325 mg.

11. On or about August 2, 2023, OCSA inspectors conducted a follow-up inspection and audit of the Respondent-Pharmacy to determine if any of the unaccounted-for

CDS could be reconciled. Present during the inspection were the Owner, another pharmacist (“Pharmacist 2”), and a pharmacy technician. At the August 2, 2023, follow-up inspection, OCSA inspectors and Pharmacist 2 engaged in a hand-count of tablets with respect to ten (10) different CDS drugs in the Respondent-Pharmacy’s inventory. An analysis of the results of the hand-count compared to the Respondent-Pharmacy’s records and reports again revealed major shortages of CDS drugs. These shortages included but were not limited to the following: oxycodone 30 mg (shortage of between 24,300 to 26,910 tablets); oxycodone 20 mg (shortage of between 7,200 to 16,391 tablets); oxycodone 15 mg (shortage of between 786 to 10,548 tablets); and amphetamine salts 30 mg (shortage of between 1,600 to 4,110 tablets).

12. At the show cause hearing, the Respondent-Pharmacy was unable to present any reasonable explanation for ordering exceptionally large quantities of CDS that did not remotely align with the Respondent-Pharmacy’s dispensing history for such drugs; nor did the Respondent-Pharmacy provide any reasonable or reliable explanation for the major discrepancies in its CDS inventory, demonstrating tens of thousands of highly addictive and dangerous CDS tablets that are currently unaccounted for.

### **Conclusion**

Based on the foregoing, the Board finds that the public health, safety or welfare imperatively requires emergency action, pursuant to Md. Ann. Code, State Gov’t. Art. § 10-226(c)(2) and COMAR 10.34.01.12.

## ORDER

Based on the foregoing, and after a Show Cause Hearing was held in which the Respondent-Pharmacy was given the opportunity to be heard as to whether a Summary Suspension should be executed, on this 11<sup>th</sup> day of December, 2023, by an affirmative vote of the Board, by authority granted to the Board by Md. Code Ann., State Gov't Art. § 10-226(c)(2) and COMAR 10.34.01.12, it is hereby,

**ORDERED** that the permit held by the Respondent-Pharmacy to operate Best Pharmacy (Permit No. P07954) is hereby **SUMMARILY SUSPENDED**, such summary suspension to be **IMMEDIATELY STAYED PROVIDED THAT** the Respondent-Pharmacy fully complies with the conditions set forth below; and be it further,

**ORDERED** that the Respondent-Pharmacy shall immediately inventory and return all existing CDS inventory through its reverse distributor and provide the Board with documentation of such return; and be it further,

**ORDERED** that the Respondent-Pharmacy shall immediately communicate with OCSA and DEA to arrange for the return of its DEA and CDS registrations; and be it further,

**ORDERED** that as of the effective date of this Order, the Respondent-Pharmacy is prohibited from dispensing, purchasing, storing, or otherwise handling controlled dangerous substances (CDS); and be it further,

**ORDERED** that the Respondent-Pharmacy shall immediately notify its wholesale drug distributors of the restrictions contained in this Order; and be it further,

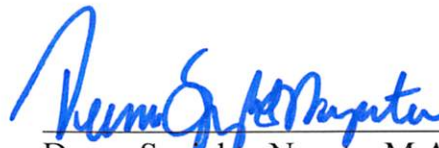
**ORDERED** that the Board, or OCSA, may conduct random inspections of the Respondent-Pharmacy to ensure compliance with the provisions of this Interim Order; and be it further,

**ORDERED** that the Respondent-Pharmacy may submit a written request to the Board within thirty (30) days of the date of this Order for an evidentiary hearing to be held before the Board on the summary suspension, which hearing may be consolidated with an evidentiary hearing on any charges issued against the Respondent-Pharmacy; and be it further

**ORDERED**, that this document constitutes a formal order of the Board and is therefore a public document for purposes of public disclosure, as required by the Public Information Act, General Prov. Art., § 4-301, *et seq.* and COMAR 10.34.01.12.

12-11-23

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Date



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Deena Speights-Napata, M.A.  
Executive Director *for*  
Neil Leikach, R.Ph., M.Sc., President  
Board of Pharmacy