

STATE OF NORTH CAROLINA  
NORTH CAROLINA BOARD OF PHARMACY

IN THE MATTER OF )  
 )  
RONALD SANDRITTER ) **FINAL ORDER**  
License Number 7089 )

THIS MATTER came on to be heard before the North Carolina Board of Pharmacy (the "Board") on July 20, 2010, pursuant to a Notice of Hearing, dated June 8, 2010, and was heard by Board Members Dr. J. Parker Chesson, Jr., E. Lazelle Marks, Robert McLaughlin, Jr. and Gene Minton at the offices of the Board. Board staff was represented by Clinton R. Pinyan, and Respondent Ronald Sandritter ("Sandritter") was present and represented himself. The Board received evidence offered without objection, and heard the testimony of witnesses. Considering the testimony and evidence, the Board hereby makes the following findings of fact and conclusions of law:

**FINDINGS OF FACT**

1. The Board is a body duly organized under the laws of the State of North Carolina and is the proper body for this proceeding under the authority granted to it in Chapter 90 of the General Statutes of North Carolina, and the rules and regulations promulgated thereunder. This matter came on for hearing pursuant to the Notice of Hearing, dated June 8, 2010. All Parties were properly before the Board, the Board has jurisdiction of the parties and of the subject matter, and Sandritter received all required notice of the hearing.

2. Since January 16, 1979, Sandritter has been licensed by the Board to practice pharmacy in the State of North Carolina and has been the holder of license number 7089.

3. On August 20, 2008, Sandritter dispensed Amlodipine Besylate 5 mg to a patient whose prescription called for Diazepam 5 mg and dispensed drugs that were mislabeled. As a result of the error, the patient consumed the incorrect medication for two (2) days.

4. On May 12, 2009, Sandritter accepted a proposed Consent Order to resolve a disciplinary complaint against Sandritter arising from the August 2008 dispensing error. The Consent Order was accepted by the Board on June 16, 2009.

5. On June 17, 2009, the Board sent the Consent Order to Sandritter and reminded him that he was responsible for complying with all mandates set out in the Consent Order.

6. The Consent Order provided that Sandritter's license would be suspended indefinitely, but that the suspension would be stayed for a period of three (3) years from the time that the order was accepted by the Board – in other words, until June 16, 2012 – so long as Sandritter complied with certain conditions. Those conditions included:

- a. Sandritter shall violate no laws governing the practice of pharmacy or the distribution of drugs;
- b. Sandritter shall violate no rules or regulations of the Board; and
- c. Sandritter shall promptly provide documentation of any known or suspected errors to the Board's Executive Director within five (5) business days of learning of such error.

7. Each and every condition was a material term of the Consent Order. The Board would have imposed additional and harsher discipline, including but not limited to an immediate and indefinite suspension of Sandritter's license, if Sandritter had not agreed to comply with every condition of the Consent Order.

8. The Consent Order provides, "If Respondent fails to comply with any terms or conditions of this Consent Order, the three-year stay described above shall be lifted and Respondent may be subject to additional disciplinary action by the Board." In addition, separate and apart from the terms of the Consent Order, the Board has the statutory authority to discipline pharmacists who violate the terms of the Board's Consent Orders.

9. At the times relevant hereto, Sandritter was employed as a pharmacist at Kerr Drug (Permit No. 6886), located at 6525 Jordan Road, Ramseur, North Carolina.

10. Between August 2009 and March 2010, Sandritter committed three (3) documented errors.

**August 2009 Error**

11. On August 14, 2009, Sandritter negligently and improperly dispensed allopurinol 100 mg to a patient who had not been prescribed allopurinol. The medication had been prescribed instead for a patient with the same first name and last initial. Sandritter admitted making this dispensing error.

12. There was some dispute at the hearing about whether Sandritter learned of the error on August 14, 2009, or on or about August 18, 2009. The Board finds as credible the testimony of Board Investigator Jason Smith that Sandritter previously admitted that Sandritter learned of the error on the same date that the drug was dispensed, August 14, 2009. But, even if the Board had credited Sandritter's testimony contradicting his prior statement, Sandritter acknowledged that he was informed of the error more than five (5) business days before he informed the Board of the error. Sandritter did not inform the Board of the error until September 1, 2009. Accordingly, Sandritter admitted violating the terms of the Consent Order with respect to notifying the Board of the error.

**February 2010 Error**

13. On February 8, 2010, Sandritter negligently and improperly dispensed Effexor 150 mg to a patient who had been prescribed Effexor 75 mg. The medication was incorrectly labeled as Effexor 75 mg. Sandritter admitted making this dispensing error.

**March 2010 Error**

14. On or about March 18, 2010, Sandritter negligently and improperly dispensed Potassium Chloride 20 percent solution to a patient who had been prescribed Potassium Chloride 10 percent solution. The patient consumed the incorrect medication, and the error was discovered when the patient's physician noticed that the patient's potassium levels had quickly risen. Sandritter admitted making this dispensing error.

**Aggravating Factors**

15. As an aggravating factor, the Board considers Sandritter's history with the Board, as well as other errors that he has self-reported to the Board. These errors were not considered for the purposes of making findings of fact or conclusions of law with respect to the violations charged in the Notice of Hearing, but instead were considered only after such determinations were made and were considered only for the purposes of determining the appropriate disciplinary action.

16. Between 2001 and 2004, the Board issued five (5) staff letters to Sandritter in connection with dispensing errors. Those errors are described in the prior Consent Order. Sandritter admitted making each of the errors that was the subject of those five (5) staff letters.

17. In addition, Sandritter admitted making two additional errors that he self-reported to the Board:

a. On June 10, 2009, Sandritter dispensed Trazadone 50 mg to a patient who had been prescribed Tramadol 50 mg.

b. On July 16, 2010, Sandritter dispensed Losartan/HCTZ 100/12.5 mg to a patient who had been prescribed Losartan/HCTZ 100/25 mg.

### CONCLUSIONS OF LAW

1. The evidence demonstrates that Sandritter violated the following statutes, rules and decisional authorities related to the practice of pharmacy and the dispensing and delivery of prescription drugs:

- a. North Carolina General Statutes § 90-85.29;
- b. North Carolina General Statutes § 90-85.38(a)(6);
- c. North Carolina General Statutes § 90-85.38(a)(7);
- d. North Carolina General Statutes § 90-85.38(a)(9);
- e. North Carolina General Statutes § 106-122;
- f. North Carolina General Statutes § 106-134;
- g. 21 N.C.A.C. 46 .1805;
- h. 21 N.C.A.C. 46 .1818; and
- k. The Board's Consent Order of June 16, 2009.

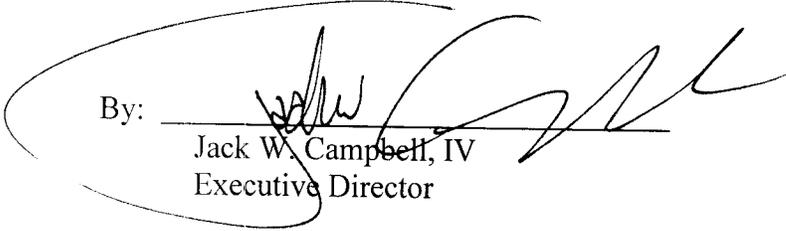
2. Considering all of the facts and circumstances of this matter, the Board finds and concludes that the discipline set forth in this Final Order is appropriate.

It is hereby ORDERED, ADJUDGED AND DECREED that Board staff's request for discipline is hereby GRANTED, and Sandritter's license is hereby INDEFINITELY SUSPENDED. As a result of the indefinite suspension, Sandritter shall not be present in any pharmacy in the State of North Carolina except as a customer, with a valid prescription from a treating physician. The Board incorporates by reference the Board's Reapplication and Reinstatement Policy.

This, the 20<sup>th</sup> day of July, 2010.

NORTH CAROLINA BOARD OF PHARMACY

By: \_\_\_\_\_

  
Jack W. Campbell, IV  
Executive Director