STATE OF NORTH CAROLINA  
NORTH CAROLINA BOARD OF PHARMACY  

IN THE MATTER OF  
FRANKLIN STREET PHARMACY  
Permit No. 4012  

CONSENT ORDER

THIS MATTER came on for consideration at a prehearing conference (hereinafter, “conference”) pursuant to 21 N.C.A.C. 46.2008. This conference was scheduled for May 14, 2012 and, after appropriate notice, was heard on that day at the office of the North Carolina Board of Pharmacy (hereinafter, “Board”) by Board member Dr. J. Parker Chesson, Jr. Respondent Franklin Street Pharmacy (Permit No. 4012) was present at the conference through John Sink, its pharmacist-manager. Board Counsel Clinton R. Pinyan and members of the Board’s investigative and legal staff were present at this conference, as were related respondents.

Respondent has agreed to waive a formal hearing in the above-referenced matter. Both parties stipulate and agree to the findings of fact and conclusions of law recited herein and to the order of discipline imposed. By its consent, Respondent also stipulates that it waives its right to appeal this Consent Order or challenge in any way the sufficiency of the findings of this Order. Based upon the consent of the parties, the Board hereby enters the following:

FINDINGS OF FACT

1. The North Carolina Board of Pharmacy is a body duly organized under the laws of North Carolina and is the proper body for this proceeding under the authority granted it in Chapter 90 of the General Statutes of North Carolina, and the rules and regulations promulgated thereunder.
2. Respondent is and was, at all relevant times referred to herein, a pharmacy permitted in the State of North Carolina with Permit No. 4012, located at 610 East Franklin Street, Monroe, North Carolina. Respondent is and was, at all relevant times referenced to herein, subject to the rules and regulations of the North Carolina Board of Pharmacy and the laws of the State of North Carolina.

3. Between approximately May 7, 2008 and July 14, 2011, Patient A presented to Respondent a total of 152 forged prescriptions for Oxycodone and Adderall in various strengths (schedule II controlled substances), Hydrocodone/APAP in various strengths (a schedule III controlled substance), and Alprazolam 2 mg and Clonazepam 1 mg (schedule IV controlled substances) that had purportedly been written for Patient A and his wife, Patient B. Respondent dispensed controlled substances pursuant to each of these forged prescriptions.

4. Each of these prescriptions had purportedly been written by Dr. Sara Beyer, a physician at Steele Creek Family Practice. Patients A and B had never been patients of Dr. Beyer, and Dr. Beyer had left Steele Creek Family Practice in January 2011. Patient A had previously passed forged prescriptions in Dr. Beyer’s name to other pharmacies and had been arrested for prescription forgery.

5. The Board attempted to attribute the prescriptions to the pharmacists whose initials appeared in Respondent’s records as the dispensing pharmacist. Respondent, through its pharmacist-manager, R. Ph. Sink, testified at length that Respondent and its pharmacists frequently dispensed prescriptions with the incorrect pharmacist initials on the labels and pharmacy records. Respondent did not require staff and pharmacists to log off of computers when the pharmacists left a work station, and Respondent improperly permitted staff to log in to computers using pharmacist log-in information, even when the pharmacists were not present in
the store. These operations by Respondent and its pharmacists made it impossible to determine
the exact number of prescriptions that each pharmacist filled.

6. In addition, Patient A frequently presented these forged prescriptions for
Patients A and B well before an earlier dispensed prescription for the same drug should have run
out, and Respondent filled those prescriptions early anyway, resulting in the dispensing of
controlled substances in significant excess of normal therapeutic use. Respondent’s records
reflect that, on at least 47 occasions, Respondent dispensed controlled substances more than two
days early (even if the prescriptions had been legitimate). Indeed, on at least 35 occasions,
Respondent dispensed controlled substances one week or more early (even if the prescriptions
had been legitimate). And, on at least 13 occasions, Respondent dispensed controlled substances
two weeks or more early (even if the prescriptions had been legitimate).

7. The circumstances surrounding the dispensing of the forged prescriptions were
such that a reasonable permit holder in Respondent’s position would have concluded that the
prescriptions were fraudulent and would have ceased filling the prescriptions. Respondent
acknowledged that its Pharmacist-Manager, R. Ph. Sink was aware that Patient A would come
into the pharmacy and specifically request to talk with pharmacist Joseph Black. R. Ph. Black
would then come out from behind the pharmacy counter and personally take the prescriptions
from Patient A, and R. Ph. Black would personally perform the data entry and filling of the
prescriptions. Patient A would come into the pharmacy at busy times, in circumstances in which
R. Ph. Black would be rushed. Respondent’s pharmacists were aware that Patient A was coming
into Franklin Street to fill controlled substance prescriptions with great frequency and was
regularly presenting prescriptions for multiple controlled substances.
8. In addition, R. Ph. Sink testified that, in June 2010, he “almost came to blows” with Patient A when Patient A insisted that a controlled substance prescription be filled immediately. This was one of the forged controlled substance prescriptions at issue in this matter. Notwithstanding both that incident and the unusual interactions between R. Ph. Black and Patient A that had come to R. Ph. Sink’s attention, R. Ph. Sink testified that Respondent continued to fill controlled substance prescriptions for Patients A and B, and that R. Ph. Sink never accessed or reviewed the patient profiles for either Patient A or Patient B, which would have confirmed that the prescriptions were being presented with questionable frequency resulting in distribution in significant excess of normal therapeutic use. Respondent and its pharmacists further never called Dr. Beyer or her practice to question the legitimacy of the prescriptions, notwithstanding the number of the prescriptions and the frequency with which they were presented.

9. R. Ph. Black did not verify the frequency of dispensing of the controlled substances because he assumed that Respondent’s computer system would alert him to early fills of controlled substances and it did not. This assumption – that dispensing was permitted as long as there was not an alert from the computer system – was an unreasonable abdication of R. Ph. Black’s responsibilities to ensure the safe and lawful distribution of controlled substances. Moreover, on or about May 11, 2011, Respondent’s computer system was updated to automatically provide a pharmacist with information about the most recent dispensing of the same drug. Between May 11, 2011 and July 8, 2011 – a period of less than two months – Respondent filled controlled substance prescriptions early for Patients A and B on at least 12 occasions, notwithstanding this additional alert.
10. On July 14, 2011, Respondent, through R. Ph. Sink, became concerned that Patient A had presented forged prescriptions. On July 15, 2011, R. Ph. Sink confirmed that the prescriptions were forged and, for the first time, researched the patient profiles for Patients A and B and determined the extent to which Respondent had previously filled forged prescriptions for Patients A and B. On July 18, 2011, Respondent terminated the employment of R. Ph. Black and reported the diversion to the local police department. Notwithstanding learning of the diversion by July 15, 2011 at the latest, Respondent failed to report the diversion to the Board until August 17, 2011.

11. Respondent has a prior disciplinary history with the Board. On March 15, 2005, the Board reprimanded Respondent for violations of federal and state pharmacy law and regulations.

**CONCLUSIONS OF LAW**

Based on the above findings, the Board concludes as a matter of law:

1. Respondent violated N.C. Gen. Stat. §§ 90-85.25, 90-85.38(b), 90-85.40(b) and (f), 90-104, 90-106, 90-108, 106-122, 106-134 and 106-134.1; 21 N.C.A.C. 46.1801, 46.1802, 46.1804(a), 46.1805, 46.2302(a) and 46.2502(a); and 21 U.S.C. §§ 331, 829 and 842.

2. Respondent admits that the conduct in this matter constitutes sufficient grounds for disciplinary action on its permit under N.C. Gen. Stat. § 90-85.38.

Based on the foregoing, and with the consent of the parties, IT IS THEREFORE ORDERED that:

1. Respondent Franklin Street Pharmacy's permit (Permit No. 4012) is hereby SUSPENDED for TWO (2) DAYS, which suspension is hereby STAYED for TWO (2)
YEARS from the date that this Order is accepted by the Board, upon the following conditions:

a. Respondent shall violate no laws governing the practice of pharmacy or the distribution of drugs; and

b. Respondent shall violate no rules or regulations of the Board.

2. Respondent shall cooperate with the Board, its attorneys, investigators and other representatives in any investigation of compliance with the provisions of this Consent Order.

3. If Respondent fails to comply with any terms or conditions of this Order, the period of stay described above shall be lifted and, in addition, Respondent may be subject to additional disciplinary action by the Board.

4. In the event that there is a change in location, entity or ownership that would require a new permit under 21 N.C.A.C. 46.1603 and 46.1604, this Consent Order will bind the new permit, and the discipline contained in this Consent Order shall be imposed upon that new permit.

This the 19th day of January 2012.

NORTH CAROLINA BOARD OF PHARMACY

By: Jay W. Campbell, IV
Executive Director
Franklin Street Pharmacy, the holder of Permit Number 4012, has full knowledge that it has the right to a hearing, at which it would have the right to be represented at its expense by counsel, in this matter. The undersigned freely, knowingly and voluntarily waives such right by entering into this Consent Order.

The undersigned understands and agrees that by entering into this Consent Order, he or she certifies that he has read the foregoing Consent Order and that Franklin Street Pharmacy voluntarily consents to the terms and conditions set forth therein and relinquishes any right to judicial review of Board actions which may be taken concerning this matter.

The undersigned further understands that should Franklin Street Pharmacy violate the terms and conditions of this Consent Order, the Board may take additional disciplinary action.

The undersigned understands and agrees that this Consent Order will not become effective unless and until approved by the Board.

The undersigned understands that Franklin Street Pharmacy has the right to have counsel of its choice review and advise it with respect to its rights and this Consent Order, and represents that it enters this Consent Order after consultation with its counsel or after knowingly and voluntarily choosing not to consult with counsel.

The undersigned certifies that its agent executing this Consent Order is duly authorized to execute the Consent Order on behalf of Franklin Street Pharmacy and to bind the permit holder.

ACCEPTED AND CONSENTED TO BY:

FRANKLIN STREET PHARMACY (Permit No. 4012)

[Signature]

Date 5/31/2012

By: [Signature]

Title: [Signature]

STATE OF

Notary Public

COUNTY

I, the undersigned Notary Public of the County and State aforesaid, do hereby certify that the following person personally appeared before me this day and acknowledged the due execution of the foregoing document: [Signature]

Date: May 31, 2012

[Signature]

Notary Public

My commission expires: June 27, 2017