



# Minnesota Board of Pharmacy

## **DISCIPLINARY ACTIVITY: July and August, 2016.**

The Board took the following disciplinary actions involving **pharmacists** at its July and August, 2016 meetings:

**Allison, Theodore C., License # 111864.** Mr. Allison served as pharmacist-in-charge of a community pharmacy located in Minnesota. During the years 2012 through 2015, quality assurance checks were not completed on thousands of prescriptions, including prescriptions for controlled substances. As pharmacist-in-charge, Mr. Allison failed to ensure that operational policies for completion of quality assurance were followed. Consequently, the Board reprimanded him and imposed a civil penalty of \$1,000 at its July, 2016 meeting.

**Benton, Gary D., License # 120764.** Mr. Benton admitted that he altered the strength and quantity of four of his own Adderall prescriptions, although he averred that the total number of milligrams of Adderall that he dispensed for himself did not exceed what was prescribed. He also admitted that he stole a 10-pack of insulin syringes from the pharmacy at which he was employed. Mr. Benton acknowledged that he has been diagnosed with bipolar and attention deficit disorders. He admitted that he attempted to self-medicate those disorders with marijuana and small amounts of methamphetamine. He stated that he did not use these substances at work but did admit that he self-

medicated a couple of hours before an overnight shift on May 22, 2015. Consequently, the Board issued a Stipulation and Consent Order at its August, 2016 meeting that reprimanded Mr. Benton and conditioned his license on participation in the Health Professionals Services Program (HPSP) - the state's impaired health care professional monitoring program.

**Blair, Brent E., License # 114509.** Licensee was cited on several occasions for failure to complete quality assurance for prescriptions. During an inspection in July, 2015, violations related to compounding were noted, including: failure to quarantine expired ingredients and drugs; compounding products using expired ingredients and drugs; and compounding copies of commercially available products without receiving a prescription which indicated that the compounded product was needed for the specific patient. Licensee also filled prescriptions with incomplete information without contacting the prescriber for clarification. Licensee also failed to monitor the temperature of a freezer in which drugs were stored; failed to reconcile the Schedule II perpetual inventory as often as required; and failed to have a written counseling policy in place. Licensee avers that he has subsequently taken appropriate corrective action. The Board issued a Stipulation and Consent Order, reprimanding the licensee, imposing a civil penalty in the amount of \$2,000 and requiring the submission of certain policies and procedures.

**Maves, Scott J., License # 114472.** Mr. Maves engaged in several inappropriate and/or illegal billing activities, including: not properly reversing charges to insurers when patients failed to pick up prescriptions; dispensing generic drugs but billing insurers for brand name drugs; dispensing a prescription of 30 Seroquel, but billing the insurer for 45, in an effort to offset the patient's copay; and waiving copays for an acquaintance and for

other customers and employees. He also dispensed expired drugs to at least five patients. Licensee also provided azithromycin to a pharmacy employee even though no valid prescription had been issued for the employee. During a conference with the Board's Committee on Professional Standings, licensee admitted that he drank codeine-containing cough syrup while on duty within the pharmacy, even though it was not prescribed for him. The Board previously reprimanded Mr. Maves and imposed a civil penalty. Licensee subsequently entered an Alford Plea in Polk County District Court for a charge of Fifth Degree Possession of a Controlled Substance. As a condition of that plea, the court ordered him to voluntarily surrender his pharmacist license. Consequently, the Board issued a Stipulation and Consent Order for Voluntary Surrender at its July, 2016 meeting.

**Parduhn, Fredrick V., License # 112848.** The Board issued a disciplinary order in August, 2015 because Mr. Parduhn had forged prescriptions in order to obtain controlled substances, including opiates and benzodiazepines. He had also used forged prescriptions to obtain muscle relaxants. The 2015 order suspended his license but stayed the suspension on condition that he pay a civil penalty of \$1,000, participate in and complete the Health Professionals Services Program, and comply with any requirements that a court might order. The Board also limited his license so that he could not practice pharmacy in the State of Minnesota in any setting wherein controlled substances are accessible. After successfully participating in HPSP for twelve months, Mr. Parduhn petitioned to have the above-mentioned limitation lifted. The Board granted the petition and issued an amended order at its August, 2016 meeting.

**Sami Estafanous, Eleni, License # 122073.** Licensee was allowed to complete the licensure transfer process in 2014 on condition that she participate in the Health Professionals Services Program. This condition was established based on Licensee's history of chemical dependency. In September of 2015, Licensee was discharged from HPSP because: she admitted using methamphetamine since November of 2014, with an increase to daily use by August, 2015; she refused to submit to a hair follicle test; she admitted to providing "fake urine" for her urine drug screens; and she admitted that she "still loves methamphetamine." A chemical dependency evaluation revealed diagnoses of: methamphetamine dependence (severe); cannabis abuse (moderate); and alcohol abuse (moderate). Consequently, the Board issued an order indefinitely suspending her license to practice pharmacy.

The Board took the following disciplinary actions involving a **pharmacy** at its July, 2016 meeting:

**Alix Rx, License #263885.** Licensee was operating automated drug distributions devices in long-term care facilities in Wisconsin without providing proper notice to the Board. Consequently, the Board reprimanded licensee and assessed a civil penalty in the amount of \$10,000.

The Board took the following disciplinary actions involving **pharmacy technicians** at its July and August, 2016 meetings:

**Curtis, Leigh-Anne, Registration # 730390.** Ms. Curtis admitted that, while working for a community pharmacy, she diverted 25 tablets of Lunesta 2mg and 8 tablets of phentermine 15mg. She also admitted stealing other, non-drug products from her employer. Consequently, the Board issued a Stipulation and Consent Order, accepting the

voluntary surrender of her pharmacy technician registration.

**Jensen, James J., Registration # 727569.** In or about August 2014, on at least five separate occasions, Mr. Jensen entered the pharmacy at which he was employed, when he was not working, and diverted an unknown quantity of hydrocodone and acetaminophen 10-325mg tablets. He did so by removing stock bottles from the shelf, placing them in wastebaskets, taking the wastebaskets outside of the pharmacy and then returning the empty wastebaskets to the pharmacy. An internal audit of the pharmacy revealed that 5,966 tablets were missing. A subsequent audit by the Board revealed that 8,263 tablets had gone missing over the course of his employment at the pharmacy. Consequently, the Board issued a Stipulation and Consent Order, accepting the voluntary surrender of Mr. Jensen's registration.