DISCIPLINARY ACTIVITY: November, 2017 through January, 2018

The Board took the following disciplinary actions involving pharmacists at its November, 2017 and January, 2018 meetings:

Rutten, Mikkal R., License # 121070. Licensee had been previously disciplined for diversion of controlled substances and his license had been suspended by the Board on July 8, 2015. Licensee petitioned the Board to have his license reinstated and he demonstrated, by the preponderance of evidence, that he is capable of conducting himself in a fit and competent manner in the practice of pharmacy. Consequently, the Board issued an Order for Reinstatement of a License in Conditional Status at its November 29, 2017 meeting. License is condition upon that he may not have access to any controlled substances in any setting in which he is employed and that he provide an exact and true copy of his order to any pharmacy employer.

The Board took the following disciplinary actions involving pharmacy technicians at its August and October, 2017 meetings:

Frichtman, Allison M., Registration # 736367. On January 10, 2017, a single tablet of Fioricet was found on the floor of the pharmacy at which the registrant worked. The pharmacy does not normally order or dispense Fioricet. Registrant produced her own prescription bottle for that drug and claimed that the tablet must've fallen out of it. On
February 16, 2017, the registrant ordered a 500-count stock bottle of Fioricet from a licensed wholesale drug distributor. The wholesaler delivered the Fioricet to the pharmacy the next day. On March 2, 2017, registrant admitted to pharmacy personnel that she had removed the bottle of Fioricet from that pharmacy and claimed to have personally transported it to another pharmacy for the purpose of returning it to the wholesaler. However, the bottle was never found and the wholesaler did not received it as a returned item.

Also on March 2, 2017, the pharmacy searched the Registrant's workplace locker and found three vials of compounded bupivacaine/lidocaine/epinephrine in the Registrant's bag. Also found in the locker were two unused tamper-tags used by the pharmacy for securing the drug contents of emergency crash carts and medication kits. Consequently, the Board adopted a Findings of Fact, Conclusions and Final Order, revoking registrant's pharmacy technician registration.

Kloehn (Ripplinger), Jennifer A., Registration # 728137. From at least April, 2016 through July, 2016, registrant diverted up to 7,285 tablets of tramadol 50mg from the pharmacy at which she was employed. Consequently, the Board issued an Order for Voluntary Surrender at its January 16, 2018 meeting.

The Board took the following disciplinary actions involving pharmacies at its November, 2017 and January, 2018 meetings:

APS Pharmacy, License # 264531. Upon request of the Board, Licensee provided the Board with documentation showing ten separate compounded products that Licensee shipped into Minnesota for "office use" over an eleven month period in 2015.
Licensee stated that shipment of these products was an oversight. Licensee also provided the Board with documentation showing nine additional prescriptions that were shipped by Licensee directly to medical clinics in Minnesota. Six of those prescriptions were in the name of the prescribing physician and two were in the name of an employee of that physician. The clinic was billed for those prescriptions. From January 5, 2015 through June 30, 2015, 39% of the prescriptions licensee dispensed and shipped into Minnesota were for veterinary medications. However, Licensee had not checked the veterinary category of licensure on its application and was thus not licensed to dispense and ship veterinary prescriptions into Minnesota. Consequently, the Board adopted a Stipulation and Consent Order, reprimanding Licensee and assessing a civil penalty of $2,500.

**CVS Pharmacy #1683, License # 262719.** During an inspection in November, 2016, a Board Surveyor observed several deficiencies. A temperature reading in the refrigerator that the licensee uses to store drugs was 32 degrees, below the minimum storage temperature for vaccines, which is 36 degrees. Licensee's pharmacist-in-charge could not produce a copy of the pharmacy's technician policy. The Surveyor issued an inspection report that noted the deficiencies. The PIC did not respond to the notice of deficiencies within 30 days, as required by law. Instead, a corporate manager of regulatory affairs located at the licensee's headquarters responded. Consequently, the Board adopted an order that reprimands licensee and assess a civil penalty of $1,500.

**CVS Pharmacy #1129, License # 262880.** In July, 2015, the Board investigated a complaint which alleged that a pharmacist employed by the licensee had failed to counsel the parent of a pediatric patient. As a result, the patient was given an incorrect dose of the drug over a three-day period of time. Licensee's pharmacist-in-charge at the
time submitted a corrective action plan and the complaint was ultimately dismissed.

In April, 2016, Licensee filed a DEA 106 form with the Board due to a technician, employed by Licensee, admitting to the theft of a substantial amount of controlled substances. On September 28, 2016 a Board Surveyor visited the pharmacy for the purpose of conducting an inspection and following-up on the DEA 106 report. The Surveyor observed several practice concerns and violations. Licensee's refrigerator/freezer temperature logs showed that vaccines and other drugs had been improperly stored. The temperature had dropped as low as 28 degrees on one day, followed by a four day period during which temperature was 32 degrees. The solution of Licensee's staff was to open the refrigerator door for three days. The Board Surveyor observed pharmacy technicians simply asking all patients whether they had any questions, even for new prescriptions that, by law, require counseling to be performed by a pharmacist.

The Surveyor issued an inspection report that noted the deficiencies. The PIC did not respond to the notice of deficiencies within 30 days, as required by law. Instead, a corporate manager of regulatory affairs located at the licensee's headquarters responded. Consequently, the Board adopted an order that reprimands licensee and assess a civil penalty of $2,500.

**Weber & Judd, Nursing Care Pharmacy License # 261295.** During a November 2013 Board inspection, a Board Surveyor observed Licensee engaged in drug manufacturing, by repackaging certain quantities of prescription drugs into prescription vials and then transferring the vials to other pharmacies owned by the same company, for the purpose of inventory replenishment. That repackaging did not conform to current
good manufacturing practice. During inspections in July 2016, Board Surveyors observed that Licensee had received returns of large quantities of drugs that had been dispensed for specific patient from the long-term care facilities in which those patients had resided. State law does not permit pharmacies to accept return of drugs from LTC facilities for destruction in the manner in which Licensee was receiving them. Consequently, the Board issued a Stipulation and Consent Order reprimanding licensee and assessing a $10,000 civil penalty.