TENNESSEE BOARD OF PHARMACY
JULY 14-15, 2009
227 FRENCH LANDING, POPLAR ROOM
NASHVILLE, TN

BOARD MEMBERS PRESENT:

Todd Bess, President
Bettie Wilson, Vice President
Larry Hill, Member
Joyce McDaniel, Consumer Member
Robert Mitchell, Member
Charles Stephens, Member
Brenda Warren, Member

STAFF PRESENT:

Kevin K. Eidson, Executive Director
Alison Cleaves, Chief Deputy Counsel
Terry Grinder, Pharmacist Investigator
Ralph Staton, Pharmacist Investigator
Tommy Chrisp, Pharmacist Investigator
Richard Hadden, Pharmacist Investigator
Ben Mezer, Assistant General Counsel
Sheila Bush, Administrator Manager

The Tennessee Board of Pharmacy convened on Tuesday, July 14, 2009 in the Poplar Room, 227 French Landing, Nashville, TN. A quorum of the members being present, the meeting was called to order at 9:02 a.m., C.D.T., by President Dr. Todd Bess. Dr. Bess welcomed the Interns from Walgreens and gave a brief explanation on how the board conducts the meetings.

The Board recognized Ms. Alison Cleaves, Chief General Counsel for her service with the Board and welcomed Mr. Ben Mezer, Assistant General Counsel as the new attorney for the board. Ms. Cleaves will no longer be working with the Board. Dr. Kevin Eidson, Executive Director, also recognized Ms. Cleaves for her distinguished service.

GENERAL DISCUSSION

Dr. Brenda Warren, asked Dr. Eidson about having the executive director's signature on the wall certificate. At the June 9 & 10, 2009 meeting, the Board requested that Dr. Eidson's name be placed back on the wall certificate as indicated when the board left the Department of Commerce and Insurance to move to the Department of Health. Dr. Eidson explained to the board that he has spoken with Elizabeth Miller, Director of Health Related Boards and Christy Allen, Assistant Commissioner, for the Department of Health and he was told that it was not in the Board's statute to have the Executive Director sign the wall certificates and is not required. Dr. Bess stated that because Dr. Eidson goes out and speaks with pharmacy schools and educates them on the statutes and rules, that his name should be listed on the wall certificate. Dr. Eidson stated that he will convey the Board's concerns to Ms. Miller.

PRESENTATION

Dr. Eidson introduced Officer Vallee, of the Nashville, TN., Metropolitan Police Department. Officer Vallee was asked to appear before the board to discuss methamphetamine. Officer Vallee stated that while most ingredients to make methamphetamine are behind the pharmacy counter, pseudoephedrine gel caps are not. The gel caps have a 90% extraction rate for pseudoephedrine, and the gel caps are not on the exclusion list. Officer Vallee requesting that the Board consider

having the gel caps removed from the exclusion list and having them placed behind the pharmacy counter, informing pharmacists about the online database and the Tennessee Methamphetamine Task Force and educating the pharmacists on what to look for concerning the purchase of the gel caps. The issue is whether the Board of Pharmacy, along with the Tennessee Bureau of Investigation and the Department of Health, have the ability to add or remove items from the exclusion list. Officer Vallee stated that 31 states have taken gel caps off the exclusion list. Dr. Warren suggested that it would be a great subject of the Board's newsletter. Ms. Cleaves stated that she is working on the newsletter.

Dr. Eidson informed the Board that ilumina Group is requesting permission to operate an e-pharmacy solutions and services in Tennessee. The ilumina Group would like to provide their services to institutional facilities for remote order entry for prescription medications. The Board had several questions, some of which centered around supervision, who would be responsible for verifying the medication and dispensing the medication to the correct patient. Dr. Warren wanted to know if the ilumina Group would be compounding drugs. After discussion, the Board is requesting that ilumina Group be invited to the next scheduled meeting. Dr. Bess informed the interns present as guest at the board meeting that the Pharmacist- In- Charge (PIC) is responsible for reporting medication errors to the Board.

Dr. Eidson introduced Chris Meulenberg, Pharmacist Mutual Companies, to discuss Pharmacy Robbery Protection commissioned by US Attorney Russ Deadrick in the Eastern District of TN. Mr. Meulenberg came before the Board in January to inform them about the rising number of claims that Pharmacist Mutual pays out due to robberies and burglaries. Mr. Meulenberg was requested to by the Board to present data from the surrounding states. Out of all the states that surround Tennessee, Arkansas and Georgia do not have a controlled substance database.

CONSENT ORDERS

The following orders were approved by the Board at the June 9 & 10, 2009 board meeting.

REVOKED-VIOLATION T.C.A. §53-10-104(a) and (b) and T.C.A. §53-10-105 (a)

Jacqueline Lachelle Newman, RT
Yolanda Mallard, RT
Shawna Jean Walker, RT
Lauren K. McClellan, RT

REVOKED-VIOLATION T.C.A. §63-10-305(4) and (5)

Melissa Michelle Shiflet, RT

CIVIL PENALTY-VIOLATION BOARD RULE 1140-3-.01(1) (a) and (f)

Seena Pradeep, DPH-paid $500.00 fine
Kroger Pharmacy #L-571 –paid $1,000.00 fine

CIVIL PENALTY-VIOLATION BOARD RULE 1140-2-.02 (1) and (2)

Robert B. Brown, DPH- paid $100.00 fine

CIVIL PENALTY- VIOLATION BOARD RULE 1140-3-.14 (2) and (3)

Patient's Choice Medical Center of Erin- paid $1000.00 fine

CIVIL PENALTY-VIOLATION BOARD RULE 1140-2-.02 (1) and (2) and 1140-2-.08

Brownsville Apothecary- paid $650.00 fine

INDEFINITE SUSPENSION

Robert Michael King, DPH

PROBATION

Pier Anderson Jackson, DPH

REINSTATEMENTS

James Patrick McNally, DPH
Kimberly Mullen, DPH
Alvis Simmons, DPH
Morris Haddox, III, DPH

REINSTATEMENT

Dr. Eidson introduced J. Chad Jaggers to the Board. Dr. Jaggers is requesting that his license be reinstated. Dr. Jaggers surrendered his Tennessee license on August 12, 2004. Dr. Jaggers also has a Mississippi license that is currently on probation for ten (10) years. After discussion, Dr. Warren made a motion to reinstate Dr. Jaggers's license. Dr. Wilson seconded the motion. The motion carried. Dr. Jaggers's license will be on probation for fifteen (15) years beginning July 14, 2009 until July 14, 2024 with the following terms and conditions:

(a) The Respondent shall completely abstain from the consumption of alcohol or any other drugs, except as specified in (b);

(b) The Respondent shall be able to consume legend drugs or controlled substances prescribed by the Respondent's physician Joseph Montgomery. The Respondent shall immediately notify the Board office of the name of his primary physician each time the Respondent changes primary physicians;

(c) The Respondent shall not obtain or attempt to obtain any prescriptions in the Respondent's name for any legend drugs, controlled substances or devices containing same from the physician other than the Respondent's primary physician or from any other health care provider, such as a nurse practitioner, physician's assistant or psychiatrist;

(d) The Respondent shall destroy any unused controlled substances prescribed (Soma and Ultram) under the provisions of subsection (b) no later than thirty (30) days following the completion of the prescribed course of treatment;

(e) The Respondent shall report to the Board, in writing, the ingestion of any and all legend drugs or controlled substances (a copy of the prescription will satisfy the requirement);

(f) The Respondent shall submit to random sampling of urine, blood or bodily tissues for the presence of drugs and alcohol, at the Respondent's own expense, by agents of the Board, for as long as the Respondent has an active license. In the event that the sampling indicates the presence of drugs for which the Respondent does not have the valid prescription or the sampling indicates the presence of alcohol, then formal disciplinary charges may be brought against the Respondent which could result in the revocation of the Respondent's remaining term of probation or the suspension or revocation of the Respondent's license to engage in the practice of pharmacy. Prior to such disciplinary charges being heard by the Board, the Respondent's license may be summarily suspended;

(g) The Respondent shall comply with all terms and conditions of the extended aftercare contract he entered into with Tennessee Pharmacist Recovery Network (TPRN). Respondent shall return a copy of said contract with this Consent Order to the Board office;

(h) The Respondent shall not serve as pharmacist-in-charge for a period of three (3) years; however, after a period of two (2) years, the Respondent may petition the Board for a modification of this Consent Order to remove the restrictions upon a show of good cause;

(i) The Respondent shall not work as a "floater" for a period of three (3) years, meaning that the Respondent shall not work at more than one (1) pharmacy location at the same time without the permission of the Board;

(j) The Respondent shall provide written notice requesting an active license, satisfy all past due continuing education, and pay all cumulative license renewal fees, take and pass the MPJE and any applicable penalties;

GENERAL DISCUSSION

Dr. Bess asked Dr. Baeteena Black, Executive Director for Tennessee Pharmacists Recovery Network (TPRN), to speak to the interns about TPRN. Dr. Black informed the interns present as guest at the meeing that TPRN has been in existence for twenty (20) years and has twenty (20) pharmacists who volunteer with the recovery program. Dr. Black stated that TPRN not only has licensed pharmacists in the recovery program, but students as well. Dr. Black stated that if anyone needs help to seek it early and that it will be confidential. Dr. Clifford Weiss explained to the interns about My Brothers Keeper. Dr. Weiss stated that it is up to the students or pharmacist to report a fellow student or pharmacists that is suspected of having a substance abuse problem to TPRN.

Dr. Warren asked Ms. Cleaves about the rules that pertain to the criminal background checks. Ms. Cleaves stated that she handed out a draft copy of the rules for the board's review but didn't receive any response. Dr. Warren asked Ms. Cleaves to resend the draft copy of the rules.

APPLICATION REVIEW

Dr. Stephens made the motion to **approve** the applications for **Margaret Henderson, D.Ph, James Lynn Dean, D.Ph, Timothy Jon Marciniak, D.Ph, Alison Leigh Lawson, D.Ph, Richard Joseph Stopczynski, D.Ph, Joyce Stokes Franklin, D.Ph, and Miyoung Cheong, D.Ph,** for licensure as pharmacists in Tennessee. Dr. Hill seconded the motion. The motion carried.

Dr. Stephens made the motion to **approve Cristen Cross, RT** denial appeal and to issue Ms. Cross registration as a pharmacy technician. Dr. Wilson seconded the motion. The motion carried.

Dr. Warren made the motion to **approve** the applications for **Nancy Angela Brown, RT, David McGinn, RT, Marvin Davenport, RT, Fredrick Skelton, RT, James Moore, RT and Lartondra Denise Jackson, RT** for registration as pharmacy technicians in Tennessee. Dr. Hill seconded the motion. The motion carried.

WAIVERS

Board rule 1140-5-.01(1)

Dr. Mitchell made the motion to **approve the request from John Q. Buchheit's, D.Ph** request for a waiver with a one year extension. Dr. Hill seconded the motion. The motion carried.

Board rule 1140-1-.07(3) (b) (c) 3

Dr. Stephens made the motion to **defer action on the request of J. Harold Shalett, D.Ph** request for a rule waiver and asked Mr. Shalett to appear at the next scheduled meeting. Dr. Mitchell seconded the motion. The motion carried.

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Board rule 1140-1-.12 and 1140-3-.14 (12)

Dr. Hill made the motion to **approve Manor Healthcare Supply's** request for a rule waiver. Dr. Wilson seconded the motion. The motion carried.

Board rule 1140-1-.07(3) (b) (5) (ii)

Dr. Warren made the motion to **approve the request of Joseph Schaneville D.Ph** for a rule waiver. Dr. Wilson seconded the motion. The motion carried.

LEGAL REPORT

1. **Case No.: L08-PHR-RBS-2008002161 Re-present**

Complainant, a physician, alleges that the Respondent pharmacy refilled his patient's prescription for Lortab 7.5/500 within seven (7) days, when the physician orders stated do not refill within thirty (30) days. Original Rx was filled on October 4, 2008 and the controlled substance monitoring database indicates that it was refilled by the same pharmacy on October 11, 2008.

PIC responded to the complaint and provided a copy of the pharmacy computer screen, which indicates that their pharmacy did not refill the Rx on October 11, 2008.

I presented this matter at a prior Board meeting at which time the Board wanted BOP staff to follow-up with the PIC and ask him/her how the information on the pharmacy computer was not the same as what was in the database and how the refill got screen populated in the database.

The PIC stated that when they performed a DUR on the Rx referenced above, they realized that it was being refilled too soon. They then tried to take the Rx back out of the system, but it was too late and information was transmitted to the BOP to comply with the database law.

Prior discipline: None

Recommendation: Dismiss

Dr. Warren made the motion to **accept counsel's recommendation**. Dr. Hill seconded the motion. The motion carried.

2. Case No.: L09-PHR-RBS-2007080411

Complainant alleges that when she went into the pharmacy to pick up a refilled prescription for diabetic testing strips and lancets, she was told by the pharmacist that they could not refill the lancets and that she had to wait nine (9) more days before it could be refilled. Complainant further alleges that the pharmacist told her that she could purchase more outside of insurance and that, failing that, that she could reuse her lancets.

D.Ph. responded to the complaint stating that the Complainant requested a refill of her blood glucose test strips and lancets on July 5th; however, when the pharmacist transmitted the prescription to the Complainant's insurance, they received a denial response because it could not be refilled until July 14th. Pharmacist informed the Complainant that she could purchase lancets outside of her insurance, but the Complainant indicated that she did not want to do that, so the pharmacist told her that she could reuse the lancets. D.Ph. indicated that she believed that it was in her best interest for the patient to continue to test her blood sugar level as directed by the physician even if it meant reusing the lancets.

Prior complaints: 1999, Unprofessional conduct, Closed

Recommendation: Dismiss

Dr. Stephens made a motion to **accept counsel's recommendation**. Dr. Wilson seconded the motion. The motion carried.

3. Case No.: L09-PHR-RBS-2009001241

Respondent, a pharmacist, was disciplined by another state's Board of Pharmacy for allowing an unregistered pharmacy technician to work at a pharmacy. Respondent was placed on a two (2) year term of probation and assessed a $5,000.00 civil penalty.

Prior complaints: None

Recommendation: Letter of Warning

Dr. Warren made a motion to issue a **Letter of Instruction**. Dr. Hill seconded the motion. The motion carried.

4. Case No.: L09-PHR-RBS-2009000571

Complainant alleges that the Respondent pharmacy committed a medication error and did it to increase revenues.

Pharmacy manager responded to the complaint indicating that the pharmacy received a prescription for one (1) pack of Ortho Tri-Cyclen Lo 0.025 mg tablet with directions: take one tablet daily with 12 refills. Under the patient's prescription benefit plan, she may receive up to a ninety (90) day supply for a copay of $35.00. The prescription was dispensed for Tri0Cyclen Lo 0.025mg from the pharmacy.

Prior complaints: None

Recommendation: Dismiss

Dr. Mitchell made a motion to **accept counsel's recommendation**. Dr. Wilson seconded the motion. The motion carried. Dr. Warren recused herself.

5. Case No.: L08-PHR-RBS-2008002561

Complainant alleges that the pharmacists at the pharmacy are allowing unlicensed individuals to perform compounding at the pharmacy.

Investigation into this matter did not reveal any violation of laws or rules. Investigator visited the pharmacy and observed pharmacists and technicians working in different areas of the pharmacy, including the compounding area; there was no indication that the technicians were working unsupervised.

Prior complaints: 2005, failure to perform a DUR, LOW

Recommendation: Dismiss

Dr. Hill made a motion to **accept counsel's recommendation**. Dr. Wilson seconded the motion. The motion carried.

7. Case No.: L09-PHR-RBS-2007060261

Complainant alleges that he was shorted twenty (20) tablets of Alprazolam. Complainant contacted the pharmacy and indicated to the pharmacy staff that twenty (20) were missing and the pharmacy staff who indicated that the Alprazolam count was accurate.

PIC responded to the complaint stating that after the Rx was dispensed and after they received a call from the Complainant (which was all in the same day), pharmacy staff

counted the on hand quantity of Alprazolam and found that it matched the computer quantity. PIC also spoke with the D.Ph. and he indicated to her that he remembered the Rx and counted it three (3) times before it left the pharmacy. The day after the prescription was filled, the Complainant contacted the pharmacy again and spoke to the PIC. At that time, the PIC counted the Alprazolam and there was no variance.

Prior complaints: None

Recommendation: Dismiss

Dr. Wilson made the motion to **accept counsel's recommendation**. Dr. Stephens seconded the motion. The motion carried.

8. Case No.: L08-PHR-RBS-2008023321

Complaint indicates that the Respondent, institutional pharmacy, failed to renew timely. Pharmacy license expired on August 31, 2008 and the pharmacy renewed on or about November 21, 2008.

Prior complaints: None

Recommendation: Authorize formal hearing (civil penalty amount)

Dr. Stephens made the motion to **dismiss the complaint**. Dr. Hill seconded the motion. The motion carried with Dr. Warren opposing.

9. Case No.: L09-PHR-RBS-2009001131

Complainant alleges that the Respondent pharmacy failed to give him a list of formulary prenatal vitamins. Without this list, the prescriber ordered a drug that was on back order, necessitating another order and a delay in the process.

PIC responded stating that the pharmacy staff told Complainant that the requested vitamins (Prenate Premier) were covered by his prescription benefit plan. The next day the pharmacy staff informed Complainant that the Prenate Premier was on backorder and would be available in one week. One week later, the prescription was still not available and the pharmacy staff informed complainant of this. Complainant asked for other options and the pharmacy staff immediately provided Complainant with the requested coverage and copayment information on several prenatal vitamins. The next day the pharmacy received a faxed prescription for Prenatal Plus, which was dispensed to the Complainant two (2) days later.

Prior discipline: none.

Last board meeting same complainant alleged that same pharmacy did not fill wife's script for Singular. PIC responded that there was no authorization for the script. Board dismissed complaint.

Recommendation: Dismiss

Dr. Stephens made the motion to **accept counsel's recommendation**. Dr. Wilson seconded the motion. The motion carried.

10. Case No.: L07-PHR-RBS-2007080271

Complaintt arose out of a pharmacy internal investigation of theft of controlled substances. Investigation revealed that it was a pharmacy technician who stole the controlled substances. Further investigation revealed that he was an unregistered technician for 5 ½ months from December 18, 2006 to May 29, 2007.

Prior discipline:
Pharmacy: 9/06 substitution issue, dismissed; 4/07 unlicensed activity, Letter of Instruction; 5/07 unlicensed pharmacy technician, Letter of Instruction.
PIC: same PIC for all aforementioned violations

Recommendation: Authorize formal hearing ($300 civil penalty to the PIC)

Dr. Hill made the motion to **authorize a formal hearing** with a $300.00 civil penalty to the PIC. Dr. Wilson seconded the motion. The motion carried.

11. Case No.: L09-PHR-RBS-2009000351

Respondent's license to engage in the practice of pharmacy was suspended in Kentucky in 2001 and reinstated in 2002 with a 5 year probationary period for alcohol and substance abuse violations. Respondent's license was placed on probation in Indiana, to run concurrent with the Kentucky probation. Both licenses are currently active with no restrictions.

Prior discipline in TN: none

Recommendation: Close

Dr. Warren made the motion to **accept counsel's recommendation**. Dr. Wilson seconded the motion. The motion carried.

12. Case No.: L09-PHR-RBS-2009001271

Complaint generated by a compliance inspection in which the BOP investigator observed medications being dispensed from the pharmacy without even an offer to counsel.

PIC responded that she started working at the pharmacy 1 ½ weeks prior to violation and has now has put into effect disciplinary procedures (including termination) that will occur if counseling is not offered.

Prior discipline:
PIC: none

Pharmacy: 1999 unauthorized refill, closed 1/00; 2002 medication error, dismissed 11/03

Recommendation: Authorize formal hearing ($1,000.00 civil penalty to the pharmacy; $500.00 civil penalty to the dispensing D.Ph. and a LOI to the PIC)

Dr. Hill made the motion to **authorize a formal hearing** with $1,000.00 civil penalty to the pharmacy, a $500.00 civil penalty to the dispensing D.Ph and a Letter of Instruction to the PIC. Dr. Warren seconded the motion. The motion carried.

13. Case No.: L08-PHR-RBS-2008002041

Complainant alleges that the Respondent acted erratically by approaching patients as they were leaving their mental health appointments and demanding that she be able to fill their prescriptions. An investigation into this matter revealed that there was no evidence to support the allegations; however, during the course of the investigation, the investigator determined that prescription orders were being received by a pharmacy technician at a pharmacy licensed by the Respondent that was not open for business and then faxed to the pharmacy where the Respondent would dispense the prescriptions. There was no pharmacist present at the pharmacy practice site where the prescription orders were being received.

Prior discipline: None

Recommendation: Letter of Warning about violation of Rule 1140-1-.12(7)

Dr. Warren made the motion to **issue a Letter of Warning** to the PIC. Dr. Wilson seconded the motion. The motion carried.

14. Case No.: L09-PHR-RBS-2007080281

Complaint generated from a pharmacy internal investigation of theft of controlled substances. Investigation revealed that it was a pharmacy technician who was responsible for removing the controlled substances from the pharmacy without authorization. Further investigation revealed that she was an unregistered technician and working unregistered at the pharmacy for a period of fourteen (14) months, from April 10, 2006 to June 5, 2007.

Prior discipline: None

Recommendation: Authorize formal hearing ($1,200.00 civil penalty to the PIC)

Dr. Hill made the motion to **authorize a formal hearing** with $1,200.00 civil penalty to the PIC. Dr. Wilson seconded the motion. The motion carried.

15. Case No.: L09-PHR-RBS-2007080291

Complaint generated from a pharmacy internal investigation of theft of controlled substances. Investigation revealed that it was a pharmacy technician who was responsible for removing the controlled substances from the pharmacy without authorization. She admitted as much to the Loss Prevention Specialist. Further investigation revealed that she was an unregistered technician employed as an unregistered technician from 12/06-6/07.

Prior discipline: None

Recommendation: Authorize formal hearing ($600.00 civil penalty to the PIC)

Dr. Hill made a motion to **authorize a formal hearing** with a $400.00 civil penalty to the PIC. Dr. Stephens seconded the motion. The motion carried.

16. Case No.: L09-PHR-RBS-2007080531

Complainant dropped off two separate prescriptions for her two children, one prescription was for Lortab elixir and the other for Amoxicillin. They were both accidentally inputed under the first child's name, but only one prescription was filled.

PIC responded that a third party rejected the second child's prescription because it was the same prescription that was filled for the first child a week earlier. When the mother came to pick up the prescriptions, the pharmacy technician discovered that both medications were typed under the first child's name and corrected the error before the Rxs left the pharmacy. At this point the pharmacist checked both prescriptions and verified all of the information.

Prior discipline: None

Recommendation: Dismiss

Dr. Hill made the motion to **accept counsel's recommendation**. Dr. Wilson seconded the motion. The motion carried.

17. Case No.: L07-PHR-RBS-2007065051

Complainants allege that their mother was given an elixir that was compounded from two non-prescription products without a prescription from a physician. The label did not have the patient's name, and stated that there were 89 refills until August 8, 2006, but it was filled on February 28, 2007. Complainants allege that the pharmacy did not have their mother's information/profile in the system.

PIC responded that they do not know who purchased the medicine, that the contents of the product were listed on the label and that it is their policy to counsel customers. PIC also stated that profiles are kept on prescription customers. PIC is compounding a product from over-the-counter products labeled as Bronkolixir/Hydramine, Chest Mixture, Take ½ teaspoonfuls every four (4) hours as needed for cough and congestion.

Prior discipline: None

Recommendation: Discuss

Dr. Hill made the motion to issue a **Letter of Instruction**. Ms. McDaniel seconded the motion. The motion carried.

18. Case No.: L09-PHR-RBS-2009001251

Respondent pharmacist had his license revoked by another State's Board of Pharmacy for dispensing somatrotropin and HCG to patients when there was no evidence of a legitimate doctor/patient relationship.

Prior discipline: None

Recommendation: Authorize formal hearing (mirror other state's discipline)

Dr. Stephens made the motion to **accept counsel's recommendation**. Dr. Wilson seconded the motion. The motion carried.

19. Case No.: L09-PHR-RBS-2007080031

Complainant alleges that the pharmacist failed to fill her prescription for Seroquel because pre-authorization we needed, that the pharmacist revealed her private health information to others, and the pharmacist suggested to the Complainant's physician that she take Percocet for her tooth pain instead of the Tylenol ordered by the physician because the Complainant may have had some Percocet left over from her prescription for back pain.

PIC responded to the complaint and denied the alleged HIPAA violation and stated that the pharmacist did contact the Complainant's physician and dentist because two (2) different controlled substances were prescribed by each of the doctors.

Prior discipline: None

Recommendation: Dismiss

Dr. Stephens made the motion to **accept counsel's recommendation**. Dr. Mitchell seconded the motion. The motion carried.

20. Case No.: L09-PHR-RBS-2009001061

Complainant alleged that she dropped off her son's prescription for Focalin XR and she was dispensed another patient's medication. Complainant realized the error when she got home, brought the incorrect medication back to the pharmacy and the pharmacy staff corrected the error.

PIC responded to the complaint. PIC filled and dispensed the Rx and indicates it was a bagging error and that he bagged the Rx. Although it was a new Rx, because the patient had been taking it previously, the Complainant denied counseling.

Prior discipline: 2007, substitution issue, LOW (PIC and DPh)

Recommendation: Letter of Instruction to dispensing pharmacist (who was PIC in this instance).

Dr. Warren made the motion to **issue a Letter of Instruction** to the dispensing pharmacist. Dr. Wilson seconded the motion. The motion carried.

21. Case No.: L09-PHR-RBS-2009001121

Complainant alleges that the pharmacy staff committed a medication error by dispensing Oxycodone IR instead of Oxycontin 15mg.

PIC responded to the complaint stating that both the PIC and the technician made calls to the doctor's office to verify that the doctor meant to prescribe Oxycontin thinking he meant to prescribe Oxycodone. The doctor's office verified Oxycontin, but they had Oxycodone on their mind and filled the Rx with that. PIC felt that the error occurred because they did not take the time to fax back the Rxs and only verified verbally.

Prior complaints: None

Recommendation: Letter of Warning

Dr. Hill made the motion to **issue a Letter of Warning**. Ms. McDaniel seconded the motion. The motion carried.

22. Case No.: L08-PHR-RBS-2008001921

Complaint generated from the BOP office alleging that the Respondent, M/W/D was engaging in unlicensed conduct by continuing to operate after its license had expired. Although Board records show that the Respondent's license expired on June 30, 2007, it appears that they attempted to renew on June 28, 2007 with a check for the renewal fee. It is unclear whether the check was processed, but it does appear that they renewed late.

Prior complaints: None

Recommendation: Dismiss

Dr. Mitchell made the motion to **accept counsel's recommendation**. Dr. Wilson seconded the motion. The motion carried.

23. Case No.: L09-PHR-RBS-2009001111

Complainant alleges that the Respondent, pharmacist, failed to dispense her Rx for Synthroid 125 mcg in strict conformity with prescriber instructions when the Rx was marked "dispense as written".

PIC (not dispensing in this instance) responded to the complaint and indicated that a medication error did occur. Rx was written for Synthroid 125 mcg and filled with Levothyroxine 125 mcg. Dispensing pharmacist indicated that she did not notice that the "DAW" box was checked. PIC indicated that no counseling was offered because the patient had been taking the medication for some time and a caregiver picked it up for her. Patient brought the medication back to the pharmacy and the error was corrected.

Prior discipline: None

Recommendation: Authorize formal hearing ($1,000.00 civil penalty to the pharmacy; $500.00 civil penalty to the dispensing D.Ph.; and LOI to the PIC). LOW to the dispensing for the medication error.

Ms. McDaniel made a motion to **authorize a formal hearing** with a $1,000.00 civil penalty to the pharmacy, a $500.00 civil penalty to the dispensing D.Ph, a Letter of Instruction to the PIC and a Letter of Warning to the dispensing D.Ph for the medication error. Dr. Mitchell seconded the motion. The motion carried.

24. Case No.: L09-PHR-RBS-2007080421

Complainant alleges that her prescription for Fioricet was filled with Butalbital; the directions on the Rx were take two (2) capsules by mouth every hour as needed; it was a new Rx. Complainant consumed the incorrect medication and began itching, was unable to move and lost vision.

PIC responded to the complaint indicating that the error did occur and that the dispensing pharmacist failed to counsel the patient about the medication. Patient signed the counseling log, but counseling was not performed.

Prior discipline: None

Recommendation: Authorize formal hearing ($1,000.00 civil penalty to the pharmacy; $500.00 civil penalty to the dispensing D.Ph.; and LOI to the PIC). LOW to the dispensing D.Ph. for the medication error.

Dr. Mitchell made a motion to **authorize a formal hearing** with a $1,000.00 civil penalty to the pharmacy, a $500.00 civil penalty to the dispensing D.Ph, a Letter of Instruction to the PIC and a Letter of Warning to the dispensing D.Ph for the medication error. Ms. McDaniel seconded the motion. The motion carried.

25. Case No.: L08-PHR-RBS-2008002281

Complainant alleges that he received another patient's Rx. Complainant was prescribed Omeprazole and it was a refilled Rx.

PIC states that the Complainant did receive the incorrect medication, which was returned to the pharmacy and the Complainant was given the correct medication. Complainant's Rx was filled correctly, just put in the wrong bag. Complainant was offered patient counseling, but he declined.

Prior discipline: None

Recommendation: LOI to the dispensing pharmacist.

Dr. Hill made the motion **to issue a Letter of Instruction** to the dispensing pharmacist. Ms. McDaniel seconded the motion. The motion carried.

26. Case No.: L09-PHR-RBS-2009001301

Complainant alleges that she received another patient's prescription. Complainant's son was prescribed Risperdal and she was given another patient's Rx for Levothyroxine. Complainant's son consumed a few tablets of the incorrect medication.

PIC admitted that the medication error occurred. It was refilled Rx and patient counseling was offered.

Prior discipline: None

Recommendation: LOW to dispensing pharmacist.

Dr. Wilson made the motion to **issue a Letter of Warning** to the dispensing pharmacist. Dr. Hill seconded the motion. The motion carried.

27. Case No.: L09-PHR-RBS-2009001091

Complaint generated from TPRN report indicating that the Respondent was not complying with his TPRN contract or his contract with the Board by testing positive for Hydromorphone and Hydrocodone. Subsequent contact with the TPRN revealed that the Respondent produced Rxs for these medications.

Prior discipline: 2006, reinstated with 15 years probation.

Recommendation: Dismiss

Dr. Hill made the motion to **accept counsel's recommendation**. Ms. McDaniel seconded the motion. The motion carried.

28. Case No.: L08-PHR-RBS-2008002241

Complainant alleges that she took her mother's prescriptions to be filled at the pharmacy and upon returning home, Complainant realized that someone else's name was marked out on the Rx label and had different instructions than to what the patient was accustomed (which was 3X the patient's dosage).

The dispensing pharmacist has no recollection of the incident and only indicated that it is the typical pharmacy practice to not reuse labels.

Prior discipline: 2009, reinstated for chemical dependency, 5 yr. term of probation

Recommendation: Dismiss

Dr. Mitchell made the motion to **accept counsel's recommendation**. Ms. McDaniel seconded the motion. The motion carried.

29. Case No.: L09-PHR-RBS-2009000611

Complainant alleges that the following violations are occurring at the Respondent pharmacy: allowing unlicensed staff to enter and count Rx's; dispensing refills without authorization; and dispensing CII's without an Rx.

Investigation into this matter did not reveal any violations of law or rules. Because patient names were not provided by the Complainant, it was difficult to substantiate any of the allegations. All members of the pharmacy staff denied the allegations. In response to the allegation of dispensing controlled drugs without a prescription, the pharmacy supervisor stated that an employee indicated to him that Hydrocodone and Viagra were being stolen from the pharmacy. In response to the allegation, they conducted an investigation, monitored inventory and counts of medication and installed a surveillance camera. The investigation was closed with no findings.

Prior discipline: None

Recommendation: Dismiss

Ms. McDaniel made the motion to **accept counsel's recommendation**. Dr. Mitchell seconded the motion. The motion carried.

30. Case No.: L09-PHR-RBS-2007080021

Complainant, a physician, alleges that the pharmacy staff refilled a patient's prescription for Clonazepam 1mg three (3) times when there were no refills on the original Rx.

PIC responded to the complaint indicating that the Rx was refilled twice without authorization. A possible reason for the error is that the pharmacist may have confused the prescribing doctor with another doctor in the area (similar name) whose practice is to have two (2) refills on a Rx. The physician whose practice it was to have refills on his Rx's was the patient's previous doctor.

Prior discipline: None

Recommendation: Letter of Warning

Dr. Warren made the motion to **issue a Letter of Warning**. Dr. Hill seconded the motion. The motion carried.

31. L09-PHR-RBS-2009001281

Complainant alleges that the Respondent, medical center acting as a physician dispensary is telling patients that they must have their prescriptions dispensed from the dispensary and that it is not reporting controlled substances dispensed from the center to the controlled substance monitoring database.

The President and Practice Administrator of the medical center deny the allegation that they are requiring their patients to have their Rx's filled at the dispensary. They indicate that only 4% of their patient population obtain their medications from the dispensary. In response to the allegation of not reporting to the database, they indicated that while they have been reporting, they have not been reporting in a timely manner. They have taken corrective action to ensure that the report is made to the Board every fifteen (15) days.

Recommendation: Dismiss

Dr. Mitchell made the motion to **accept counsel's recommendation**. Dr. Wilson seconded the motion. The motion carried.

32. Case No.: L09-PHR-RBS-2007080351

Complainant alleges that the Respondent, hospital pharmacy, is storing and dispensing sample medications that are brought in by the physician who works at the hospital.

Director of Pharmacy at the facility responded to the complaint denying the allegation that the pharmacy stored or dispensed sample medications.

Prior discipline: None

Recommendation: Dismiss

Dr. Mitchell made the motion to **accept counsel's recommendation**. Dr. Wilson seconded the motion. The motion carried.

33. Case No.: L09-PHR-RBS-2009000671

Complainant alleges that the pharmacy staff mislabeled her son's prescription by placing the incorrect doctor's name on the label.

PIC responded to the complaint indicating that the patient's prescription for Lodine 400mg was mislabeled with the incorrect doctor's name on it. This was a new Rx and patient counseling was not performed. There is no indication that the incorrect medication was in the bottle.

Recommendation: Letter of Warning about patient counseling to the dispensing D.Ph.

Dr. Hill made the motion **authorize a formal hearing** with a $500.00 civil penalty to the dispensing D.Ph, a $1,000.00 civil penalty to the pharmacy and Letter of Instruction to the PIC. Dr. Wilson seconded the motion. The motion carried.

34. Case No.: L09-PHR-RBS-2009000631

Complainant alleges that her prescription for Januvia 100mg was dispensed as 50mg. Complainant contacted the pharmacy when she thought she was given the wrong medication and informed them that she was also prescribed Cozaar 100mg and that a label for Cozaar was on the back of the bottle from the pharmacy, but the pharmacy label said Januvia 59mg. Complainant consumed the incorrect medication for an undetermined period of time.

PIC responded to the complaint admitting that the medication error did occur and that it was a new Rx. PIC was not involved with the dispensing of the medication and is not sure if patient counseling was performed.

Prior discipline: None

Recommendation: Letter of Warning to the dispensing pharmacist.

Dr. Stephens made the motion to **issue a Letter of Warning** to the dispensing pharmacist. Dr. Mitchell seconded the motion. The motion carried.

35. Case No.: L09-PHR-RBS-2009000401

Complainant alleges that the Respondent, a pharmacy technician, removed Hydrocodone from the pharmacy without authorization. Investigation into the matter revealed that that pharmacy did experience shortages of Hydrocodone, but it is unknown whether the Respondent was responsible for the shortages. Investigation indicates that there were

shortages after the period of time when the Respondent worked and the shortages stopped when she stopped working at the pharmacy. The investigation did reveal that she took her prescription medicine from the pharmacy without paying for it.

Prior discipline: None

Recommendation: Discuss

Dr. Hill made the motion to **issue a Letter of Warning** to the pharmacy technician. Dr. Warren seconded the motion. The motion carried.

36. Case No.: L09-PHR-RBS-2009000131

Original complaint alleged that the pharmacy technician working at this pharmacy was stealing controlled substances from the pharmacy. Investigation did not yield any evidence to support this allegation and the complaint against the technician was dismissed; however, during the course of the investigation, BOP investigator found that there were significant losses of controlled substances. While the number of losses were significant, the losses, compared with the volume of Rx's dispensed from the pharmacy, were within the acceptable range. Both the BOP and the PIC conducted an audit. BOP audit was for dates June 1, 2006 to June 19, 2008. The BOP actually counted the audited drugs on June 19, 2008 while the PIC use their latest biennial inventory dated June 17, 2008. Examples of audit results are as follows: Phentermine 37.5mg – BOP (-395) and PIC (-3815); Hydrocodone/APAP 7.5/500- BOP (-3092) and PIC (824); Hydrocodone/APAP 10/500- BOP (-5083) and PIC (-1656); Hydrocodone/APAP 5/500- BOP (-761) and PIC (674); Hydrocodone/APAP 10/650- BOP (-1077) and PIC (-659); Hydrocodone APAP 7.5/750- BOP (-509) and PIC (-949); Alprazolam 1mg- BOP (-1856) and PIC (-1856); and Alprazolam 2mg- BOP (-1375) and PIC (-877). The PIC cannot explain the losses.

Prior discipline: None

Recommendation: Authorize formal hearing (revocation)
Dr. Stephens made the motion to **issue a Letter of Warning**. Dr. Hill seconded the motion. The motion carried.

Dr. Hill made the motion to adjourn. Dr. Wilson seconded the motion. The motion carried.

JULY 15, 2009

The Tennessee Board of Pharmacy convened on Wednesday, July 15, 2009 in the Poplar Room, 227 French Landing, Nashville, TN. A quorum of the members being present, the meeting was called to order at 9:05 a.m., C.D.T., by President Dr. Todd Bess.

Dr. Bess formally thanked Dr. Mitchell for his excellence service to the board and the State of Tennessee for the last six years. Dr. Mitchell's term expires July 31, 2009.

PRESENTATION

Dr. Eidson introduced Dr. Bill Irving, Director of Regulation Compliance for CVS CareMark. Dr. Irving stated that CVS Caremark is in the process of opening a call center in Rhode Island and would like permission from the board to open a call center in Tennessee if the business opportunity arises. Tennessee has been identified by CVS Caremark as a potential site for another call center. The goal of the call centers will be to support the pharmacies. The call center in RI is set to open December 2009 with 120 employees and if Tennessee is selected for the next site, the date set for opening will be May 2010.

Dr. Irving introduced Dr. Stacy Inman, Clinical Manager for CVS Caremark, who was the overseer of the call center in RI during the trial period. Dr. Inman stated that the number listed on the prescriptions will not change but that if the customer wants to speak to a live person, that call would be routed to the call center. Some of the calls that the call center will be handling will be general questions pertaining to the order status of a prescription, clinical counseling provider questions and requests for review of phoned-in prescriptions, e-prescriptions and refill authorizations. The call center will be staffed with licensed pharmacists and registered pharmacy technicians and built with the ratio of 4:1 in mind. The ratio for pharmacy to pharmacy technicians in Tennessee is 3:1 with one of the pharmacy technicians being a certified pharmacy technician. The call center can help eliminate some of the basic calls that come to the pharmacy staff and it will allow for changes in dispensing efficiency via workload balancing, more time for pharmacy staff to focus on patient centered activities, enhanced collaboration with health care providers, and provide a positive environment for patient counseling.

Mr. Brent Tafora, Senior Director of Customer Care stated that CVS Caremark is looking at opening five (5) centers geographically around the United States.

Some of the questions that the Board had pertained to whether the pharmacists and pharmacy technicians would have to be licensed in Tennessee (which they are willing to do if decided by the Board), would there be a certain section in the call center that will answer only calls routed from Tennessee, if there is someway that the Board would know who took a particular call and if the calls are recorded. After discussion, Dr. Warren made the motion that the pharmacy must be licensed in Tennessee. Dr. Wilson seconded the motion. The motion carried. Dr. Hill made the motion to have the technicians be registered in Tennessee. Dr. Wilson seconded the motion. The motion carried with Dr. Warren opposed. After further discussion, Dr. Stephens made the motion to rescind the previous motion for the technicians to be licensed and to do further study for the license requirement for pharmacists and registered technicians. Dr. Wilson seconded the motion. The motion carried. Ms. McDaniel stated that she wanted to make sure that this item will be on the agenda for September.

Dr. Eidson introduced Dr. Matt Starr, Vice President of InstyMeds Corporation. Dr. Starr informed the Board that InstyMeds is working with St. Mary's Medical Center in Knoxville, TN on implementing an automated dispensing system in the emergency department. The physician will be keying the information into the system, the pharmacists will load the medication into the system and the patient will be given a code to key into the machine in order to receive and pay for their medication. Some of the concerns of the Board are: is this system considered retail pharmacy, physician dispensing or direct patient access to the machine and how the drugs will be reported to the control substance data base. After discussion, the Board recommended that Dr. Starr read and study on board rules 1140-4-.15 and 1140-4-.06 to see how InstyMeds Corporation can correctly used the automated dispensing system at St. Mary's Medical Center.

LEGAL REPORT

6. Case No.: L09-PHR-RBS-2007061541

Complainant alleges that the following medication errors occurred at the pharmacy: (1) dispensed the incorrect strength of a drug for seizures; (2) dispensed a muscle relaxant instead of an antibiotic; (3) dispensed medication prescribed to someone else.

D.Ph. responded to the complaint stating that the Complainant's name was entered in error on a prescription that was not hers along with her own prescription. At that time, there was a visiting pharmacist on duty who missed the erroneous entry.

Prior complaints: 2005, medication error, $500.00 civil penalty to pharmacy and LOW to DPh

Recommendation: LOW to the visiting pharmacist

Dr. Hill made the motion to **issue a Letter of Warning** to the visiting pharmacist. Dr. Mitchell seconded the motion. The motion carried.

37. Case No.: L09-PHR-RBS-2007080361

Complainant alleges that the Respondent pharmacy was selling samples.

Investigators performed a thorough search of the pharmacy and there were no samples found and the PIC provided a statement that samples were not being sold at the pharmacy.

Recommendation: Dismiss

Dr. Mitchell made the motion to **accept counsel's recommendation**. Ms. McDaniel seconded the motion. The motion carried.

38. Case No.: L09-PHR-RBS-2009000591

Respondent, a pharmacist created Rx's for herself for Lortab, Phentermine, Zanaflex, Lunesta, Ambien, Tramadol and Miralax. Except for the Phentermine and the Tramadol, all Rx's stemmed from an original prescription written by a licensed prescriber that the Respondent refilled on her own. Respondent billed the fraudulent Rx's to her insurance in the amount of $1,700.00. All of the charges were reversed.

Prior discipline: None

Recommendation: Authorize formal hearing (revocation) (probation in the past)

Dr. Stephens made the motion to **authorize a formal hearing** for revocation. Dr. Mitchell seconded the motion. The motion carried.

39. Case No.: L08-PHR-RBS-2008002251

Respondent, pharmacy technician, removed Hydrocodone from the pharmacy without authorization. Respondent admitted to the conduct. DEA 106 substantiates the admission. Respondent's employment was terminated.

Prior discipline: None

Recommendation: Authorize formal hearing (revocation)

Dr. Mitchell made the motion to **authorize a formal hearing** for revocation. Ms. McDaniel seconded the motion. The motion carried.

40. Case No.: L09-PHR-RBS-2007080781

Complaint generated from compliance inspection in which BOP investigator found five (5) pharmacy technicians being supervised by one (1) pharmacist. In response to the complaint the PIC states that on the date that the compliance inspection was conducted, a second pharmacist was scheduled to arrive a noon, but due to an incoming delivery additional technicians were scheduled to pick up the order. Three (2) techs were scheduled to be involved in the fill process and two (2) were scheduled to put away the medication delivery.

Prior discipline: None

Recommendation: Authorize formal hearing ($250.00 civil penalty to PIC)

Dr. Hill made the motion to **authorize a formal hearing** with $250.00 civil penalty to the PIC. Ms. McDaniel seconded the motion. The motion carried.

41. Case No.: L09-PHR-RBS-2007080261

Complainant alleges that his Zyrtec-D and Zyrtec prescriptions were not dispensed with the correct amount of tablets and sent only one (1) package of Fosamax Plus instead of three (3) packages for a ninety (90) day supply. Complainant also alleges that her prescription to Premarin Cream 42.5gm was not filled correctly. Complainant also indicates that pharmacy technicians were filling Rxs instead of pharmacists and that she was being charged additional co-pays for her medication.

PIC responded stating that the Complainant was prescribed Fosamax Plus D tablets, #12, take one (1) tablet every wee, thirty (30) day supply with six (6) refills. Complainant wanted a ninety (90) day supply and was advised that a new Rx would be required. PIC also states that Complainant was prescribed Zyrtec-D tablets 5/120mg and Zyrtec tablets 10mg; PIC indicates that they were dispensed as directed. In terms of the Complainant's Premarin Cream, Complainant was prescribed Premarin Vaginal Cream a/AP 42.5gm, ninety (90) day supply, four (4) refills. One tube corresponds to a seventy-four (74) day supply. Dispensing two (2) tubes would have surpassed the plan sponsor's limit for a ninety (90) day supply, so one (1) tube was dispensed.

Prior discipline: None

Recommendation: Dismiss

Dr. Mitchell made the motion to **accept counsel's recommendation**. Dr. Wilson seconded the motion. The motion carried. Dr. Warren recused herself.

42. Case No.: L09-PHR-RBS-2009001321

Complainant alleges that the Respondent, a licensed M/W/D, has distributed a drug (mtehylprednisolone acetate) to a doctor's office in Tennessee that is commercially available.

Recommendation: Letter of Warning

Dr. Mitchell made the motion to issue a **Letter of Warning**. Ms. McDaniel seconded the motion. The motion carried.

43. Case No.: L09-PHR-RBS-2009001341

Complainant alleges that the Respondent (unlicensed as an M/W/D in this state) is manufacturing and distributing methylprednisolone actate in this State without a license.

Prior complaints: None

Recommendation: C & D

Dr. Mitchell made the motion to issue **a Cease and Desist letter** to the respondent. Ms. McDaniel seconded the motion. The motion carried.

44. Case No.: L09-PHR-RBS-2009001371

Respondent, pharmacy technician, admitted to removing Xanax and Hydrocodone from the pharmacy without authorization.

Recommendation: Authorize formal hearing (revocation)

Dr. Stephens made the motion to **authorize a formal hearing** for revocation. Dr. Wilson seconded the motion. The motion carried.

45. Case No.: L09-PHR-RBS-2009001291

Complainant alleges that she did not receive the medication that was prescribed.

PIC and CRT provided responses to the complaint; both deny the allegation that the Complainant received the incorrect medication. PIC states that the Complainant was prescribed Glucovance 5/500 that pharmacy staff filled for one year until it expired on April 28, 2009. The technician contacted the doctor's office for refill and also the generic since that is what the Complainant wanted. The doctor was not in the office that day and the nurse informed the tech that the Complainant would have to take the glimeperide and metformin that she was prescribed in March. Complainant thought that the technician was telling the doctor's office what to prescribe, when according to the technician, she was not. A couple of days later, the doctor was in the office and called in a Rx for Glucovance generic, which was what the patient wanted.

Prior complaints: None

Recommendation: Dismiss

Dr. Wilson made the motion to **accept counsel's recommendation**. Ms. McDaniel seconded the motion. The motion carried.

46. Case No.: L09-PHR-RBS-2009001071

Complainant alleges that his prescription for Lortab had four (4) refills on it, but was dispensed by the pharmacy with no refills. Complainant also indicates that he requested a copy of her Rx's and the pharmacy staff would not give them to him.

PIC responded to the complaint stating that she was not aware that the Complainant has requested his Rx's, but would have provided a copy if the request had been known. Also, the PIC provided a copy of the Rx's that shows that no refills were ordered.

Prior discipline: None

Recommendation: Dismiss

Dr. Hill made the motion to **accept counsel's recommendation**. Dr. Wilson seconded the motion. The motion carried.

47. Case No.: L09-PHR-RBS-2007080391

Complainant alleges that a fraudulent prescription for Oxycontin was dispensed from the Respondent pharmacy.

Investigator spoke to the PIC who states that neither he nor the other pharmacist remembers anything about the patient or the prescription nor do they remember calling the physician about the Rx. PIC supplied the patient printout which shows that two (2) Rx's for this patient written by an APN were dispensed from the pharmacy. PIC states that he has gone back and compared the Rx's in question with other Rx's written by the same APN and said there is nothing that would raise any suspicion that the Rx's might not be legitimate.

Prior discipline: 2005, unlicensed activity, LOW

Recommendation: Dismiss

Dr. Hill made the motion to **accept counsel's recommendation**. Dr. Wilson seconded the motion. The motion carried.

48. Case No.: L09-PHR-RBS-2009000881

Complainant alleges that the Respondent pharmacy dispensed Propoxyphene to a pet in dangerous amounts, more specifically alleging that the pharmacy staff failed to perform a DUR.

Investigation into this matter revealed that the dog received the following amounts of Propoxyphene/APAP 650mg:

December, 2007: 120
January, 2008: 220
July, 2008: 60
September, 2008: 60
October, 2008: 60
November, 2008: 180
December, 2008: 80
January, 2009: 145
February, 2009: 60
March, 2009: 120
April, 2009: 30

When investigators went to the pharmacy, 19 out of the 34 requested prescriptions could not located on an initial visit; fifteen (15) of those were found within an eighteen (18) day period and four (4) were never located. Pharmacist indicated to investigators that he did not have concerns regarding the treatment or dosages being prescribed for the dog.

Prior discipline: None

Recommendation: LOW about the Rxs not being readily retrievable and authorize a formal hearing ($500.00 civil penalty to the dispensing D.Ph. for failure to perform a DUR). Refer the matter to the Board of Veterinary Medical Examiners.

Dr. Mitchell made the motion **to issue a Letter of Warning, to authorize** a **formal hearing** with $500.00 civil penalty to the dispensing D.Ph for failure to perform a DUR and refer the matter to the Board of Veterinary Medical Examiners. Dr. Wilson seconded the motion. The motion carried.

49. Case No.: L09-PHR-RBS-2009001391

Respondent, a registered technician, admitted to removing Suboxone from the pharmacy without authorization. I received the case July 10, 2009 and at that time, Respondent's license had already expired on September 30, 2007.

Prior discipline: None

Recommendation: Close and flag upon reapplication

Dr. Warren made the motion to **accept counsel's recommendation**. Dr. Wilson seconded the motion. The motion carried.

50. Case No.: L09-PHR-RBS-2009000031

Complainant, APN, alleges that the pharmacy dispensed unauthorized prescriptions for a patient whose mother is a pharmacy technician at the pharmacy. Complainant alleges that the patient had not been seen by the prescriber since 2004.

Investigator spoke to the PIC who provided copies of handwritten prescriptions on the prescriber's preprinted Rx pads with the prescriber's signature on the Rx dated August 23, 2006 for Singular (90 days supply with 3 additional refills) and Advair (90 days supply with 3 additional refills). PIC contends that all refills were authorized by the prescriber through verbal orders. Even though the verbal orders were provided as memorialized, none of them have the name of the person who took the verbal order.

Prior complaints: None

Recommendation: Letter of Warning about failure to properly document a verbal prescription
Dr. Stephens made the motion to issue a **Letter of Warning**. Dr. Warren seconded the motion. The motion carried.

51. Case No.: L09-PHR-RBS-2009000701 and 2009000711

This case was presented at the last Board meeting, at which time the Board authorized ao check to see if any of the FDA findings were rescinded. The attorney for the Respondent indicated that nothing was rescinded.

Respondent, entered into a Consent Decree with the FDA for distributing adulterated products across state lines. The Consent Decree dated March 2, 2009 required the Respondent to destroy all drugs that were the subject of a recall as well as in-process drugs, drug components, and finished drugs. The decree also requires the Respondent to ensure that drugs are manufactured in conformity with CGMP; to establish and document management control over quality assurance; to establish and follow scientific product development and manufacturing process design procedures; to retain an independent person who is qualified to inspect the Respondent's drug manufacturing facilities; and to submit protocols that identifies a work plan for the CGMP.

Respondent's representative provide information that the products recalled were at the wholesale or retail level and were not at the consumer level; the products were primarily morphine sulfate. Upon the approval of the FDA, the products that were already in the consumer's hands, were already there. Although some consumer have filed suit, the Respondent is unaware of any harm associated with the recalled products.

Prior discipline: None

Recommendation: Authorize formal hearing (five (5) year probation; abide by all terms contained in the Consent Decree and abide by all federal and state laws and rules relative to drugs and to the practice of pharmacy)

Dr. Stephens made the motion to **accept counsel's recommendation**. Dr. Wilson seconded the motion. The motion carried.

52. Case No.: L09-PHR-RBS-2009000891

Complainant alleges that the Respondent, pharmacist (PIC) has been repackaging mail order prescriptions and then dispensing them to a nursing home.

Investigation into this matter revealed that the PIC was and currently is conducting this practice after being told the by BOP investigator that this practice is prohibited.

Prior complaints: 2008, unregistered technicians, $1,900.00 civil penalty

Recommendation: Authorize formal hearing (10 day suspension)

Dr. Warren made the motion to **authorize a formal hearing** with a ten (10) day suspension and to refer the matter to Health Care Facilities. Dr. Wilson seconded the motion. The motion carried.

53. Case No.: L01-PHR-RBS-2001023611

Complainant alleges that the Respondent pharmacists filled prescriptions for a person that were authorized by DVM. The pharmacist who received the Rx's by phone has been revoked. LOW have already been issued against the other pharmacists who took some of the Rx's by phone. The only issue remaining is whether to of discipline the pharmacist who filled one of the Rx's.

Recommendation: Letter of Warning

Dr. Mitchell made the motion to issue the **Letter of Warning**. Dr. Wilson seconded the motion. The motion carried.

54. Case No.: L08-PHR-RBS-2008000301

Complainant alleges that her prescription written for Levign was filled with Levothyroxine with directions to take one (1) tablet by mouth four (4) times a day at bedtime and thirty (30) minutes before meals.

PIC responded to the complaint stating that the Rx was written for Hyoscyamine 0.125mg and it was dispensed Levothyroxine 0.125mg. It was a new Rx and after consulting with the pharmacist on duty, they cannot recall if patient counseling was

performed. The error was caught when the patient attempted to have the Rx refilled. The Rx refilled with the correct medication and at that time, the patient was counseled.

Prior discipline: None

Recommendation: Letter of Warning to dispensing pharmacist for misfill. Authorize formal hearing ($1,000 civil penalty to pharmacy; $500.00 to dispensing pharmacist; LOI to PIC)

Dr. Hill made a motion to issue a **Letter of Warning** to the dispensing pharmacist for misfill, **authorize a formal hearing** with $1,000.00 civil penalty to the pharmacy, $500.00 to dispensing and a **Letter of Instruction** to PIC. Dr. Wilson seconded the motion. The motion carried.

55. Case No.: L09-PHR-RBS-2009001261

Complainant alleges that the patient, nursing home resident was dispensed Decadron instead of Medrol.

Patient was prescribed Medrol 8mg in the AM and 4mg in the PM, and instead Decadron 4mg tablet (take two (2) tablets once daily and one (1) at bedtime) was dispensed. PIC admits the error occurred. To prevent this error from happening in the future, PIC states that he will add additional staff. PIC is also having data entry specialists recheck all orders on a daily basis and orders on new admissions are being checked by a second pharmacist to ensure accuracy.

Prior discipline: 2007, medication error, $1,000 civil penalty to dispensing pharmacist

Recommendation: Discuss

Dr. Hill made the motion to **issue a Letter of Warning** to the dispensing D.Ph and a letter of Instruction to the PIC. Dr. Wilson seconded the motion. The motion carried. Dr. Stephens was recused.

56. Case No.: L09-PHR-RBS-2009000771

Complainant alleges that the Respondent, pharmacist in charge, is employing unregistered individuals as technicians at the pharmacy. PIC responded to the complaint stating that the technician in question has been employed at the pharmacist as a pharmacy technician since June 11, 2008; the individual is a pre-pharmacy student who has completed a technician certification program.

Prior discipline: 2002, medication error, LOW

Recommendation: Authorize formal hearing ($1,100.00 civil penalty)

Dr. Wilson made the motion to **authorize a formal hearing** with a $1,100.00 civil penalty. Ms. McDaniel seconded the motion. The motion carried.

57. Case No.: L07-PHR-RBS-2007080941

Complainant alleges a medication error in that the patient was prescribed Zaroxolyn, but dispensed Methotrexate. Patient consumed the incorrect medication for fifteen (15) days. It is also alleged that because the patient ingested the incorrect medication, she required hospitalization and further nursing care. It was a new prescription. PIC indicates that he reviewed the signature log and the patient's husband signed the line indicating that he did not wish to speak to the pharmacist about the prescription.

Prior discipline: None

Recommendation: Letter of Warning about the misfill and patient counseling to dispensing pharmacist. LOI to PIC.

Dr. Warren made the motion to issue a **Letter of Warning** about the misfill and patient counseling to dispensing pharmacist and **Letter of Instruction** to the PIC. Dr. Wilson seconded the motion. The motion carried.

58. Case No.: L09-PHR-RBS-2009000291

Complainant alleges that the pharmacists at the hospital pharmacy dispensed tainted Heparin to a patient. Investigation into this matter revealed that the pharmacists removed all of the recalled Heparin from the hospital pharmacy when they received the recalled notices. Based on the recalled notices that they had at the pharmacy at the time of dispensing, the pharmacists did not dispense any Heparin that they knew was tainted.

Prior discipline: None

Recommendation: Dismiss

Dr. Hill made the motion to **accept counsel's recommendation**. Dr. Wilson seconded the motion. The motion carried.

MINUTES

Dr. Mitchell made the motion to accept the minutes from the June 9-10, 2009 as amended. Dr. Wilson seconded the motion. The motion carried.

DIRECTOR'S REPORT

Dr. Eidson informed the board that there have been a lot of candidates applying and passing the NAPLEX for Tennessee. Dr. Eidson also passed out documents that will be discussed at the Tennessee Pharmacy Association (TPA) meeting to be held in South Carolina on July 19-22, 2009.

Dr. Bess thanked Dr. Black for her input on several issues that was presented before the board.

Dr. Hill made the motion to adjourn. Dr. Wilson seconded the motion. The motion carried.

Minutes ratified at the November 5, 2009 meeting.