

BEFORE THE KANSAS STATE BOARD OF PHARMACY

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KANSAS STATE  
Board of Pharmacy

KANSAS BOARD OF PHARMACY	)		
v.	)		
MARK C. POINDEXTER,	)	Case No.	06-91, 07-88, 08-22 C
	)	OAH No.	08BP0001
HOGAN'S PHARMACY, INC.,	)	Case No.	06-91, 07-88, 08-22 A
	)	OAH No.	08BP0002
JOLANE POINDEXTER,	)	Case No.	06-91, 07-88, 08-22 B
	)	OAH No.	08BP0003
RICK KLOXIN, R.PH.,	)	Case No.	06-91, 07-88, 08-22 D
Appellants.	)	OAH No.	08BP0004

INITIAL ORDER

NOW, on these 16<sup>th</sup>, 17<sup>th</sup> and 19<sup>th</sup>, days of December, 2008, this matter comes on for formal hearing. The hearing was held at the Office of Administrative Hearings, 1020 S. Kansas Avenue, Topeka, Kansas. The petitioner, Kansas State Board of Pharmacy appears by and through counsel Derenda Mitchell, Assistant Attorney General. The respondents, Hogan's Pharmacy, Jolane Poindexter and Mark Poindexter, appear in person and through counsel, Richard Morefield. The Respondent, Rick Kloxin, appears in person and through counsel Gregory Bell.

Pursuant to K.S.A. 77-514, Margaret A. Graham was duly appointed as the Presiding Officer.

FINDINGS OF FACT

1. Hogan's Pharmacy ("Hogan's") is duly licensed by the Kansas Board of Pharmacy ("Board") and is located in Lyons, Kansas.
2. The Board issued registration number 2-09719 to Hogan's on October 26, 2001.

Hogan's is also permitted to sell over-the-counter medications pursuant to registration number 10-39460. This allows Hogan's to sell both prescription medications when a licensed pharmacist is on duty as well as over-the-counter medications when the prescription portion of the pharmacy is closed.

3. Each pharmacy licensed in Kansas must have a licensed pharmacist in charge employed by the pharmacy at all times. A pharmacist in charge is a pharmacist licensed by the Board who is also specifically designated as the person responsible to the Board for the operations of the pharmacy.
4. Rick Kloxin is a pharmacist licensed in the State of Kansas and has been since 1974. Mr. Kloxin has been the pharmacist in charge at Hogan's since July 1, 2002.
5. Jolane Poindexter and Mark Poindexter, husband and wife, are the owners and operators of Hogan's. Both are registered pharmacy technicians through the Board. Mr. Poindexter's registration number is 14-03566. Ms. Poindexter's registration number is 14-02565.
6. Larry Leamer was a licensed pharmacist employed by Hogan's, however, he died during the pendency of this matter.
7. Amber Boyd was employed as a pharmacy technician at Hogan's from March 2007 to August 2007. Ms. Boyd is a registered pharmacy technician with the Board.
8. Rosie Grow was employed by Hogan's from January 2007 to September 2007. Ms. Grow is not a registered pharmacy technician with the Board.
9. The Poindexters' essentially ran two different businesses out of Hogan's. In what was called the "front" of the store, the Poindexter's maintained what could be considered a traditional pharmacy in which customers brought in written prescriptions from their local physicians to be filled, and local physician's called in prescriptions for patients who then personally went to Hogan's to receive their medication. They also sold over-the-counter medications to local customers in the "front" of the store. Mr. Kloxin primarily worked in the "front" of the store.
10. In what was the "back" of the store, the Poindexters ran what is termed and "internet pharmacy". This area was reserved for filling prescriptions received over the internet. Mr. Leamer primarily worked in the "back" of the store.
9. To run the internet pharmacy, the Poindexters set up a business model whereby Hogan's would receive prescriptions for non-scheduled pharmaceuticals via the internet, would fill those prescriptions, then would ship the medication directly to the customer. The Poindexters entered into an agreement with two internet web-sites,

Rx Limited and Mypharmacy.com to fill prescriptions.

10. Customers using these web-sites were required to complete an on-line questionnaire regarding their medical history, personal information and the medication they were requesting. No safe-guards were in place to ensure that the information provided by the customers was accurate.
11. After completion, the questionnaire was then transmitted to a physician somewhere for review. The physician never actually saw the customer in person, nor did the physician speak with the customer by telephone or any other means. The only information provided to the physician was the on-line questionnaire.
12. Upon receipt of the questionnaire, the physician would authorize a prescription for the medication requested. The prescription was then transmitted to Hogan's to be filled. At no time did Hogan's have any direct contact with the customer or physician at this point in the process.
13. Hogan's had two computers set up in the back. One computer was provided by Rx Limited and prescriptions to be filled for that company were received on that computer. The other computer was provided by Mypharmacy.com and prescriptions to be filled for that company were received on that computer. A third computer was located in the front of the store and was used to fill prescriptions received from walk-in customers and called in by local physicians. The three computers were not linked in anyway, so the pharmacy was unable to determine whether a customer received the same prescription from both internet companies and through the front of the store unless a Hogan's staff member happened to remember the customer's name.
14. Ms. Poindexter trained Ms. Boyd to assist with the filling and shipping of the prescriptions received over the internet. Her duties included receiving the prescriptions from the internet companies and determining whether the prescriptions were appropriate to be filled. Ms. Poindexter also instructed Ms. Boyd to add or change patient information on the computer when Hogan's refilled a prescription for a customer if the information on the current questionnaire differed from the information provided on a past questionnaire. Ms. Boyd changed information on the questionnaires approximately three times to reflect "headache" rather than "pain".
15. Mr. Kloxin was not aware that information on the questionnaire's was being altered or added to match the drug requested. Mr. Kloxin did not train the pharmacy technicians.
16. Ms. Boyd pulled the patient questionnaires from each computer and printed them.

She then reviewed the questionnaires to ensure the prescriptions could be filled. Ms. Poindexter had trained her to reject prescriptions that were asked to be filled to soon, or if another problem existed with the prescription such as Viagra being prescribed for a woman, or a request from an attorney or a government employee.

17. If Ms. Boyd determined that there were no obvious problems with the prescription, she sent the questionnaire along with the drug label, drug information insert and an invoice to the person filling the prescription. Often, she filled the prescription bottles herself, but she also observed Ms. Grow fill prescriptions by placing the medication into the bottles. Ms. Grow is not a registered pharmacy technician and was not permitted to fill prescriptions. Ms. Boyd did not see Ms. Grow place labels on any of the bottles that she filled.
18. Once the prescription was filled, Mr. Kloxin or Mr. Leamer reviewed and approved the prescriptions. The prescriptions were then placed into a package with the invoice and drug information documents, and were shipped to the customer. The only thing that a pharmacist did in the processing of the medication orders from the internet was to be the final check of the medication before it went out the door. The pharmacist simply compared the prescription bottle with the second sticky label and looked at the medication in the bottle.
19. Hogan's filled approximately 600-1,200 prescriptions each day by this method.
20. Ms. Boyd received approximately two to three complaints registered to the pharmacy, each day. She informed Ms. Poindexter about the complaints, but did not share them with Mr. Kloxin.
21. When Ms. Boyd rejected a prescription, it was shredded at Hogan's at the end of the day.
22. Hogan's failed to maintain incident reports that contained the information that they were required to keep in violation of the Board's statutes and regulations.
23. Carrie Wachter is a resident of Denver, Colorado. Ms. Wachter experienced a back injury and her physician prescribed a medication called Soma to relieve her pain. After a period of time, Ms. Wachter became addicted to Soma and as a result, her treating physician refused to continue to prescribe Soma to her. She continued to receive Soma prescriptions from several other doctors for a period of time. Eventually she was unable to receive the prescription from any of her treating physicians.

24. As a result of her addiction, Ms. Wachter then turned to the internet to find a way to obtain Soma. After a search of web-sites for the medication, she eventually filled out the questionnaire for Hogan's, but was not entirely truthful in the information that she provided.
25. The completed questionnaire was then forwarded to Hogan's to be filled. Hogan's subsequently did fill the prescription and ship the medication to Ms. Wachter on several occasions.
26. When the medication was shipped to Ms. Wachter it was done without counseling Ms. Wachter or offering to counsel her about the medication she would be receiving. Instead, an insert was provided that stated in part, "Important note, The following information is intended [sic] to supplement, not substitute for, the expertise and judgment of your physician, pharmacist or other health care professional. It should not be construed to indicate the use of the drug is safe, appropriate, or effective for you. Consult your health care professional before using this drug. ..."
27. Ms. Wachter received Soma from Hogan's in this manner on five occasions. On each occasion, she received 90 Soma tablets from Hogan's.
28. Sometime in September 2006, Ms. Billingsley attended a function that was also attended by pharmacists from across Kansas. At that function she was approached by someone who expressed concerns about Hogan's selling medications through the internet.
29. On October 6, 2006, Tom Frazier, and investigator for the Board, conducted an annual inspection of Hogan's. All pharmacies licensed in Kansas are inspected annually to ensure compliance with the statutes and regulations governing licensed pharmacies.
30. Mr. Frazier's report of the inspection revealed that he did not observe any violations of any statutes or regulations governing licensed pharmacies. However, he did send a memo to the Board informing it of the internet sales business that Hogan's was conducting.
31. On at least one occasion, Mr. Frazier did tell the Poindexters that their internet pharmacy was illegal. Ms. Poindexter responded that "the internet business is the business of the future."
32. On November 15, 2006, Ms. Billingsley sent a memo to Mr. Frazier asking him to seize Hogan's prescriptions in an effort to get Mr. Frazier to take the internet situation seriously. In the memo, she requested that he seize all of Hogan's internet

prescriptions so that she could report Dr. Buckley to the New York Board of Pharmacy and so that "we can maybe rock their world a little bit."

33. Dr. Buckley is a physician with a license limited by the State of New York to Watertown, New York and limited to only the practice of gynecology. However, her name appeared on the vast majority of the prescriptions filled by Hogan's through the internet business.
34. Dr. Buckley did not personally see or talk to any of the patients for whom she wrote prescriptions outside of her practice in Watertown, New York. Rather, she obtained her information from the on-line questionnaire's filled out by the customers. Based solely on the information contained in the questionnaire's, Dr. Buckley wrote prescriptions for the requested medication and the prescriptions were sent to Hogan's to be filled.
35. Dr. Buckley was not an authorized prescriber for the medications that she prescribed and were filled by Hogan's as her license was limited to the practice of gynecology in Watertown, New York.
36. On January 4, 2007, the Board issued a subpoena for Hogan's records regarding their internet sale of medications in order to review the records and determine the nature and extent of Hogan's internet sales.
37. Subsequently, Richard Morefield, the attorney for Hogan's and the Poindexters, contacted Ms. Billingsley to discuss compliance with the subpoena, as well as the Board's concerns regarding Hogan's internet pharmacy. As a result of that conversation, Ms. Billingsley sent an e-mail to the Board's investigators stating in part, Mr. Morefield asked "me what the violation was and I told him I did not know if there was a violation until we reviewed the records. He said that the inspection of the pharmacy was fine and I told him that the inspection had no bearing on whether we found something in these records we are requesting. We did talk a little bit about the standard of care in a pharmacist making sure that a patient was actually being seen by the physician. Obviously this guy wants there to be some law that specifically says that they can't do what they are doing. I would love that too but since we don't have anything like that, I would certainly want to look at the records and then see if we can find any violations. We may have to be inventive."
38. On January 19, 2007, Mr. Morefield sent a letter to Ms. Billingsley informing her that Hogan's would fully comply with the subpoena and would also send additional records for the Board to review. Mr. Morefield also informed Ms. Billingsley that Hogan's believed that it was in compliance with current pharmacy laws and regulations, and asked that if the Board found it was not in compliance to notify him immediately so that they could discuss a plan for bringing Hogan's into full compliance.

39. Hogan's sent several boxes of documents to the Board pursuant to the January 4, 2007, subpoena. However, James Kinderknecht, one of the Board's investigators assigned to the matter, was unable to review the documents during the winter and spring of 2007 because he was involved in another matter that was taking all of his time and attention.
40. In the spring of 2007, Mr. Kinderknecht made a brief review of the documents and determined that it would be easier for the Board to determine if there were any violations if the Board was able to review the daily summaries of Hogan's internet sales.
41. In June 2007 Mr. Kinderknecht called Mr. Kloxin and requested that the daily printouts be copied and ready for the inspectors to pick up. Mr. Kloxin agreed and that printouts were ready for Mr. Kinderknecht on July 13, 2007.
42. On July 13, 2007, Mr. Kinderknecht and Carly Haynes, another investigator for the Board, investigated and inspected Hogan's. They also served a second subpoena requiring Hogan's to produce the requested daily printouts.
43. When they arrived at Hogan's that day, Mr. Kloxin was in the front of the store and Mr. Leamer was in the back. The staff at Hogan's continued to conduct business as usual during the inspection and answered questions asked of them by the inspectors.
44. During that visit, Mr. Kinderknecht asked Mr. Kloxin about the internet sales. Mr. Kloxin told him that he was relying on Ms. Poindexter to verify the legitimacy of the physicians who were writing the prescriptions because the Poindexters owned the business and he was their employee.
45. Also during the inspection, Ms. Haynes observed hundreds of unlabeled bottles filled with repackaged pills in violation of the Board's statutes and regulations.
46. Mr. Leamer told Ms. Haynes that he checked three hundred to four hundred prescriptions each day.
47. Drop shipping is a method by which a prescription is mailed to a location where it is held by a third party for the intended recipient to pick up. Examples of drop shipping include the delivery of the medication to a FedEx location to be later picked up by the recipient, or delivery of the medication to a Holiday Inn to be later picked up by the recipient. Drop shipping is prohibited by the Board and through its investigation, the Board found numerous instances in which Hogan's drop shipped prescriptions.

48. Subsequent to the inspection, Ms. Haynes authored a report in which she alleged a number of violations with regard to the day to day operations of the pharmacy. This included the failure of staff to wear name-tags, labels not being affixed to prepackaged drugs, and incomplete incident reports. Ms. Haynes also expressed concerns that the three computers at Hogan's were not connected to allow staff to verify that a requested prescription had already been filled.
49. Ms. Wachter's father, Rod Champney, called Hogan's to complain about the prescription medication that his daughter was receiving. Ms. Poindexter told him "We can't control abuse any more than the store that sells alcohol." and dismissed his complaint. She also told him that she did not know where the doctor who issued the prescription was licensed and that she had not read the web-site that was referred to in the package insert that Hogan's had sent to Ms. Wachter.
50. On July 25, 2007, Mr. Champney sent a letter to the Board complaining about how Ms. Wachter was getting prescription medications from Hogan's. He informed the Board that Ms. Wachter should not be able to get the medication because she was a drug addict.
51. On July 27, 2007, Deborah Billingsley, the Executive Director for the Board, sent Mr. Champney a form letter acknowledging the receipt of his complaint. Having not heard further from the Board, Mr. Champney sent an e-mail to Ms. Billingsley on January 31, 2008 inquiring as to the status of his complaint. However, the Board never responded to Mr. Champney's complaint or request for information.
52. Tracy Taylor, a resident of Kansas, was able to obtain Soma from Hogan's in the same manner as Ms. Wachter obtained the medication. Mr. Taylor had not seen a physician to receive the prescription, but instead simply filled out the on-line questionnaire. He had abused Soma in the past and was a drug seeker. He first obtained the medication from Hogan's on July 7, 2007.
53. On August 25, 2007 Mr. Taylor's wife Kelly Taylor discovered that her husband had died after he told her he was going to take a nap.
54. Mr. Taylor had been taking approximately 15 Soma pills each day and was receiving them at his home and place of business.
55. The November 15, 2007 autopsy report issued subsequent to Mr. Taylor's death listed the cause of death as mixed drug intoxication. Ambien and Soma were found to be in his system.

56. Mr. Taylor had not received a prescription for Soma from any source other than Hogan's at the time of his death.
57. In January 2008, Ms. Billingsley learned of Mr. Taylor's death due to the overdose. She received a copy of the autopsy report on February 8, 2008.
58. On July 17, 2007 the State of Missouri issued a cease and desist order against Hogan's for shipping medication into Missouri without a license. The State of Utah issued a similar citation to Hogan's on September 11, 2007. In addition, on September 20, 2007, the state of Colorado issued a cease and desist order against Hogan's for shipping medications into Colorado without a license.
59. On March 12, 2008, Ms. Billingsley received an email from David Fitzpatrick informing her that Mr. Fitzpatrick's sister had received medication from Hogan's on September 13, 2007.
60. Christina Boyd, a pharmacy technician at Hogan's received three complaints of overdoses just the week before March 12, 2008, and yet there were no incident reports found at Hogan's for these overdose reports as is required.
61. On March 10, 2008, the Board issued Emergency Orders immediately closing Hogan's and immediately suspending the licenses of Rick Kloxin and Hogan's, and registrations of Jolane Poindexter and Mark Poindexter.
62. On March 12, 2008 Darren Fox, an investigator with the criminal division of the Kansas Attorney General's office served the Emergency Order on the respondents. He was also involved in the search of Hogan's and the Poindexter's home. The search of the Poindexter's home revealed that Ms. Poindexter had been authorizing internet prescriptions from her home. Mr. Fox also observed several boxes containing unlabeled bottles of repackaged medications at Hogan's.
63. Each of the respondents, Hogan's Pharmacy, Jolane Poindexter, Mark Poindexter and Rick Kloxin, timely filed appeals from the Board's emergency order of suspension. On October 10, 2008, the Board issued a Petition requesting that the license of Rick Kloxin and Hogan's Pharmacy, and the registrations of Jolane Poindexter and Mark Poindexter be revoked, and civil penalties be assessed against Rick Kloxin, Hogan's, Jolane Poindexter and Mark Poindexter for violations of the Board's statutes and regulations. The hearing on the Petition and the Emergency Order were consolidated for hearing at the request of the parties.

### CONCLUSIONS OF LAW

1. The burden of proof in this matter is upon the Board to prove by a preponderance of the evidence that the licenses of Hogan's and Rick Kloxin and the registrations of Jolane Poindexter and Mark Poindexter should be revoked and civil penalties assessed for violations of the Board's statutes and regulations.
2. At the hearing, Rick Kloxin, Jolane Poindexter and Mark Poindexter were called to testify on behalf of the Board. Each of them asserted their fifth amendment right against self incrimination and refused to answer any substantive questions posed to them. As this is an administrative action, the Board is entitled to an adverse inference as a result of the respondent's refusal to answer the Board's questions. Therefore, it shall be inferred that the answers given would have been favorable to the Board.
3. There are no specific statutes, regulations or applicable policies promulgated by the Board regarding the engagement in the business of internet sales of prescription medications by a pharmacy or pharmacist licensed in Kansas.
4. Kansas Statutes Annotated (K.S.A.) 77-536 authorizes an Agency or Board to use emergency proceedings when a situation poses an immediate danger to the public health, safety or welfare.
5. K.S.A. 65-1627 authorizes the Board to discipline a pharmacist under any of the conditions outlined in subsection (a).
6. K.S.A. 65-1627(e) authorizes the Board to discipline a pharmacy upon a finding that the pharmacy has been operated in such a manner that violations of the provisions of the pharmacy laws occurred in connection with the pharmacy's operation.
7. K.S.A. 65-1663(e) authorizes the Board to discipline a pharmacy technician on any ground that authorizes the Board to take action against a pharmacist.
8. K.S.A. 65-1658 authorizes the Board to assess a civil penalty against any licensee or registrant not to exceed \$5,000.00 for each violation.
9. Pursuant to K.S.A. 65-1626(hh)(4), (7) and (9), "unprofessional conduct" means intentionally falsifying or altering records or prescriptions, conduct likely to harm the public, and the commission of any act of exploitation related to the licensee's professional practice.
10. Pursuant to K.S.A. 65-1626(ee), "professional incompetency" means one or more instances involving failure to adhere to the applicable standard of pharmaceutical care to a degree which constitutes gross negligence or repeated instances of ordinary negligence.

11. Pursuant to K.S.A. 65-1627(a)(3), the Board may revoke, suspend, place on probationary status or deny a license to a pharmacist who is found guilty of unprofessional conduct or professional incompetency.
12. Pursuant to K.S.A. 65-1637, "In every store, shop or other place defined in this [pharmacy] act as a 'pharmacy' there shall be a pharmacist in charge and, except as otherwise provided by law, the compounding and dispensing of prescriptions shall be limited to pharmacists only."
13. Pursuant to Kansas Administrative Regulation (K.A.R.) 68-1-2a(c) a pharmacist in charge must sign an acknowledgment that states that the pharmacist has reviewed the pharmacy act and the board's regulations and is aware of the responsibilities of a pharmacist in charge.
14. Pursuant to K.S.A. 65-1626(ff), a "pharmacy technician" is defined as an individual who, under the direct supervision and control of a pharmacist, may perform packaging, manipulative, repetitive or other nondiscretionary tasks related to the processing of a prescription or medication order and who assists the pharmacist in the performance of pharmacy related duties, but who does not perform duties restricted to a pharmacist.
15. Pursuant to K.S.A. 65-1663(g), a pharmacy technician shall work under the direct supervision and control of a pharmacist and the supervising pharmacist shall be responsible for the acts and omissions of the pharmacy technician in the performance of the pharmacy technician's duties.
16. The Board may limit, suspend, or revoke a pharmacy technician's registration or deny an application for issuance or renewal of any registration as a pharmacy technician on any ground which would authorize the board to take action against the license of a pharmacist under K.S.A. 65-1627.
17. Pursuant to K.A.R. 68-2-20, only a pharmacist may read and interpret the prescription of the prescriber.
18. The pharmacist in charge is required to insure that each pharmacy technician complies with the training requirements of K.A.R. 68-5-15.
19. Pursuant to K.A.R. 68-5-15, the pharmacist in charge is required to insure that pharmacy technicians are trained in a course that addresses "knowledge and understanding of the duties and responsibilities of a pharmacy technician in relationship to other pharmacy personnel and knowledge of standards, ethics, laws and regulations governing the practice of pharmacy."

20. Pursuant to K.A.R. 68-7-12, the pharmacist in charge is also responsible for developing, supervising and coordinating all pharmaceutical services carried on within the pharmacy to ensure compliance with the Kansas pharmacy act, the Kansas Uniform Controlled Substances act, federal drug laws and all applicable regulations.
21. The pharmacist in charge must also develop or approve written policies and procedures for the pharmacy that provide that any incident that occurs as a result of an alleged or real error in filling or dispensing a prescription or medication order is brought to the attention of the pharmacist in charge and completely documented in accordance with K.A.R. 68-7-12(b).
22. K.A.R. 68-2-20(a)(9) provides that a pharmacist shall "interpret and verify patient medication records and perform drug regiment reviews."
23. K.A.R. 68-2-22(a) allows for electronic prescription transmissions but requires that the prescriber act within the course of "legitimate professional practice".
24. K.A.R. 68-2-22(b)(3) requires that each prescription drug order communicated by electronic transmission be transmitted by an "authorized prescriber".
25. K.A.R. 68-2-16 prohibits pharmacists and pharmacy technicians from drop shipping or shipping to a location where a prescription is held or retrieved later by the recipient.
26. Pursuant to K.S.A. 65-1627(e), the Board may revoke, suspend, place in probationary status or deny a renewal of the registration of a pharmacy upon a finding that the registrant has had a registration revoked, suspended or limited, has been censured or has had other disciplinary action taken by the registering authority of another state.
27. The Board may only revoke the respondents' licenses or registrations based upon the allegations contained in the Board's petition and emergency order. *See Reed v. Kansas Racing Comm'n*, 253 Kan. 602, 860 P.2d 684, 691 (1993).
28. As the pharmacist in charge, Mr. Kloxin is ultimately responsible to the Board for the conduct of the pharmacy technicians and pharmacy staff working under him. Although this put him in the difficult position of having to monitor the acts and omissions of his employers, Jolane and Mark Poindexter, that relationship does not relieve him of his duties and responsibilities as the pharmacist in charge. As such, even though he may not have known about some violations that were occurring at Hogan's or may have trusted that Ms. Poindexter was taking care of things, he is still ultimately responsible for her actions as well as the other pharmacy technicians and staff working at Hogan's.

29. Ms. Poindexter engaged in unprofessional conduct when she directed Ms. Boyd to alter or add to the questionnaires that Hogan's received in the course of filling prescriptions received over the internet.
30. Mr. Kloxin failed to properly supervise pharmacy technicians when he permitted them to make decisions that required the professional judgment of a pharmacist for approving or denying medication orders. Doing so it outside of the authority of pharmacy technicians.
31. As the pharmacist in charge, Mr. Kloxin should not have permitted Jolane and Mark Poindexter to perform pharmacy functions, such as approving prescription orders, from their home. Their home is not a pharmacy licensed by the Board. Even if Mr. Kloxin did not specifically permit those actions by Jolane and Mark Poindexter, he did not report their actions to the Board as he should have done.
32. The public health, safety and welfare is threatened and harm is likely when pharmacy technicians are permitted to make decisions reserved for pharmacists or are permitted to conduct their duties outside of the supervision of the pharmacist.
33. By conducting pharmacy business from her home, Ms. Poindexter engaged in unprofessional conduct.
34. Rick Kloxin, Jolane Poindexter and Mark Poindexter engaged in unprofessional conduct and professional incompetency that was likely to cause harm when they allowed Ms. Grow to perform pharmacy technician duties without the proper training and without be a registered pharmacy technician.
35. Rick Kloxin, Jolane Poindexter and Mark Poindexter engaged in unprofessional conduct and professional incompetency that was likely to cause harm when they dispensed a high volume of prescriptions so as not to permit sufficient time to verify the prescription and to ensure accuracy in the dispensing.
36. Rick Kloxin, Jolane Poindexter and Mark Poindexter engaged in unprofessional conduct and professional incompetency that was likely to cause harm when they dispensed prescriptions from Dr. Buckley when she prescribed medications for customers who resided outside of the Watertown, New York area and for medications outside of the field of gynecology because Dr. Buckley was not an authorized prescriber for prescriptions sent to Hogan's from 2005 through 2007. It was a violation of K.A.R. 68-2-22(b)(3) to dispense medication based upon an order from Dr. Buckley.
37. Jolane Poindexter, Mark Poindexter and as the pharmacist in charge, Rick Kloxin, engaged in professional misconduct and professional incompetence when they

- continued to dispense medications to people who were drug seeking or drug addicts after they were placed on notice that this was occurring in 2007 and after.
38. Rick Kloxin failed to verify patient medication records and to perform drug regimen reviews as required by K.A.R. 68-2-20 when he failed to link the three computers to ensure that medications were not being improperly dispensed to customers.
  39. Rick Kloxin violated K.A.R. 68-2-20 when he failed to offer a personal consultation to each customer with a new prescription dispensed by Hogan's. The package insert provided with each prescription filled, and the assumption from the questionnaires that the customer had taken the medication before, are inadequate and do not excuse Mr. Kloxin from his responsibility to offer a personal consultation to each customer with a new prescription. Because this behavior is likely to cause harm, it constitutes unprofessional conduct as that term is defined in K.S.A. 65-1626.
  40. Hogan's, Rick Kloxin, Jolane Poindexter and Mark Poindexter failed to file incident reports as required by K.A.R. 68-7-12 when they learned of a reportable incident involving their dispensing of a prescription medication.
  41. Hundreds of bottles of unlabeled prescription medications were observed by Ms. Haynes and Mr. Fox when they inspected and searched Hogan's. Such bottles must be labeled pursuant to K.A.R. 68-7-16 to insure that medications are not incorrectly dispensed. Unlabeled bottles create a risk that one medication will be mistaken for another and as a result, a customer will receive the wrong medication. Allowing unlabeled prescription medication bottles to remain in the pharmacy, Mr. Kloxin, Ms. Poindexter and Mr. Poindexter created a likelihood of harm, which constitutes unprofessional conduct as that term is defined in K.S.A. 65-1626.
  42. The Board alleges that the cease and desist orders issued by the States of Colorado, Missouri and Utah constitute disciplinary action against Hogan's by those states. However, this argument is not supported by the evidence. Although Hogan's actions were found to be inappropriate, a cease and desist order of this nature is not formal discipline as those states did not have jurisdiction over disciplining Hogan's because it was not a licensed pharmacy in those states.
  43. Upon a careful review of the totality of the evidence, it is clear that Hogan's Pharmacy, Rick Kloxin, Jolane Poindexter and Mark Poindexter violated numerous provisions of pharmacy act through their internet pharmacy business that occurred in the back portion of Hogan's Pharmacy from at least early 2007 through early 2008. Although the burden of proof in this matter is by a preponderance of the evidence, it is found that the Board proved the violations alleged in its petition, and addressed above, by clear and convincing evidence, thereby exceeding the burden of proof required of them.

## SANCTIONS

The Board has requested the following licensing actions for each of the respondents:

1. Rick Kloxin:

Revocation of his pharmacist license for unprofessional conduct as defined by K.S.A. 65-126(rr); for his exploitation of persons with drug seeking tendencies; for his failure to train and supervise pharmacy technicians; for misleading and concealing information from the Board; and for his numerous violations of the Kansas Pharmacy laws, including his failure to counsel patients.

The evidence is clear that Mr. Kloxin failed to properly supervise the pharmacy technicians working under him. Although "supervising" his employers did put him in a difficult position, that does not relieve him of his duties and responsibilities as a licensed pharmacist and pharmacist in charge. Mr. Kloxin failed to take action to ensure that the internet pharmacy run from Hogan's was approved by the Board. Instead he inappropriately relied upon Ms. Poindexter, a pharmacy technician to do that. He also failed to take steps to correct the practice of allowing Ms. Boyd to make determinations as to whether a prescription should be filled or not and of allowing Ms. Grow to fill prescriptions. He failed to report to the Board complaints and instances of drug overdose that were reported to Hogan's, he allowed hundreds of unlabeled prescription bottles of medications to remain in the pharmacy, and he failed to counsel patients as required by the Pharmacy Act. It has not been established that Mr. Kloxin exploited persons with drug seeking tendencies or that he mislead or concealed information from the Board. However, he has substantially failed to comply with the statutes and regulations governing licensed pharmacists and has created an environment that is a threat to the public health, safety and welfare. Rick Kloxin's license shall be revoked.

2. Jolane Poindexter:

Revocation of her pharmacy technician registration for unprofessional conduct as defined by K.S.A. 65-126(rr); for her exploitation of persons with drug seeking tendencies; for her usurpation of the duties and responsibilities of a pharmacist; for the alteration of patient records under her direction; for misleading and concealing information from the Board; and for her numerous violations of the Kansas Pharmacy laws.

The evidence is clear that Ms. Poindexter was the "ring leader" of the internet pharmacy operation at Hogan's. The evidence was overwhelming that she exploited

persons with drug seeking tendencies when she failed to take action after receiving multiple complaints, including the complaint from Mr. Champney. Ms. Poindexter not only failed to take measures to insure that Hogan's was not aiding drug seekers in obtaining prescription medication, but she was disrespectful and unprofessional in addressing Mr. Champney's concerns. Ms. Poindexter seemed to see herself as a pharmacist in her own right, even absent an actual license. She took it upon herself to direct the dispensing of medications by other pharmacy technicians, she instructed them to alter records, she permitted a staff member who was not a registered pharmacy technician to fill prescriptions and she authorized filling of prescriptions from her home without the supervision of a pharmacist. She misled the Board and concealed information when she failed to produce requested documents, then produced them in such a fashion and volume as to render them essentially useless to the Board. Ms. Poindexter has substantially failed to comply with the statutes and regulations governing registered pharmacy technicians and has created an environment that is a threat to the public health, safety and welfare. Jolane Poindexter's registration shall be revoked.

3. Mark Poindexter:

Revocation of his pharmacy technician registration for unprofessional conduct as defined by K.S.A. 65-126(rr); for his exploitation of persons with drug seeking tendencies; for his usurpation of the duties and responsibilities of a pharmacist; for misleading and concealing information from the Board; and for his numerous violations of the Kansas Pharmacy laws.

The evidence presented as to the acts of Mr. Poindexter was considerably less than that presented as to Mr. Kloxin and Ms. Poindexter. Clearly, as an owner of Hogan's he had a responsibility to ensure that the pharmacy was complying with the statutes and regulations of the Board, and he clearly failed to do so. However, there was no direct evidence presented to show that he had actual knowledge daily operations of the pharmacy. The evidence was that he worked primarily in the morning and that he took care of orders, put labels on bottles and ordered stock. There was evidence that he was the one who taught Ms. Grow how to use the machine that counted the pills into the bottles for shipping. Mr. Poindexter knew or should have known that because she was not a registered pharmacy technician, she was not permitted to fill prescription bottles with medication. Although there is less evidence that Mr. Poindexter violated the Pharmacy Act, there is sufficient evidence to find that he substantially failed to comply with the statutes and regulations governing registered pharmacy technicians and has created an environment that is a threat to the public health, safety and welfare. Mark Poindexter's registration shall be revoked.

4. Hogan's Pharmacy:

Revocation of the registration of Hogan's Pharmacy for the unprofessional conduct, incompetence, discipline in other states, and numerous violations of the pharmacy laws occurring at Hogan's Pharmacy.

Certainly, a building cannot engage in any of the acts that are alleged by the Board and attributed to "Hogan's Pharmacy". However, the Board does have the authority to license the "building" as a pharmacy and therefore has authority to take disciplinary action against that license. Had Hogan's been owned by an individual, individuals or a corporation not a party to this action, it would be difficult to find a basis to revoke the license issued to the pharmacy. However, in this case, the owners are two of the respondents and their actions must be considered in a decision regarding the pharmacy's license. Considering the evidence as a whole along with the actions of Jolane Poindexter and Mark Poindexter, the Board has met its burden to show that the license issued to Hogan's pharmacy shall be revoked as long as Jolane Poindexter and Mark Poindexter own the pharmacy. Should it be sold to another party approved by the Board, nothing in this order shall be construed as prohibiting that individual from seeking licensure for Hogan's Pharmacy.

The Board had also requested the following civil fines be assessed against each of the respondents:

1. Rick Kloxin:

\$500.00 per violation for 20,399 violations for a total civil fine of \$10,199,500.000.

Certainly, a civil fine is appropriate for Mr. Kloxin's actions, but a fine of over 10 million dollars is excessive. Mr. Kloxin shall be fined as follows:

- A. \$1,000.00 for adulteration of records by a pharmacy technician;
- B. \$1,000.00 for allowing untrained and unlicensed individuals to fill medication bottles;
- C. \$1,000.00 for failing to properly supervise pharmacy technicians;
- D. \$1,000.00 for the conduct of pharmacy technicians in approving and denying medication orders;
- E. \$2,000.00 for failing to interpret and verify patient medication records;
- F. \$2,000.00 for failing to counsel customers;
- G. \$2,000.00 for dispensing medication prescribed by an unauthorized prescriber;
- H. \$1,000.00 for drop shipping violations;
- I. \$1,000.00 for failing to prepare incident reports;