| | | |
|---|---|---|
| **IN THE MATTER OF** | * | **BEFORE THE** |
| **JOHN D. HOELSCHER, P.D.** | * | **STATE BOARD** |
| **License No.: 11115** | * | **OF** |
| **Respondent** | * | **PHARMACY** |

* * * * * * * * * * * * *

## ORDER FOR SUMMARY SUSPENSION

Pursuant to Md. State Gov't Code Ann. §10-226(c)(1999 Repl. Vol.), the State Board of Pharmacy (the "Board") hereby suspends the license to practice pharmacy in Maryland issued to John Hoelscher, P.D., (the "Respondent"), under the Maryland Pharmacy Practice Act (the "Act"), Title 12, Md. Health Occ. Code Ann. (2000 Repl. Vol.). This Order is based on the following investigative findings, which the Board has reason to believe are true:

## BACKGROUND

1. At all times relevant hereto, the Respondent was licensed to practice pharmacy in Maryland. The Respondent was first licensed on July 30, 1987. The Respondent's license expires on July 31, 2001. At all times relevant herein the Respondent was working at either Heritage Pharmacy in Bolliver, West Virginia or at K Mart in Frederick, Maryland.

2. The Respondent has a history of substance abuse and self-prescribing. Consequently, he voluntarily surrendered his pharmacist license on June 30, 1995 after being reported by the Pharmacists Rehabilitation Committee (PRC), the predecessor of the Pharmacists Education and Assistance Committee (PEAC), to the Board for practicing pharmacy while under the influence of unprescribed Darvocet N-100 while he was the

owner and sole pharmacist at Medicap Pharmacy in Walkersville, Maryland.

On April 23, 1996, the Respondent appeared before the Board and requested that his license be reinstated, which request was granted. Subsequently, the Respondent was placed on probation, with conditions including signing a new contract with PRC for two years, urine screenings, NA/AA meetings, group therapy, daily observations of work environment by a local Maryland State Trooper, random audits of CDS, quarterly PRC therapist and self-reports, abiding by PRC recommendations for treatment, notification to the Board of change of address, and refraining from conduct that led to the voluntary surrender.

On May 9, 1997, the Board issued an Order suspending the Respondent's pharmacy license after receiving reports from the PRC that he was self-medicating with carisoprodol and meprobamate, in violation of his PRC contract. An Order of Summary Suspension of the pharmacy permit for Medicap was also issued on May 14, 1997.

On September 17, 1997, the Respondent's license was reinstated and he was placed on Probation for two years with the following terms: non-dispensing employment; no access to drugs; health care employment approved by the Board; PEAC and /or Board to observe work setting; urine screens; quarterly employer/therapist/PEAC reports; PEAC contract; AA/NA meetings; follow therapist recommendations; notify Board of change of address; prior approval if employment changed; notification to employer and therapist of Probation with a copy of the Consent Order to each.

In September 1999, the Respondent was released from Probation.

3. On or about March 7, 2001, the Board received an anonymous report by

telephone that the Respondent was self-medicating and diverting Serzone, oxycodone and hydrocodone from his former place of employment, Heritage Pharmacy. The caller also stated that the Respondent was then employed at K Mart.

4. On March 28, 2001, Michelle Andoll, P.D., J.D., Pharmacy Compliance Officer of the Board, contacted the Respondent at K Mart. The Respondent informed her that he was the pharmacy manager at that store and had been since February 2001. On March 29, 2001, Ms. Andoll contacted Heritage regarding the Respondent's employment. She was informed that Heritage closed on February 1, 2001 and records were transferred to Jefferson Pharmacy. Bob Blair, an investigator for the West Virginia[1] Board of Pharmacy, had conducted an audit of Heritage's CDS records from December of 1999 to February of 2001[2], which he later reported to Ms. Andoll on April 16, 2001, as follows:

| | | | |
|---|---|---|---|
| 1. | Hydrocodone/APAP | 10/650mg | -1911 (-short/+over) |
| 2. | " | 7.5/500 | -1328 |
| 3. | " | 7.5/650 | -4035 |
| 4. | " | 7.5/750 | -1215 |
| 5. | " | 5/500 | -417 |
| 6. | Hydrocodone/APAP | 10/500 | +132 |
| 7. | Propoxyphene/APAP | N-100 | -487 |
| 8. | OxyContin | 10mg | -341 |

[1] The Respondent also has a West Virginia license which expires on 6/30/01. The West Virginia Board was to hold a hearing on 4/23/01 regarding the information uncovered by Mr. Blair regarding the Respondent's practice.

[2] The Respondent resigned from Heritage in December 2000; thus, some of the audit findings are not attributable to the Respondent, due to the two month gap between his resignation and the end-period of the audit.

| | | | |
|---|---|---|---|
| 9. | OxyContin | 20mg | -168 |
| 10. | " | 40mg | -20 |
| 11. | Oxazepam | 10mg | +40 |
| 12. | " | 15mg | -93 |
| 13. | " | 30mg | -300 |
| 14. | Adderall | 5mg | -100 |
| 15. | " | 10mg | +5 |
| 16. | " | 20mg | -400 |

5. On April 10, 2001, Jack Freedman, Chief of the Division of Drug Control (DDC), and Cathy Putz, P.D., a DDC employee, conducted an audit at K Mart on April 10, 2001. Kelly Shanahan, the Respondent's supervisor, was at the store that day. The pharmacy had recently been added to Ms. Shanahan's territory. Although Mr. Freedman reported that there were some shortages of Adderall and some other drugs, he did not deem these to be significant. However, the audit disclosed that the Respondent filled two Adderall 20 mg prescriptions for himself with double quantities of Adderall 10 mg[3], an amphetamine, which is a violation of K Mart company policy for employees to fill their own prescriptions. The audit further disclosed that prescriptions for one particular strength of hydrocodone/APAP were filled with a different strength on several occasions without any indication that the change was authorized.

6. These findings, in addition to other operational problems uncovered by Ms. Shanahan, indicated unacceptable work performance, which resulted in the Respondent's termination from K Mart on April 16, 2001.

[3] The Adderall prescriptions were later confirmed to be valid, inasmuch as the Respondent's psychiatrist issued same.

7. Ms. Shanahan's findings are as follows:

"The floor of the Pharmacy department at K Mart was covered in mud and dirt....prescriptions had not been organized, sorted, placed in numerical order, or bundled in California folders[4] since the beginning of January . . . not using the KARxE[5] program at all. . . a number of stock bottles on the shelves with no caps on them[6]. . . 6 prescriptions vials, that were evidently return (sic) to stocks that were sitting on an empty shelf, not where they belonged, with no lids on them as well...a customer approached the window, who wanted a transfer from County Market. Approximately, 30 minutes later, she returned to the window and I waited on her. When I could not find her prescription in the will call bin, I asked [the Respondent] if he knew anything about her prescription, and he told me that it had no more refills per Count (sic) Market. I asked if we were waiting for a call back from the doctor, or if we had called the doctor, and he snapped at me, and told me that he had not had time to do that....Later that day, she returned to pick up her medication, and we still did not have it ready. [The Respondent] explained that he had called the doctor and had given them the information, but they (sic) had (sic) called back. This was the end of the discussion. He made no attempt to reach the customer at home when the doctor indicated they (sic) would call back later, he did not offer to try to make a follow up call to

[4] A California folder is a jacket that pharmacists use to wrap prescription forms for filing and to record prescription numbers on for identification, e.g., Rx #s 1-100.

[5] K Mart has a drug utilization and quality assurance program, which checks things such as dosing and allergies.

[6] Open bottles allow moisture inside, which can cause tablets to lose their potency before the expiration date.

the doctor or anything. . . . Additionally, he was placing bottles in the speed shelf[7] that did not belong there (without the scanner label), and I found a number of items that were placed on the shelves in front of the wrong scanner label, and in the wrong order. . . In reviewing the print-outs, I noted a number of prescriptions filled for drugs that we did not have in stock, so I began to try to match the actual prescriptions up to the print-out in an attempt to find what was actually dispensed. . . There were 10 prescriptions filled on the report for Roxicet 5/500, a drug that we do not even carry. I could on(sic) find 9 of the original prescriptions, all 9 of which were written for Percocet 5. When questioned [the Respondent] presumes he actually dispensed Roxicet 5/325[8] . . . Another prescription was filled in the computer for Roxicet Solution, another product that we do not stock. The original prescription was written for Percocet 5, and, again, [the Respondent] presumes he dispensed Roxicet 5/325 . . . There were also 4 prescriptions on the printout. . . 2 of which were filled for Oxycodone 5 mg (which we do not carry), and 2 for Oxycodone/APAP 5/500. Only 3 of the original prescriptions would be found, all of which were written for OxyIR 5[9] mg. . I then showed him the prescriptions and asked what he had dispensed, and he presumes that in all instances he dispensed the Oxycodone/APAP 5/500. . . I additionally found several examples of prescriptions that were filled under the incorrect patient's name and profile. . . On Thursday, since we were still missing 12 hardcopy prescriptions for CIIs

---

[7] This is a "fast mover" shelf where certain drugs which are dispensed in high volume are placed, rather than being kept on shelves under the alphabetical listing; only the drug labeled which matches the scanner label on this shelf should be placed there.

[8] If dispensing a different strength than the prescriber ordered, one should obtain and document authorization from the prescriber.

[9] This is immediate release Oxycodone, which the pharmacy did not carry.

. . . we were never able to locate the original prescriptions. I then began a CIII-CV inventory. While doing that, I came across a branded Tylenol #3 tablet in the bottle with the generic Tylenol #3.

## FINDINGS OF FACT

1. As set forth above, the Respondent demonstrated significant dispensing errors at K Mart, often involving controlled dangerous substances. The huge shortages of controlled dangerous substances evidenced at Heritage also present a potential risk to the public, especially given both the Respondent's history of drug abuse and the report that he has been self-medicating.

2. The above actions also constitute violations of the Pharmacy Practice Act, Md. Health Occ. Code Ann., tit. 12 (2000 Repl. Vol.). Specifically, the Respondent violated the following provision of § 12-313 of the Act:

> (20) Is professionally, physically, or mentally incompetent [;].

## CONCLUSIONS OF LAW

Based on the foregoing, the Board finds that the public health, safety or welfare imperatively requires emergency action, pursuant to Md. St. Gov't Code Ann. §10-226(c)(2) (1999 Repl. Vol.).

## ORDER

Based on the foregoing, it is therefore this 27 day of **April**, 2001, by a unanimous vote of a quorum of the State Board of Pharmacy, by authority granted by the Board by Md. St. Gov't Code Ann. §10-226(c)(2) (1999 Repl. Vol.), the license held by the Respondent to practice pharmacy in Maryland, License No. 11115, is hereby **SUMMARILY SUSPENDED;** and be it further

**ORDERED**, that upon the Board's receipt of a written request from the Respondent, a Show Cause Hearing shall be scheduled within thirty days of said request, at which time the Respondent will be given an opportunity to be heard as to whether the Summary Suspension should be lifted/terminated, regarding the Respondent's fitness to practice pharmacy and the danger to the public; and be it further

**ORDERED**, that the Respondent shall immediately turn over to the Board his wall certificate and wallet-sized license to practice pharmacy issued by the Board; and be it further

**ORDERED,** that this document constitutes a final Order of the Board and is therefore a public document for purposes of public disclosure, as required by Md. State Gov't Code Ann. §10-617(h) (1999 Repl. Vol.).

Stanton G. Ades, P.D., President
Board of Pharmacy

## NOTICE OF HEARING

A Show Cause hearing to determine whether the Summary Suspension shall be lifted/terminated will be held before the Board at 4201 Patterson Avenue, Baltimore, 21215 following a written request by the Respondent for same.