

October 28, 2021

KIMBERLY TROUPE
9601 WILD HORSE RD
MCLOUTH, KS 66054

RE: Case No. 21-114

Dear Ms. Troupe:

Enclosed you will find a Summary Order issued by the Kansas Board of Pharmacy (Board) in the above-referenced matter. Please read the order in its entirety. In addition, a civil fine has been assessed totaling \$500. Please submit a check or money order made payable to the Kansas Board of Pharmacy and include your case number in the check memo.

If you disagree with the findings of fact, you have the right to request a hearing. Instructions for filing a written request are included under the "Notices" section of the order. Hearings are held before the full Board during their regularly scheduled quarterly meetings.

According to KSA 65-1627h, the Board is required to recoup the costs of administrative hearings when the decision is adverse to the licensee. These costs may include charges for services rendered by the Board's disciplinary counsel, an administrative law judge, and, if applicable, a court reporter.

In addition to the Summary Order and fine, the Board has determined that additional cautions should be noted and instructed the investigator to issue the enclosed warning letter.

If you have any questions, feel free to contact the Board at Pharmacy.Compliance@ks.gov.

Sincerely,

Kansas Board of Pharmacy

Enclosure



800 SW Jackson St., Suite 1414
Topeka, KS 66612

Phone: (785) 296-4056
Fax: (785) 296-8420
pharmacy@ks.gov
www.pharmacy.ks.gov

Alexandra Blasi, Executive Secretary

Laura Kelly, Governor

Kimberly Troupe, RPh
F.W. Huston Pharmacy
509 Delaware St.
Oskaloosa, Kansas 66066

July 23, 2021

Dear Ms. Troupe,

On 8/1/2019, you dispensed a prescription with the wrong directions for Mila Schwinn, DOB, 2/27/2019. I wrote an investigation report based on your Incident Report, CQI, and the consumer's complaint. At a Board of Pharmacy Investigative Committee Meeting this week, the Investigative Member of the Kansas Board of Pharmacy reviewed my report and the consumer complaint. The Board Member was concerned about the error and **cited deficiencies** in your Incident Report and CQI. The Board Member requested I write you a warning letter expressing their concerns. I have listed the two regulations below and you can see you did not meet **all** requirements. Because this was a knowledge error by your pharmacy technician, I encourage you to review and update your technician training especially in calculations.

Regulation 68-7- 12b Incident Reports

(c) As soon as possible after discovery, the pharmacist shall prepare a report containing the following information:

- (1) The name, address, age, and phone number of any complainant.
- (2) The name of each pharmacy employee and the license number of each licensee involved.
- (3) The date of the incident and date of the report.
- (4) A pharmacist's description of the incident.
- (5) The prescriber's name and whether the prescriber was contacted.
- (6) The signatures of all pharmacy employees involved.

Regulation 68-19-1 Continuous Quality Improvement Program (CQI).

- (1) Review all incident reports since the last quarterly meeting.
- (2) For each incident report reviewed, establish the steps to be taken to prevent a recurrence of the incident.
- (3) Review each Board newsletter published since last quarterly meeting.
- (4) Create a report of the meeting including the following information.
 - (A) A list of persons in attendance.
 - (B) A list of incident reports and newsletters reviewed.
 - (C) A description of the steps to be taken to prevent recurrence of each incident.

I would like to bring your attention to some similarities about this complaint C-5942 and a complaint C-5314 filed on 4/1/2020 by Joann and Ken Willits concerning your pharmacy. Sarah Schwinn, stated on August 22, 2019, she called the pharmacy and reported the error to the tech. The tech replied I will let my pharmacist know. Ms. Schwinn reported she never received a call back as of August 30, 2019. The crux of the complaint C-5314 dated 4/1/2020 and filed by Joann and Ken Willits was miscommunication and no communications.

Continued

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Referring to complaint C-5942, Ms. Schwinn stated she did speak to you in September 2019 about the error and you were not apologetic, and you said, "mistakes happen". That is not what a mother of a 6-month-old baby that had just received a large overdose of a drug wants to hear. Being apologetic about the error and steps you have taken to improve your pharmacy practice often prevents someone from filing a complaint.

I know you do a good job of managing F.W Huston Pharmacy by providing much needed pharmaceutical services in Oskaloosa and the surrounding area.

These complaints reflect on your responsibility as pharmacist-in-charge to develop, supervise, and coordinate all pharmaceutical services carried on within the pharmacy. I hope you use these incidents as a reminder to continually review your policies and procedures and look for ways to improve your pharmacy practice and that of your pharmacy staff.

Thanks for your assistance in this matter,



James Kinderknecht
Pharmacy Inspector

BEFORE THE KANSAS BOARD OF PHARMACY

In the Matter of)
)
Kimberly Troupe)
)
License No. 1-12502)

Case No. 21-114

SUMMARY ORDER

NOW, on this 28th day of October 2021, comes before the Kansas Board of Pharmacy (the “Board”), through its Executive Secretary, the matter of Kimberly Troupe (“Respondent”).

Pursuant to the authority granted to the Board by the Kansas Pharmacy Act, K.S.A. 65-1625, *et seq.*, and in accordance with the Kansas Administrative Procedure Act, K.S.A. 77-501, *et seq.*, the Board’s Executive Secretary enters this Summary Order in the above-captioned matter. After reviewing the investigation materials and being otherwise duly advised in the premises, the Board makes the following findings, conclusions and order:

FINDINGS OF FACT

1. The Board has previously issued Respondent License No. 1-12502 which entitles Respondent to practice as a pharmacist in the State of Kansas.
2. On June 7, 2021, the Board received a complaint from a member of the public (“the Complainant”) alleging that a prescription (“the Prescription”), dispensed at Respondent’s place of work (“the Pharmacy”) and subsequently received by the Complainant, had contained a labeling error (“the Error”) concerning its directions for use.
3. Subsequently, the Board’s Inspector investigated the allegation.
4. On June 24, 2021, the Board’s Inspector submitted a summary of findings which included the following:

- Respondent was recorded as the pharmacist that conducted the final verification of the Prescription.
 - The Complainant was found to have subsequently received the Prescription.
 - The Prescription was found to have been subsequently administered as labeled.
 - The Error was found to have been subsequently discovered by a nurse corresponding with the Complainant about the Prescription.
 - The Prescription was found to have been mislabeled in the Pharmacy, with the labeling Error written as 2.5ml doses instead of the ½ cc doses originally directed by the prescriber.
5. The Board's records list Respondent as the Pharmacy's Pharmacist-in-Charge.

CONCLUSIONS OF LAW

1. Pursuant to K.S.A. 65-1658, the Board may assess a civil fine not to exceed \$5,000, after notice and an opportunity to be heard, to any registrant for violation of the Pharmacy Act of the State of Kansas or any other rules or regulations of the State Board of Pharmacy.

2. Pursuant to K.S.A. 65-1637(g), all prescriptions shall be filled or refilled in strict conformity with any directions of the prescriber.

3. Pursuant to K.S.A. 65-1626(n), the responsible pharmacist shall observe and direct the activities of a pharmacy student or pharmacy technician to a sufficient degree to assure that all such activities are performed accurately, safely and without risk or harm to patients, and complete the final check before dispensing.

4. Respondent's failure to ensure accuracy during her final verification of the Prescription's conformity with the prescriber's directions before dispensing is a violation of K.S.A. 65-1637(g) and K.S.A. 65-1626(n). Respondent was ultimately responsible for this labeling Error,

which carried the risk of harm to a patient, and is basis to assess a fine to Respondent per K.S.A. 65-1658.

ORDER

Based upon the foregoing findings of fact and conclusions of law, Respondent is ordered to **pay a fine of \$500** to the Board for the violation. Respondent has 30 days from the date of this order to pay the total \$500.

NOTICES

The Respondent is hereby notified as follows:

1. The Respondent may request a hearing pursuant to the Kansas Administrative Procedure Act by filing a written request with the Kansas Board of Pharmacy, 800 SW Jackson, Suite 1414, Topeka, KS 66612-1231 within fifteen (15) days after service of this order.

2. If a hearing is not requested as described above, the Order shall become a final order of the Board, effective upon the expiration of the time to request a hearing.

3. Within fifteen (15) days after entry of a final agency order, either party may file a petition for reconsideration pursuant to K.S.A. 77-529.

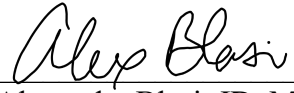
4. Within the time limits established in K.S.A. 77-613, either party may seek judicial review of a final agency order, pursuant to said statute. The agency officer designated to receive service of a petition for judicial review is:

Alexandra Blasi
Executive Secretary
Kansas Board of Pharmacy
800 SW Jackson, Suite 1414
Topeka, KS 66612

IT IS SO ORDERED.

10/28/2021

Date



Alexandra Blasi, JD, MBA
Executive Secretary
Kansas Board of Pharmacy

CERTIFICATE OF SERVICE

I hereby certify that I did, on the 28th day of October 2021, deposit in business mail a copy of the foregoing Summary Order, which is then placed in the United States Mail, postage prepaid, properly addressed to the following:

KIMBERLY TROUPE
9601 WILD HORSE RD
MCLOUTH, KS 66054



Kansas Board of Pharmacy Staff