WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

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STATE OF WISCONSIN
BEFORE THE PHARMACY EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
KARI L. SEELIG, R.PH., RESPONDENT.	:	ORDER 0007112

Division of Legal Services and Compliance Case Nos. 19 PHM 284 and 20 PHM 009

The parties to this action for the purpose of Wis. Stat. § 227.53 are:

Kari L. Seelig, R.Ph.
Cameron, WI 54822

Wisconsin Pharmacy Examining Board
P.O. Box 8366
Madison, WI 53708-8366

Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 7190
Madison, WI 53707-7190

The parties in these matters agree to the terms and conditions of the attached Stipulation as the final disposition of these matters, subject to the approval of the Pharmacy Examining Board (Board). The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. Respondent Kari L. Seelig, R.Ph., (DOB: XX/XX/1959) is licensed in the state of Wisconsin to practice pharmacy, having license number 12253-40, first issued on January 17, 1995, and current through May 31, 2022. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is located in Cameron, Wisconsin 54822.

2. At all times relevant to this proceeding, Respondent was employed as the managing pharmacist at a pharmacy (Pharmacy), located in Barron, Wisconsin. As managing pharmacist, Respondent is responsible for the professional operations of the Pharmacy.

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3. On November 6, 2019, the Division of Legal Services and Compliance (Division) received a complaint from Doctor A alleging that the Pharmacy had been filling prescriptions for tramadol for her patient, Patient B, without a valid prescription.

4. The last prescription (prescription number 4002720) Doctor A provided to Patient B for tramadol was on July 23, 2019, with zero (0) refills. The Pharmacy dispensed the prescription to Patient B on July 23, 2019.

5. Pharmacy dispensed tramadol to Patient B on August 20, 2019, September 12, 2019, and October 8, 2019, under Doctor A's name, using prescription number 4002720, even though the prescription was not refillable.

6. Respondent provided a response to the Division regarding the allegations as follows:

a. On July 23, 2019, a technician renewed prescription number 4002720 allowing the auto-populate feature to enter incorrect refill information belonging to a January 4, 2019 prescription for Patient B. The technician did not verify that the correct information was entered.

b. Patient B had a previous prescription for tramadol on file with the Pharmacy, number 4001882, which was written on January 4, 2019, for 168 tabs plus five (5) additional refills. This was the prescription that the technician incorrectly allowed to auto-populate into the July 23, 2019 prescription.

c. Respondent was responsible for verifying and dispensing the unauthorized refills of prescription number 4002720 that occurred on August 21, 2019 and September 12, 2019.

d. While gathering information to respond to this complaint, Respondent discovered that the submission to the Prescription Drug Monitoring Program (PDMP) for the January 4, 2019 prescription (number 4001882) contained the wrong prescribing doctor's name. Respondent accepted responsibility for the incorrect entry into PDMP and corrected the erroneous information in PDMP.

e. Respondent admitted that renewing off of a prior prescription was a process meant to save time and that using the auto-populate feature was not a specific policy but was a voluntary action. However, since this incident, Respondent is now aware of the potential errors associated with auto-populating and going forward, Respondent instructed Pharmacy staff to manually input all information on controlled substance prescriptions into Pharmacy's database system. Furthermore, Respondent instituted a manual check-off of the doctor, quantity, and number of refills to ensure accuracy.

f. Aside from the above error associated with the auto-populate feature, Respondent is unaware of any similar errors taking place at Pharmacy due to the use of the auto-populate feature.

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7. On January 9, 2020, the Department received a Medical Professional Liability Insurance Claim document (Claim) from the Office of the Commissioner of Insurance (OCI) which indicated that a claim had been paid by the insurance company of the Pharmacy for dispensing an incorrect medication to a 29-year old male patient (Patient C).

8. On April 26, 2019, Respondent dispensed mirtazapine (an anti-depressant), instead of Patient C's prescribed medication, meloxicam (an anti-inflammatory).

9. Patient C ingested the mirtazapine for an unknown number of days, unaware that he was dispensed the incorrect medication, which lead to an emergency department (ED) visit.

10. On May 3, 2019, Patient C presented to the hospital with complaints of dizziness. ED staff determined that the patient likely experienced an adverse drug reaction due to a medication error made at the Pharmacy. The ED stated that Patient C's prescription bottle dated April 26, 2019 for meloxicam 7.5mg actually contained mirtazapine 7.5mg.

11. Respondent provided a response to the Department regarding the allegations and stated the following:

    a. On April 26, 2019, Respondent mistakenly dispensed mirtazapine to Patient C instead of the medication listed on the prescription, meloxicam. Respondent was unaware of her error until she was contacted by ED on May 4, 2019.

    b. Respondent was the verifying and dispensing pharmacist concerning this matter.

    c. Respondent attempted to contact Patient C multiple times during the next two days but was unsuccessful until Patient C returned her call.

    d. Respondent relocated the mirtazapine to a different shelf and placed the medication in a shelf box specifically identifying the product.

    e. Pharmacy's policies and procedures regarding filling, verifying, and dispensing are clear and provide appropriate safeguards. Respondent's error as identified above was the result of personal negligence and not a failure of Pharmacy policies and procedures.

    f. Respondent reviewed and re-trained all staff on Pharmacy filling, verifying and dispensing policies.

12. In resolution of these matters, Respondent consents to the entry of the following Conclusions of Law and Order.

CONCLUSIONS OF LAW

1. The Wisconsin Pharmacy Examining Board has jurisdiction to act in this matter pursuant to Wis. Stat. § 450.10(1), and is authorized to enter into the attached Stipulation pursuant to Wis. Stat. § 227.44(5).

2. The managing pharmacist shall be responsible for the professional operations of the pharmacy pursuant to Wis. Stat. § 450.09(1)(a).

3. Pursuant to Wis. Stat. § 961.20(4)(e) and Wis. Admin. Code § CSB 2.36, tramadol is a schedule IV controlled substance and a monitored prescription drug.

4. Pursuant to Wis. Admin. Code §§ CSB 4.04(2) and 4.05(1), a dispenser of a monitored prescription drug shall compile the prescription number, quantity dispensed, practitioner's full name, and practitioner's DEA registration number, among other details, and submit such dispensing data to the PDMP. Implicit in these sections is that the data compiled is accurate.

5. By failing to accurately enter PDMP data as required by Wis. Admin. Code §§ CSB 4.04(2) and 4.05(1), Respondent engaged in unprofessional conduct via Wis. Stat. § 450.10(1)(a)2. by violating a state statute or rule substantially related to the practice of pharmacy.

6. By failing to accurately ensure that the technician read and interpreted a prescriber's directions for use for the purpose of accurately transferring the instructions to the prescription label, and by failing to make a final check on the accuracy and correctness of a prescription as required by Wis. Admin. Code § Phar 7.01(1)(b) and (d), Respondent engaged in unprofessional conduct via Wis. Stat. § 450.10(1)(a)2. by violating a state statute or rule substantially related to the practice of pharmacy.

7. By the conduct described in the Findings of Fact, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § Phar 10.03(2), by engaging in any pharmacy practice which constitutes a danger to the health, welfare, or safety of patient or public, including by not limited to, practicing in a manner which substantially departs from the standard of care ordinarily exercised by a pharmacist which harmed or could have harmed a patient.

8. As a result of the above violations, Respondent is subject to discipline and a forfeiture pursuant to Wis. Stat. §§ 450.10(1)(b)1. and 450.10(2).

ORDER

1. The attached Stipulation is accepted.

2. Respondent is REPRIMANDED.

3. The license to practice pharmacy issued to Respondent (license number 12253-40) is LIMITED as follows:

a. Within 120 days from the date of this Order, Respondent shall successfully complete twelve (12) hours of education on the topics of patient safety and medication errors, best practices for a managing pharmacist and/or pharmacist in charge, and pharmacist responsibilities in the dispensing and management of controlled substances. Such courses shall be offered by a provider pre-approved by the Board's monitoring liaison, including taking and passing any exam offered for the courses.

b. Respondent shall submit proof of successful completion of the ordered education in the form of verification from the institution providing the education to the Department Monitor at the address stated below.

c. None of the education completed pursuant to this requirement may be used to satisfy any continuing education requirements that have been or may be instituted by the Board or Department, and also may not be used in future attempts to upgrade a credential in Wisconsin.

d. This limitation shall be removed from Respondent's license after satisfying the Board or its designee that Respondent has successfully completed all of the ordered education.

e. The Board's monitoring liaison may change the number of credit hours and/or education topics in response to a request from Respondent. The monitoring liaison may consider the topic availability and/or hours of education when determining if a change to the ordered education should occur.

4. Within ninety (90) days from the date of this Order, Respondent shall pay a FORFEITURE in this matter in the amount of $500.00.

5. Within ninety (90) days from the date of this Order, Respondent shall pay COSTS of this matter in the amount of $1,115.00.

6. Payment of costs (made payable to the Wisconsin Department of Safety and Professional Services) shall be sent by Respondent to the Department Monitor at the address below:

Department Monitor
Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 7190, Madison, WI 53707-7190
Telephone (608) 267-3817; Fax (608) 266-2264
DSPSMonitoring@wisconsin.gov

Respondent may also submit this information online via the Department's Monitoring Case Management System at

https://dspsmonitoring.wi.gov

7. In the event that Respondent violates any term of this Order, Respondent's license (no. 12253-40) to practice pharmacy in the state of Wisconsin may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of the Order. The Board may, in addition and/or in the alternative refer any violation of this Order to the Division of Legal Services and Compliance for further investigation and action.

8. This Order is effective on the date of its signing.

WISCONSIN PHARMACY EXAMINING BOARD

by: Philip Trapskin C.P. 12/3/2020

A Member of the Board Date

STATE OF WISCONSIN
BEFORE THE PHARMACY EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	STIPULATION
KARI L. SEELIG, R.PH., RESPONDENT.	:	ORDER 0007112

Division of Legal Services and Compliance Case Nos. 19 PHM 284 and 20 PHM 009

Respondent Kari L. Seelig, R.Ph., and the Division of Legal Services and Compliance, Department of Safety and Professional Services stipulate as follows:

1. This Stipulation is entered into as a result of a pending investigation by the Division of Legal Services and Compliance. Respondent consents to the resolution of this investigation by Stipulation.

2. Respondent understands that by signing this Stipulation, Respondent voluntarily and knowingly waives the following rights:

- the right to a hearing on the allegations against Respondent, at which time the State has the burden of proving those allegations by a preponderance of the evidence;
- the right to confront and cross-examine the witnesses against Respondent;
- the right to call witnesses on Respondent's behalf and to compel their attendance by subpoena;
- the right to testify on Respondent's own behalf;
- the right to file objections to any proposed decision and to present briefs or oral arguments to the officials who are to render the final decision;
- the right to petition for rehearing; and
- all other applicable rights afforded to Respondent under the United States Constitution, the Wisconsin Constitution, the Wisconsin Statutes, the Wisconsin Administrative Code, and other provisions of state or federal law.

3. Respondent is aware of Respondent's right to seek legal representation and has been provided an opportunity to obtain legal counsel before signing this Stipulation.

4. Respondent agrees to the adoption of the attached Final Decision and Order by the Wisconsin Pharmacy Examining (Board). The parties to the Stipulation consent to the entry of the attached Final Decision and Order without further notice, pleading, appearance or consent of the parties. Respondent waives all rights to any appeal of the Board's order, if adopted in the form as attached.

5. If the terms of this Stipulation are not acceptable to the Board, the parties shall not be bound by the contents of this Stipulation, and the matter shall then be returned to the Division

of Legal Services and Compliance for further proceedings. In the event that the Stipulation is not accepted by the Board, the parties agree not to contend that the Board has been prejudiced or biased in any manner by the consideration of this attempted resolution.

6. The parties to this Stipulation agree that the attorney or other agent for the Division of Legal Services and Compliance and any member of the Board ever assigned as an advisor in this investigation may appear before the Board in open or closed session, without the presence of Respondent, for purposes of speaking in support of this agreement and answering questions that any member of the Board may have in connection with deliberations on the Stipulation. Additionally, any such advisor may vote on whether the Board should accept this Stipulation and issue the attached Final Decision and Order.

7. Respondent is informed that should the Board adopt this Stipulation, the Board's Final Decision and Order is a public record and will be published in accordance with standard Department procedure.

8. The Division of Legal Services and Compliance joins Respondent in recommending the Board adopt this Stipulation and issue the attached Final Decision and Order.

Kari L. Seelig

Kari L. Seelig, R.Ph., Respondent
Cameron, WI 54822
License no. 12253-40

10-26-20
Date

Gretchen Mrozinski

Gretchen Mrozinski, Attorney
Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53707-7190

11/2/2020
Date