STATE OF VERMONT
SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF PHARMACY

IN RE:	**) Docket Nos.**
Walgreen Company and	**) 2022-___**
Walgreens Stores:	**)**
#11526 (Farrell St) Lic. No. 038.0074574	**) 2022-___, 2022-___**
#01756, License No. 038.0003345	**) 2022-___, 2022-___**
#07270, License No. 038.0003340	**) 2022-___, 2022-___, 2022-___, 2022-___, 2022-___**
#17183, License No. 038.0134028	**) 2022-___, 2022-___**
#17185, License No. 038.0134018	**) 2022-___, 2022-___, 2022-___, 2022-___**
#17379, License No. 038.0134037	**) 2022-___, 2022-___, 2022-___, 2022-___, 2022-___,) 2022-___**
#17447, License No. 038.0134025	**) [no specific docket no.]**
#17471, License No. 038.0134042	**) 2022-___, 2022-___, 2022-___, 2022-___, 2022-___,) 2022-___, 2022-___**
#17475, License No. 038.0134027	**) [no specific docket no.]**
#17485, License No. 038.0134026	**) [no specific docket no.]**
#17518, License No. 038.0134012	**) 2022-___, 2022-___**
#17596, License No. 038.0134041	**) 2022-___**
#17625, License No. 038.0134019	**) 2022-___, 2022-___, 2022-___**
#17631, License No. 038.0134023	**) 2022-___**
#17713, License No. 038.0134021	**) 2022-___**
#17747, License No. 038.0134013	**) [no specific docket no.]**
#17749, License No. 038.0134030	**) 2022-___, 2022-___**
#18020, License No. 038.0134036	**) 2022-___, 2022-___, 2022-___, 2022-___, 2022-___,) 2022-___, 2022-___**
#18043, License No. 038.0134020	**) [no specific docket no.]**
#18090, License No. 038.0134017	**) 2022-___, 2022-___, 2022-___, 2022-___**
#18265, License No. 038.0134015	**) 2022-___**
#18278, License No. 038.0134031	**) 2022-___**
#18325, License No. 038.0134033	**) 2022-___**
#18354, License No. 038.0134038	**) [no specific docket no.]**
#18375, License No. 038.0134016	**) [no specific docket no.]**
#18418, License No. 038.0134034	**) 2022-___, 2022-___, 2022-___, 2022-___, 2022-___,) 2022-___, 2022-___, 2022-___**
#18977, License No. 038.0134013	**) 2022-___, 2022-___**
#19233, License No. 038.0134022	**) 2022-___, 2022-___, 2022-___, 2022-___**
#19346, License No. 038.0134029	**) [no specific docket no.]**
#19449, License No. 038.0134024	**) [no specific docket no.]**
#19570, License No. 038.0134040	**) [no specific docket no.]**
#19795, License No. 038.0134032	**) 2022-___, 2022-___, 2022-___**

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following charges against Respondent Walgreen Company and the specific Walgreens Store locations identified above by store number and license number:

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Board Authority

1. The Vermont State Board of Pharmacy (the "Board") has authority to issue warnings or reprimands; suspend, revoke, limit, or condition current licenses; or prevent the renewal of lapsed licenses if, after disciplinary hearing, the Board finds that Respondents have engaged in unprofessional conduct. 3 V.S.A. §§ 129, 129a; 3 V.S.A. § 814; 26 V.S.A. Chapter 36; the Administrative Rules of the Vermont Board of Pharmacy ("BOP Rules"); and the Administrative Rules of the Office of Professional Regulation ("OPR Rules").

Statement of Facts

I. Introduction

2. Walgreen Company ("Respondent Corporation"), a subsidiary of Walgreens Boots Alliance, is the corporate owner of retail pharmacies in forty-nine of the fifty United States and is headquartered in Deerfield, Illinois. Respondent Corporation has the second-largest pharmacy store chain in the United States.

3. On October 14, 2021, Walgreens Boots Alliance reported highlights of its fourth quarter and fiscal year financial performance:
"Fourth quarter sales from continuing operations increased 12.8 percent year-over-year, to $34.3 billion, up 11.8 percent on a constant currency basis" and
"Fiscal 2021 sales from continuing operations increased 8.6 percent to $132.5 billion, up 7.5 percent on a constant currency basis."[1]

4. On October 14, 2021, Walgreens also reported additional highlights of its financial news: "Net cash provided by operating activities in fiscal 2021 was $5.6 billion, an increase of $70 million compared with fiscal 2020; Free cash flow was $4.2 billion, up $65 million year-over-year."[2]

5. Respondent Corporation owns and operates the largest number of instate retail pharmacies in the State of Vermont, with thirty-two Walgreens locations ("Respondent Stores").

6. The following thirty-two Walgreens locations are actively licensed by the State of Vermont as Instate Pharmacies with licenses that expire on July 31, 2023:

Walgreens Eastern Co, Inc. dba Walgreens #11526, License No. 038.0074574, Farrell St, Burlington
Walgreens Eastern Co, Inc. dba Walgreens #17379, License No. 038.0134037, Wilmington
Walgreens Eastern Co, Inc. dba Walgreens #17475, License No. 038.0134027, Williston
Walgreens Eastern Co, Inc. dba Walgreens #17518, License No. 038.0134012, Barre
Walgreens Eastern Co, Inc. dba Walgreens #17596, License No. 038.0134041, Montpelier

[1] (2021, October 14) *Walgreens Boots Alliance Reports Fiscal Year 2021 Earnings.* https://s1.q4cdn.com/343380161/files/doc_news/Walgreens-Boots-Alliance-Reports-Fiscal-Year-2021-Earnings-2021.pdf

[2] *Id.*

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Walgreens Eastern Co, Inc. dba Walgreens #18020, License No. 038.0134036, Manchester Cntr
Walgreens Eastern Co, Inc. dba Walgreens #18043, License No. 038.0134020, Bristol
Walgreens Eastern Co, Inc. dba Walgreens #18090, License No. 038.0134017, St. Johnsbury
Walgreens Eastern Co, Inc. dba Walgreens #18265, License No. 038.0134015, Brandon
Walgreens Eastern Co, Inc. dba Walgreens #18278, License No. 038.0134031, West Rutland
Walgreens Eastern Co, Inc. dba Walgreens #18325, License No. 038.0134033, Shelburne
Walgreens Eastern Co, Inc. dba Walgreens #18375, License No. 038.0134016, Middlebury
Walgreens Eastern Co, Inc. dba Walgreens #19233, License No. 038.0134022, Bellows Falls
Walgreens Eastern Co, Inc. dba Walgreens #19449, License No. 038.0134024, Cherry St., Burlington
Walgreens Eastern Co, Inc. dba Walgreens #19570, License No. 038.0134040, North Ave, Burlington
Walgreens Pharmacy #01756, License No. 038.0003345, Rutland
Walgreens Pharmacy #07270, License No. 038.0003340, Canal St., Brattleboro
Walgreens #17183, License No. 038.0134028, Colchester
Walgreens #17185, License No. 038.0134018, Hardwick
Walgreens #17447, License No. 038.0134025, South Burlington
Walgreens #17471, License No. 038.0134042, Susie Wilson Rd, Essex Junction
Walgreens #17485, License No. 038.0134026, Winooski
Walgreens #17625, License No. 038.0134019, Lyndonville
Walgreens #17631, License No. 038.0134023, Bennington
Walgreens #17713, License No. 038.0134021, Newport
Walgreens #17747, License No. 038.0134013, Milton
Walgreens #17749, License No. 038.0134030, Pearl St, Essex Junction
Walgreens #18354, License No. 038.0134038, Fair Haven
Walgreens #18418, License No. 038.0134034, Putney Rd., Brattleboro
Walgreens #18977, License No. 038.0134013, Morrisville
Walgreens #19346, License No. 038.0134029, Enosburg Falls
Walgreens #19795, License No. 038.0134032, St. Albans

7. Respondent Corporation's retail pharmacies account for over 25% of all Vermont-licensed instate retail pharmacies.

8. Respondent Corporation's instate pharmacies constitute a chain under Vermont law. *See* 26 V.S.A. § 2053(b).

9. The Vermont Legislature, OPR and the Vermont Board of Pharmacy have enacted statutes and rules governing retail pharmacies to promote, preserve, and protect the health, safety, and welfare of the public by ensuring that retail pharmacies operate safely.

10. In Vermont, the Board of Pharmacy may impose disciplinary sanctions against all drug outlets in a retail pharmacy chain if: unprofessional conduct has occurred at one or more drug outlets; unprofessional conduct is attributable to corporate policies, practices, systems, or procedures; and sanctions are appropriate to protect the public.

II. Overview

11. In 2020, 2021, and 2022, Respondent Corporation's instate retail pharmacies experienced significant staffing shortages resulting in unanticipated store closures throughout the store locations in Vermont and unsafe pharmacy conditions.

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12. The structure of Respondent Corporation as it relates to management of local stores is that at each Walgreens location, pharmacy staff is made up of a pharmacist-manager, staff pharmacists, floater pharmacists and pharmacy technicians. The Retail Store Manager, who may or may not have pharmacy credentials or experience, oversees the pharmacist-manager and other pharmacy staff. District Managers and the Area Health Care Supervisor supervise the Store Managers and oversee pharmacy operations at various store locations.

13. In 2021 and 2022, Respondent Corporation operated multiple Walgreens retail pharmacies in Vermont without the required Pharmacist-Manager, contrary to Vermont law.

14. A substantial cause of reported patient safety issues at Vermont Walgreens locations is insufficient staffing for the pharmacy workload, which includes filling prescriptions, verifications, patient consultations, administering vaccinations, conducting Covid tests, ordering medications, conducting perpetual and controlled substance inventories, and maintaining the pharmacy in good working order.

15. In 2021 and 2022, Respondent Corporation utilized an online vaccine scheduler, which enabled patients to schedule vaccine appointments at Vermont Walgreens locations at time intervals designated by Respondent Corporation without regard for or consideration of available staffing at the specific store on a certain date.

16. Pharmacy staff working in Vermont Walgreens locations had no ability to disable the online vaccine scheduler for their respective locations when pharmacy staff was limited or when the volume of pharmacy work was unmanageable for the available staff.

17. Lack of adequate pharmacy staff resulted in over three hundred and twenty-five days in which unexpected and unscheduled Walgreens retail pharmacy closures occurred throughout the State between July 2020 and April 2022, leaving thousands of patients without access to prescription medications.[3]

18. The Walgreens computer system continues to process and bill prescriptions and refills even when a store location is closed unexpectedly.

19. Once Walgreens processes and bills a prescription to a patient's insurance or Medicaid, the patient cannot fill the prescription at an external pharmacy unless Walgreens reverses the billing or the patient pays out-of-pocket, even when the patient cannot retrieve the filled prescription due to an unexpected Walgreens pharmacy closure.

20. Prior to February 2022, most pharmacy staff at Vermont Walgreens locations had not been trained or did not know how to reverse the billing for prescriptions in Respondent Corporation's computer system.

[3] The store closures identified in this document do not include late store openings or early closures.

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21. On numerous occasions during OPR's investigations, the Area Supervisor for Respondent Corporation informed investigators that Walgreens had a "centralized fill" process called PHLEX, which the pharmacy staff at a particular location could activate to help reduce the onsite workload during busy times.

22. In 2022, an interview with a different employee of Respondent Corporation clarified that PHLEX was not a "centralized fill" service and that central fill was not an available tool in Vermont Walgreens locations.

23. PHLEX is a service in which two steps from the in-store pharmacy prescription filling process, namely the typing of the prescriptions and the verification that prescriptions are typed into the system correctly, are conducted at an off-site location. However, when a Vermont store implements this off-site assistance, it is only for one hour at a time and then the pharmacist must go back into the system and request the off-site service again for the service to remain active.

24. During the relevant time, unprofessional conduct occurred at multiple Walgreens retail locations in Vermont on multiple occasions.

25. Unprofessional conduct that occurred at Walgreens locations in Vermont during the relevant time was attributable in part to the policies, procedures, systems, or practices of Respondent Corporation.

III. Unexpected Pharmacy Closures Without Notice to Patients[4]

A. Unexpected Store Closures in 2020

26. In July 2020, the following Walgreens pharmacies were closed unexpectedly and without notice to patients:
July 17, 18, 19, 2020 – Store #17631 (Bennington),
July 18-19, 2020 – Store #18265 (Brandon),
July 18-19, 2020 – Store #17185 (Hardwick),
July 18-19, 2020 – Store #17625 (Lyndonville),
July 18-19, 2020 – Store #18278 (West Rutland),
July 19, 2020 – Store #18977 (Morrisville),
July 24, 2020 - Store #17185 (Hardwick),
July 25, 2020 – Store #18977 (Morrisville),
July 25, 2020 - Store #11526 (Farrell St., Burlington),
July 26, 2020 – Store #18278 (West Rutland),
July 26, 2020 - Store #17625 (Lyndonville).
Respondent Corporation did notify OPR of these closures.

27. Immediately preceding the closures in July 2020, Respondent Corporation laid off eleven pharmacists in Vermont. However, Respondent Corporation has refused to identify how many pharmacists were laid off and the dates those layoffs occurred.

[4] Due to the volume of complaints and closures continuing on an ongoing basis, there have been more store closings than those identified in this document.

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B. Unexpected Store Closures in 2021 and 2022

Manchester Center, Store #18020

28. From September 4, 2021 through September 9, 2021, Store #18020 in Manchester Center was closed unexpectedly. A sign posted on the storefront indicated the store's server was down, the store was "closed until further notice," and customers should call the Bennington or Rutland locations, both of which are over 30 miles away.

29. When Store #18020 was reopened in September 2021, ostensibly because the computer issue had been resolved, all patient prescriptions in the "will call" category were changed in the system to a status that indicated the prescriptions had been delivered.

30. This systemic malfunction created further delay for patients who were attempting to obtain their prescriptions at other pharmacies.

31. On September 14, 2021, Store #18020 closed unexpectedly due to a fire.

32. Respondent Corporation failed to notify the Board of Pharmacy of this unplanned and indefinite closing within 48 hours.

33. Respondent Corporation failed to notify the general public of the intent of the licensee and the future location of prescription files by advertising in a newspaper with a general circulation in the area served.

34. During Store #18020's extended closure, Respondent Corporation did not deactivate the automatic processing for patient refills or new prescriptions for existing patients.

35. Respondent Corporation's computer system continued to automatically process insurance billing for medication prescriptions the store could not fill and dispense to patients because it was closed; thus patients did not have access to medications for which their insurance was billed by Walgreens.

36. The automatic processing/billing for Store #18020, which Respondent Corporation did not deactivate or address systemically, created significant barriers for patients to get their medications elsewhere, including patients having to pay out-of-pocket and patients not being able to get their controlled drug prescriptions since they appeared to have been filled.

37. Some patients of Store #18020 went without prescription medications for periods of time for significant medical conditions such as heart and thyroid issues.

38. Patients including G.H., R.H., J.R., J.F., L.G., W.R., A.C., S.K., T.C., A.T., D.S., D.P., C.T., L.K. all experienced delay in receiving their prescription medications due to the unanticipated closure of Store #18020 and the continued automatic processing of their prescriptions during the closure.

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39. Pharmacist D.H. from the other local pharmacy in Manchester Center contacted Respondent Corporation on two occasions by phone on October 20, 2021 and approximately a week later requesting that Respondent Corporation stop the automatic processing of patient prescriptions during the indefinite store closure.

40. After speaking to various individuals from Respondent Corporation asking for the automatic processing for Store #18020 to be stopped, Pharmacist D.H. continued trying, unsuccessfully many times, to help Walgreens patients get their medications. Among the Patients were A.K., L.K., and R.W., whose prescription refills were all denied during the closure, even though the prescriptions had not been dispensed and were not available to the patients, because the Walgreens system had already processed and billed their refills.

41. On November 8, 2021, Respondent Corporation communicated with OPR stating that the Manchester Center Store had been closed since the fire, and Respondent Corporation desired to reopen the location week of November 15, 2021.

42. Respondent Corporation inquired whether notice of the closure had been provided to the Board of Pharmacy and whether any additional items were required prior to the re-opening of Store #18020.

43. Store #18020 reopened on December 11, 2021. Respondent Corporation did not notify the Board of Pharmacy of the store's re-opening on that date.

44. From Thursday January 6, 2022 through Saturday January 8, 2022, Store #18020 was closed unexpectedly. The sign posted on the door said: "Unfortunately Manchester Walgreens will be CLOSED until further notice. *for Rx needs please call Bennington…." The phone system on both days indicated the location was open.

45. From January 9 through 13, 2022, Store #18020 was closed unexpectedly, and the sign posted on the door said: "Unfortunately Manchester Walgreens will be closed until further notice. *for Rx needs call Rutland Pharmacy…."

Brattleboro, Stores #07270 (Canal Street) and #18418 (Putney Road)

46. On Wednesday, May 12, 2021, when a re-assigned pharmacist arrived to work for three days at Store #18418 (Putney Road, Brattleboro), the pharmacy was in a state of significant disorganization, with prescription vials and pills on the floor, two unlabeled vials on shelves with a variety of pills in them, cluttered counter space and generally unclean conditions.

47. In the mid-afternoon on Thursday, May 13, 2021, Respondent Corporation's District Manager directed the pharmacist to immediately close Store #18418.

48. Store #18418 was closed from the afternoon on Thursday, May 13, 2021 through Friday, May 14, 2021.

49. Store #18418 is normally closed on Saturdays and Sundays.

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50. Patients did not receive notification that Store #18418 would be closed on May 13 and 14, 2021.

51. Patients did not receive notice they would be unable to obtain their medications from Thursday 13, 2021 until Monday, May 17, 2021.

52. Store #18418 did not post signage to inform patients of how to obtain their medications during the unexpected and unscheduled store closure.

53. The Walgreens phone system did not advise patients that Store #18418 had closed unexpectedly or that the store would reopen on Monday, May 17, 2021. The phone system also did not advise patients of how to get their medications while the store was closed.

54. Patient L.N. missed multiple doses of his strict medication protocol for a tick-borne illness due to the unexpected closure of Store #18418 in May 2021.

55. Patient L.N. and his family member spent hours attempting to get L.N.'s medication, including calling Store #18418 multiple times, travelling to Store #18418 during normal store hours to find it closed, spending time on the phone with Walgreens to get the prescription filled at a different location, and travelling to a Walgreens in New Hampshire to retrieve the prescription.

56. The family of Patient R.T., a minor who takes two prescription medications each day, made numerous trips to Store #18418 on May 13 and 14, 2021 during normal business hours attempting to pick up a refill of R.T.'s medication.

57. Patient R.T.'s family, after communications with Respondent Corporation, was able to retrieve Patient R.T.'s medications on Saturday, May 15, 2021 at a different store location.

58. Patient D.K. was unable to retrieve prescribed antibiotics from Store #18418 on May 14, 2021.

59. Patient D.K. called Walgreens on May 14, 2021 and waited on the phone for over an hour before hanging up.

60. When Patient D.K. went to Store #18418 to retrieve antibiotics during normal business hours, he found the store closed, with no signage indicating where patients could get prescriptions.

61. Individual T.F. has a son ("Patient 1") with epilepsy and other medical conditions.

62. T.F. and T.F.'s spouse made numerous calls to Store #18418 on May 13 and 14, 2021 to refill Patient 1's epilepsy medication, which was running out.

63. The Respondent Corporation's phone system gave a "next in line" phone message to T.F.'s spouse, who waited on the phone for over forty minutes.

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64. When Store #18418 reopened on Monday, May 17, 2021, T.F. waited in a long line to retrieve Patient 1's medication. When T.F. arrived at the front of the line, pharmacy staff of Store #18418 informed T.F. they could not locate Patient 1's prescription. Eventually when staff located Patient 1's prescription, T.F. was informed the medication could be ready in half an hour to forty minutes.

65. Neither Respondent Corporation nor Store #18418 reported the closure of Store #18418 in May 2021 within 48 hours to the Board of Pharmacy.

66. On Monday, June 21, 2021, Store #18418 closed unexpectedly in the mid-afternoon during normal business hours and remained closed on Tuesday, June 22, 2021.

67. Patients did not receive notification that Store #18418 would be closed June 21 and 22, 2021.

68. Store #18418 did not post signage to inform patients of how to obtain their medications during the June 2021 store closure.

69. On the following dates in 2021 and 2022, Store #07270 (Canal Street, Brattleboro) was closed unexpectedly and without notice to patients:
May 29, 2021,
June 9, 2021,
June 12, 2021,
August 21, 2021,
August 22, 2021,
October 21, 2021,
January 10, 2022,
January 29, 2022,
February 1, 2022,
February 2, 2022.
This location is also closed regularly on Sundays.

70. On the following dates in 2021 and 2022, Store #18418 (Putney Road, Brattleboro) was closed unexpectedly and without notice to patients:
May 13, 2021,
May 14, 2021,
June 21, 2021,
June 22, 2021,
January 10, 2022,
January 11, 2022,
January 17, 2022,
January 27, 2022,
January 28, 2022,
February 1, 2022,
February 2, 2022,
February 3, 2022.
This location is also regularly closed on Saturdays and Sundays.

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71. During the May and June 2021 closures, Store #18418 did not post signage to inform patients of how to obtain their medications.

72. In May 2021, the Walgreens phone system did not advise patients that Store #18418 had closed unexpectedly or that the store would reopen on Monday, May 17, 2021. The phone system also did not advise patients of how to get their medications while the store was closed.

73. The closest Walgreens pharmacy to the Brattleboro stores is just over 30 miles away in Manchester Center, which also had unplanned closures in January 2022.

St. Albans, Store #19795

74. Store #19795 (St. Albans) was closed unexpectedly and without notice to patients on the following dates in 2021 and 2022:
September 4, 2021,
October 1, 2021,
October 3, 2021,
October 13, 2021,
October 23, 2021,
October 26, 2021,
October 30, 2021,
October 31, 2021,
November 4, 2021,
December 10, 2021,
December 14, 2021,
December 17, 2021,
December 24, 2021,
December 26, 2021,
December 28, 2021,
December 30, 2021,
January 13, 2022,
February 4, 2022,
February 10, 2022.

Essex, Stores #17471 (Susie Wilson Road) and #17749 (Pearl Street)

75. On the following dates in 2021 and 2022, Store #17471 (Susie Wilson Road, Essex Junction) was closed unexpectedly and without notice to patients:
April 25, 2021,
April 28, 2021,
October 14, 2021,
October 15, 2021,
December 13, 2021,
December 17, 2021,
December 18, 2021,
December 20, 2021,
December 21, 2021,

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December 26, 2021,
December 30, 2021,
December 31, 2021,
February 25, 2022.

76. On the following dates in 2021, Store #17749 (Pearl St., Essex Junction) was closed unexpectedly and without notice to patients:
May 20, 2021,
May 21, 2021,
May 22, 2021,
June 19, 2021,
November 11, 2021,
December 23, 2021.

Wilmington, Store #17379

77. In January 2021, Store #17379 (Wilmington) closed early and/or did not open at all for several days due to a lack of pharmacy staff.

78. In February 2021, Store #17379 was closed on two occasions during normal business hours without notice to patients.

79. Store #17379 was closed unexpectedly and without notice to patients on:
June 24, 2021,
October 15, 2021,
January 29, 2022.

Morrisville, Store #18977

80. On the following dates in 2021 and 2022, Store #18977 (Morrisville) was closed unexpectedly and without notice to patients:
May 6, 2021,
May 14, 2021,
May 15, 2021,
May 16, 2021,
May 22, 2021,
May 25, 2021,
September 9, 2021,
October 15, 2021,
December 21, 2021,
January 6, 2022,
January 13, 2022,
February 1, 2022,
February 2, 2022,
February 11, 2022.

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St. Johnsbury, Store #18090

81. On the following dates in 2021 and 2022, Store #18090 (St. Johnsbury) was closed unexpectedly and without notice to patients:
May 13, 2021,
October 20, 2021,
December 23, 2021,
December 24, 2021,
December 26, 2021,
December 30, 2021,
December 31, 2021,
January 1, 2022,
January 2, 2022,
January 6, 2022,
February 11, 2022,
February 14, 2022,
February 15, 2022,
February 16, 2022,
February 22, 2022,
February 25, 2022.

Colchester, Store #17183

82. On the following dates in 2021 and 2022, Store #17183 (Colchester) was closed unexpectedly and without notice to patients:
May 15, 2021,
May 18, 2021,
May 20, 2021,
October 21, 2021,
January 7, 2022.

Bellows Falls, Store #19233

83. On the following dates in 2021 and 2022, Store #19233 (Bellows Falls) was closed unexpectedly and without notice to patients:
May 16, 2021,
May 30, 2021,
August 21, 2021,
January 14, 2022,
May 19, 2022,
May 20, 2022
May 26, 2022,
May 27, 2022,
May 31, 2022,
June 9, 2022.

84. In May 2022, a Registered Nurse B.S. complained to OPR that the consecutive unexpected closures of Store #19233 in May 2022 had a significant impact on the

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patients who were prescribed suboxone because the prescriptions were only issued for a week at a time.

85. Some of the patients referenced by RN B.S. were unable to travel to the nearest Walgreens to retrieve their suboxone when the Bellows Falls location was closed unexpectedly.

86. For some patients, when Store #19233 had already billed their insurance for suboxone, Walgreens was unable to reverse the billing so that the patients could get their suboxone at a different pharmacy.

87. In May 2022, in at least separate three instances, patients were able to get their doctor's office to send a replacement suboxone prescription to another local pharmacy after Walgreens had already billed the patient's insurer but was closed when the patient needed to pick up the prescription. In those three instances, the patients were required to pay out-of-pocket to the non-Walgreens local pharmacy for their suboxone.

Burlington, Store #19449 (Cherry Street), #19570 (North Avenue) and Farrell Street (#11526)

88. On the following dates in 2021, Store #19449 (Cherry Street, Burlington) was closed unexpectedly and without notice to patients:
December 18, 2021,
December 19, 2021.

89. On the following dates in 2021 and 2022, Store #19570 (North Ave, Burlington) was closed unexpectedly and without notice to patients:
May 16, 2021,
May 25, 2021,
October 15, 2021,
February 25, 2022.

90. On the following dates in 2021 and 2022, Store #11526 (Farrell Street, Burlington) was closed unexpectedly and without notice to patients:
October 28, 2021,
December 21, 2021,
December 24, 2021,
January 7, 2022,
January 17, 2022,
February 24, 2022,
February 25, 2022.

Shelburne, Store #18325

91. On the following dates in 2021 and 2022, Store #18325 (Shelburne) was closed unexpectedly and without notice to patients:
May 17, 2021,

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May 18, 2021,
June 5, 2021,
June 27, 2021,
July 17, 2021,
November 2, 2021,
November 13, 2021,
December 26, 2021,
February 8, 2022.

92. When Store #18325 was closed on November 2, 2021, Respondent Corporation's online listing for Store #18325 indicated that the store would be open on November 2, 2021 from 9:00 a.m. to 7:00 p.m.

93. Multiple complaints were filed with OPR as the result of these closures because patients were unable to retrieve prescriptions and missed dosages of their medications, such as antibiotics and seizure medications.

Williston, Store #17475

94. On the following dates in 2021, Store #17475 (Williston) was closed unexpectedly and without notice to patients:
May 17, 2021,
November 17, 2021,
December 24, 2021.

Milton, Store #17747

95. On the following dates in 2021 and 2022, Store #17747 (Milton) was closed unexpectedly and without notice to patients:
July 16, 2021,
December 11, 2021,
December 12, 2021,
December 16, 2021,
January 13, 2022,
February 3, 2022,
February 22, 2022,
February 23, 2022,
February 24, 2022.

South Burlington, Store #17447

96. On the following dates in 2021, Store #17447 (South Burlington) was closed unexpectedly and without notice to patients:
August 3, 2021,
October 9, 2021,
December 16, 2021.

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Brandon, Store #18265

97. On the following dates in 2021 and 2022, Store #18265 (Brandon) was closed unexpectedly and without notice to patients:
August 3, 2021,
December 18, 2021,
December 23, 2021,
February 17, 2022,
February 18, 2022.

Lyndonville, Store #17625

98. On the following dates in 2021, Store #17625 (Lyndonville) was closed unexpectedly and without notice to patients:
October 10, 2021,
November 6, 2021,
November 7, 2021.

99. Between February 3, 2022 and April 15, 2022, the Lyndonville Pharmacy #17625 was closed thirty-two (32) times due to family leave for one pharmacist and the other pharmacist resigning.

100. On February 21, 2022, Patient P.M. went to Store #17625 to retrieve two prescription medications which she had confirmed, using the automated phone system the day prior, would be ready at that time.

101. On February 22, 2022, Patient P.M. called Store #17625 about picking up the same medications. Patient P.M. learned the pharmacy was closed and was transferred to the nearest open Walgreens in Hardwick, which was a forty-five-minute drive away.

102. On March 7, 2022, Patient L.H. went to Store #17625 after being told it would be open, but instead found it closed. L.H. was told by Walgreens staff she had to go to the St. Johnsbury location, a fifteen-minute drive away.

103. Patient L.H. also complained that Store #17625 often did not have any of the medication to fill her prescription or that the pharmacy did not have adequate amounts to completely fill the prescription.

104. The sign posted inside the Lyndonville Store in March 2022 stated (emphasis in original):

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ATTENTION CUSTOMERS

YOUR LYNDONVILLE WALGREENS PHARMACY WILL **ONLY** BE OPEN ON THE FOLLOWING DAYS FOR THE NEXT WEEKS DUE TO STAFFING LEVELS AVAILABLE. THIS SCHEDULE IS SUBJECT TO CHANGE. WE APOLIGIZE [SIC] FOR ANY INCOVENIENCE [SIC].
LYNDONVILLE LOCATION WILL BE OPEN:
MONDAY 3/7 9AM TO 7PM
FRIDAY 3/11 9AM TO 7PM

ST. JOHNSBURY LOCATION WILL BE OPEN:
WEDNESDAY 2/23 9AM TO 7PM
THURSDAY 2/24 9AM TO 7PM
MONDAY 2/28 9AM TO 7PM
WEDNESDAY 3/2 9AM TO 7PM
MONDAY 3/4 9AM TO 7PM
MONDAY 3/14 9AM TO 7PM.

105. The sign posted in the Lyndonville store did not state: where customers should go for prescriptions on the closed days; the closest non-Walgreens pharmacy; or phone numbers to contact Walgreens for assistance.

106. Respondent Corporation failed to provide the Board of Pharmacy and the general public through online or media advertisements with the same advance notice as indicated by the signage posted in the store.

Middlebury, Store #18375

107. On the following dates in 2021, Store #18375 (Middlebury) was closed unexpectedly and without notice to patients:
October 13, 2021,
October 30, 2021,
October 21, 2021.

Enosburg Falls, Store #19346

108. On the following dates in 2021 and 2022, Store #19346 (Enosburg Falls) was closed unexpectedly and without notice to patients:
October 30, 2021,
December 23, 2021,
January 6, 2022,
January 29, 2022,
February 3, 2022.

Winooski, Store #17485

109. On the following dates in 2021 and 2022, Store #17485 (Winooski) was closed unexpectedly and without notice to patients:
November 13, 2021,

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January 6, 2022,
February 3, 2022,
February 5, 2022.

Hardwick, Store #17185

110. On the following dates in 2021 and 2022, Store #17185 (Hardwick) was closed unexpectedly and without notice to patients:
December 10, 2021,
December 17, 2021,
December 24, 2021.
January 10, 2022,
January 13, 2022,
January 28, 2022,
February 25, 2022.

111. On February 25, 2022, R.C., the father of a minor child, complained to OPR that on dates including and prior to February 25th, he had gone to Store #17185 to obtain life-saving medication for his child and found the store closed during normal business hours.

112. R.C. stated:

> The last two times I have called ahead and been assured it was open. Today I was told the prescription would be ready after 3:00. I drove there in a snowstorm because my son doesn't have enough medication to get through the weekend. I arrived at 3:30. Closed! Again! Is this pharmacy even open anymore? How can they just close any time when so many rely on this vital service?....

Bristol, Store #18043

113. On the following dates in 2021 and 2022, Store #18043 (Bristol) was closed unexpectedly and without notice to patients:
December 31, 2021,
February 2, 2022,
February 3, 2022,
February 4, 2022.

Newport, Store #17713

114. On the following dates in 2021 and 2022, Store #17713 (Newport) was closed unexpectedly and without notice to patients:
May 4, 2021,
February 12, 2022,
February 19, 2022.

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Walgreens Pharmacies with Fewer Than Three Closures

115. On December 31, 2021, Store #1756 (Rutland) was closed unexpectedly and without notice to patients.

116. Store #17631 (Bennington) was closed unexpectedly and without notice to patients on May 21, 2021 and August 26, 2021.

117. Store #17518 (Barre) was closed unexpectedly and without notice to patients on September 9, 2021 and October 23, 2021.

118. Store #17596 (Montpelier) was closed unexpectedly and without notice to patients on May 1, 2021.

119. OPR also received two complaints regarding an early and unexpected closure of Store #17596 (Montpelier) location on January 26, 2022. A sign in the window indicated that the pharmacy was temporarily closed but did not direct patients to an alternate pharmacy or provide contact information for assistance.

C. Impacts of Unexpected Store Closures

120. Unexpected Vermont Walgreens pharmacy closures prevent patients from getting prescription medications in a timely manner and deny essential pharmacy services, thereby negatively impacting patients.

121. When a Vermont Walgreens pharmacy is closed unexpectedly, the Walgreens computer system continues to process and bill prescriptions and refills even though the medications are not physically dispensed and patients are not able to retrieve the medications from their usual Walgreens.

122. Once Walgreens processes and bills a prescription to a patient's insurance or Medicaid, the patient is not able to have the prescription filled at an external pharmacy unless Walgreens reverses the billing or the patient pays out-of-pocket, even though the patient cannot retrieve the filled prescription due to an unexpected Walgreens pharmacy closure.

123. For patients with prescriptions for controlled medications, once Walgreens processes and bills the prescription, the patient is not able to obtain the prescription at an external pharmacy, even if the patient cannot retrieve the prescription from their local Walgreens due to an unexpected closure.

124. As of February 2022, pharmacy staff at most, if not all, Vermont Walgreens locations did not know how to reverse the billing for prescriptions in Respondent Corporation's computer system.

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125. Respondent Corporation failed to train Vermont Walgreens pharmacy staff so they would know how to reverse the billing for patient prescriptions that were processed for a location that was closed unexpectedly. Only certain Walgreens Corporate employees knew how to reverse the billing for a patient prescription.

126. One pharmacist-manager interviewed in mid-April 2022 stated that a new prescription for a Schedule II Controlled Drug could not be transferred or reverse-billed. The pharmacist-manager stated new prescriptions for Schedule III through Schedule V Controlled Drug could be reverse-billed and transferred only if authorized by the pharmacist in the transferring pharmacy, which was not possible in some instances, such as the extended Manchester Center Walgreens closure.

127. In mid-April 2022, one Walgreens pharmacist-manager stated to investigators that reverse billing for controlled drugs had to be done by corporate employees and could not be done at a local level.

128. In mid-April 2022, a different Walgreens pharmacist stated to investigators that she could not reverse the billing for any controlled drugs.

129. For many patients in rural areas, a Walgreens pharmacy is the only pharmacy located within close proximity to where they live, making it difficult to change pharmacies.

130. Unexpected pharmacy closures lead to increased workload for Walgreens pharmacists and pharmacy staff and unsafe pharmacy conditions following such closures.

131. Many patients who cannot afford to pay out-of-pocket have gone without medications because their local Vermont Walgreens has already billed insurance and is closed without notice.

132. During OPR's investigation, Walgreens Corporation refused to disclose specific information Walgreens Corporation utilizes to determine pharmacy staffing requirements, claiming it was proprietary information.

IV. Lack of Phone Accessibility

133. In addition to patients experiencing a lack of accessibility to pharmacy services and prescriptions caused by unexpected store closures and billing issues, numerous complaints made regarding Walgreens in 2020 and 2021 arose from a lack of patient/customer access caused by Respondent Corporation's phone system not functioning properly; informing callers that a particular store was open when, in fact, the store was closed unexpectedly during regular business hours; and/or not routing calls from closed locations to open locations.

134. In 2021, lack of appropriate access via telephone to Vermont Walgreens locations directly and negatively impacted patient care, in particular for Patients E.M. (Store #17379, Wilmington) and Patient G.F. (Store #18090, St. Johnsbury).

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135. Between March 2 and March 10, 2021, the phone system for Store #17185 (Hardwick) experienced significant outages which resulted in patients not being able to speak to pharmacy staff by phone and not being able to use credit or debit cards at the store.

136. In August 2021, Store #17185 (Hardwick) again experienced significant phone system issues in which calling parties were not able to connect to pharmacy staff.

137. A pharmacist from an outside pharmacy who was attempting to call Store #17185 to transfer an elderly patient's insulin prescription filed a complaint regarding the Hardwick Store phone issue due to its direct negative impact on patient care.

138. While Respondent Corporation's phone system did indicate the pharmacy was closed, it did not route the calls to an open Walgreens pharmacy location.

V. Interruption of Pharmacy Services After Acquisition of Independent Pharmacy in August 2020

139. In August 2020, Respondent Corporation acquired the retail pharmacy business of an independent pharmacy located in Rutland, Vermont.

140. Upon the acquisition, Respondent Corporation did not notify patients whose prescriptions had transferred to Walgreens, so patients contacted their former pharmacy, found it closed and learned their prescriptions had been transferred to Walgreens without warning or notice.

141. Many patients did not want their prescriptions transferred to Store #01756 (Rutland) and contacted another local pharmacy to have their prescriptions transferred there.

142. Respondent Corporation's pharmacy system was not able to electronically integrate all patient prescriptions from the pharmacy it acquired into its own system.

143. After the acquisition, Respondent Corporation learned that the pharmacy it acquired provided specialized prescription services that Respondent Corporation was not able to provide, such as certain blister-packed medications.

144. Due to system integration issues, Store #01756 was not able to identify all patients and prescriptions that were transferred into Walgreens, which caused delay in patient prescriptions being filled.

145. Store #01756 was also not able to send via electronic transfer prescriptions to the local pharmacy where many patients wanted their prescriptions to go, which caused delay in patient prescriptions being filled.

146. Store #01756 was not able to timely transfer many patient prescriptions to the other local pharmacy where patients wanted their prescriptions to go, so the receiving pharmacy had to directly contact the prescribers for the patients' prescriptions in order to get the medications to the patients in a timely manner.

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VI. Stores Operating Without a Pharmacist-Manager

147. BOP Rules Part 6 provide that the designated Pharmacist-Manager of a pharmacy is responsible for important pharmacy duties and standards in each retail pharmacy. Pharmacist-Manager must be physically present in a retail pharmacy for a sufficient amount of time to provide supervision and control over the security and pharmacy practice in the pharmacy.

148. BOP Rule 1.10(37) defines a "Pharmacist-Manager," also referred to as "Pharmacist in Charge" or "PIC," as:

> a pharmacist currently licensed in this state who has held and unencumbered license in this or another state for at least two years, who accepts responsibility for the operation of a pharmacy in conformance with all laws and rules pertinent to the practice of pharmacy and the distribution of drugs, and who is personally in full and actual charge of such pharmacy and personnel.

149. BOP Rule 6.3 sets forth required duties of the pharmacist-manager, which include: enforcing security standards in the prescription area; assuring pharmacy employees are properly licensed; reporting to the BOP any disciplinary action taken against employees for diversion or violation of BOP rules; and filing reports required by federal and state law, among other required duties.

150. The role of Pharmacist-Manager is so critical to the safe functioning of retail pharmacies that numerous BOP Rules require a retail pharmacy to have a designated Pharmacist-Manager.

151. BOP Rule 6.1 provides: "Pharmacist-Manager Required. No pharmacy may operate unless its designated pharmacist-manager has been approved by the Board."

152. BOP Rule 7.5 provides: "No pharmacy shall be operated without a designated pharmacist-manager approved by the Board."

153. BOP Rules, Part 9 Standards for Pharmacies provide in Rule 9.1(a): "Minimum requirements for a pharmacy: (a) No pharmacy may operate without a designated pharmacist-manager."

154. Between June 18, 2020 and August 11, 2020, Store #01756 (Rutland) operated without a designated pharmacist-manager approved by the Board.

155. Between September 22, 2020 to October 4, 2020, Store #18265 (Brandon) operated without a designated pharmacist-manager approved by the Board.

156. Between December 17, 2020 and April 12, 2021, Store #19233 (Bellows Falls) operated without a designated pharmacist-manager approved by the Board.

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157. Between May 6, 2021 and May 24, 2021, Store #19233 (Bellows Falls) operated without a designated pharmacist-manager approved by the Board.

158. Between May 28, 2021 to September 21, 2021 Store #07270 (Canal Street, Brattleboro) operated without a designated pharmacist-manager approved by the Board.

159. Beginning September 24, 2021 and continuing to February 17, 2022, Store #19795 (St. Albans) operated without a designated pharmacist-manager approved by the Board.

160. Respondent Corporation asked the pharmacist-manager for Store #19346 (Enosburg Falls) to also fill the pharmacist-manager position at Store #19795 in St. Albans, a request the pharmacist-manager declined.

161. Beginning October 8, 2021 and continuing at least to March 15, 2022, Store #17471, (Susie Wilson Road, Essex Junction) has operated without a designated pharmacist-manager approved by the Board.

162. Between December 21, 2021 and May 3, 2022, Store #18090 (St. Johnsbury) operated without a designated pharmacist-manager approved by the Board.

VII. Controlled Drug Inventories Filed with the Board When Pharmacist-Manager Changed at Various Walgreens Locations

163. BOP Rule 6.7 also imposes important requirements on retail pharmacies which govern "Change of Pharmacist-Manager," including that the outgoing pharmacist-manager shall conduct a physical written inventory of all controlled drugs, explain any discrepancies in full, certify the inventory as true and correct, ad retain a copy for his or her records."

164. The incoming pharmacist-manager must certify the inventory as true and correct and both the outgoing and incoming pharmacist-manager must sign the inventory of controlled drugs and file it with the BOP.

165. Between 2019 and 2022, controlled drug inventories conducted for the following stores when the designated pharmacist-managers changed did not have the required signatures of the outgoing pharmacist-managers or Walgreens Corporation:

a. Store #18354 Fair Haven;
b. Store #01756 Rutland;
c. Store #17518 Barre;
d. Store #18265 Brandon;
e. Store #19233 Bellows Falls;
f. Store # 07270 Canal Street, Brattleboro;
g. Store #18375 Middlebury;
h. Store #19795 St. Albans;
i. Store #17749 Lyndonville;

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j. Store #17471 Susie Wilson Road, Essex;
k. Store #17447 South Burlington;
l. Store #17185 Hardwick;
m. Store #18090 St. Johnsbury.

VIII. Change in Pharmacist-Manager Application and Controlled Drug Inventory for Store #18090 (St. Johnsbury) in May 2022

166. On or about May 3, 2022, Respondent Corporation submitted an Application for Instate Pharmacy Change in Manager ("Application") for Store #18090 (St. Johnsbury).

167. On the Application, a pharmacist with the initials "S.G." was identified as the "Name of the Current Pharmacist Manager (outgoing)" but no license number was listed for S.G.

168. The new incoming Pharmacist-Manager was identified in the Application as "N.F." with an accompanying license number.

169. Under the pains and penalties of perjury, certifying that all information provided in the Application was true and accurate, and subject to criminal charges and unprofessional conduct charges, both S.G. and N.F. signed the Application on April 7, 2022.

170. In addition, and also under the same pains and penalties of perjury and certification of truth and accuracy, "B.B.," an individual who is identified as the "Vice President," signed in the box for "Name and Title of Owner or Corporate Officer" on April 27, 2022.

171. The Change in Pharmacist in Charge Inventory that accompanied the Application was dated March 14, 2022 and appears to have only the signature of N.F., the incoming Pharmacist-Manager, in two places.

172. N.F. reported he began working as the Pharmacy Manager at Store #18090 on March 14, 2022.

173. On May 26, 2022, OPR communicated with Respondent Corporation inquiring about the information in the form because a Pharmacy Manager Application was never submitted by Respondent Corporation to OPR for S.G. to be the designated Pharmacy Manager in St. Johnsbury.

174. The written response from the Area Healthcare Supervisor indicated that the previously approved Pharmacist-Manager for Store #18090, "V.M.," had departed that position in December 2021, and the Pharmacist-Manager position was not filled until N.F. started working at the St. Johnsbury location.

175. The Area Healthcare Supervisor acknowledged that S.G. had never been a pharmacist-manager at Store #18090 and claimed S.G. "signed as a witness on [N.F.]'s Controlled Substance inventory and application."

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176. At the time she signed the Pharmacy Manager Application, S.G. was a licensed pharmacist but was an intern at Store #18090 because she was new to working for Respondent Corporation.

177. Incoming Pharmacist-Manager N.F. confirmed there was not a second pharmacist at Store #18090 when he conducted the controlled drug inventory on March 14, 2022.

IX. Unsafe Conditions and Accessibility Issues at Specific Locations

178. Unsafe conditions in Respondent Corporation's pharmacies in Vermont have resulted in heightened risk of prescription errors, vaccine administration errors, and risk of patient harm.

179. In 2021, a recurring complaint from Walgreens pharmacy staff has been that the Respondent Corporation's vaccine scheduler, an online program that allows Walgreens customers to schedule vaccination appointments, permitted such high volumes of appointments, at times as many as one appointment every 5 to 10 minutes, that the pharmacy was unable to safely operate with the number of pharmacy staff present.

180. Neither the pharmacy manager, nor the staff pharmacist at each Vermont Walgreens location had the capability or authority to reduce or eliminate vaccine appointments in order to maintain safe staffing levels and pharmacy conditions in their stores.

181. In July 2021, a corporate employee of Walgreens informed the OPR Investigator that Respondent Corporation did not have any policies that specifically addressed staffing levels in the context of COVID vaccine administration.

A. Store #17749 (Pearl Street, Essex Junction)

182. In October 2021, Store #17749 (Pearl Street, Essex Junction) experienced unsafe pharmacy conditions due to staffing shortages.

183. On Monday, October 11, 2021, the pharmacist at Store #17749 had an estimated 200 prescriptions to fill and over 80 immunizations scheduled, in addition to other pharmacist duties, with only the help of one pharmacy technician for eight hours.

184. When the pharmacist contacted Respondent Corporation's District Manager and informed the District Manager of the workload, the District Manager told the pharmacist to figure it out.

185. When the pharmacist suggested to the Respondent Corporation's District Manager that the scheduled vaccination appointments would need to be cancelled to maintain a safer workload, the District Manager informed the pharmacist that cancellation of vaccine appointments was not permitted but did not offer further assistance.

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186. On Wednesday, October 13, 2021, the pharmacist at Store #17749 again had an estimated 240 prescriptions to fill and 85 immunizations to administer, in addition to other pharmacist duties, and again with only the help of one pharmacy technician for eight hours.

187. Essentially, the Walgreens vaccine scheduler was allowing an immunization to be scheduled approximately every five minutes.

188. The pharmacist for Store #17749 characterized the working conditions at the store as unsafe.

189. The pharmacist for Store #17749 gave her notice in October 2021 because of the unsafe conditions.

190. In one week alone between October 5 and October 12, 2021, there were at least two pharmacy errors, including a patient who was given a Pfizer booster vaccine instead of the regular flu shot the patient requested.

191. In October and early November 2021, vaccine appointments at Store #17749 ranged from 36 to 66, and many of those patients sought multiple vaccines per appointment.

B. Store #17471 (Susie Wilson Road, Essex Junction)

192. In the months leading up to and including October and November 2021, Store #17471 (Susie Wilson Road, Essex Junction) experienced unsafe pharmacy conditions due to inadequate staffing levels for the pharmacy workload.

193. Each day, the workload at Store #17471 included filling over 200 prescriptions, administering 40-60 Covid tests, administering 40-80 scheduled immunizations, and administering regular flu shots.

194. Respondent Corporation also tasked Store #17471 with unscheduled walk-in Walgreens employee Covid testing.

195. The pharmacist-manager at Store #17471 worked 12-hour shifts daily, would report early for her shifts and stay late after her shifts, and was asked to work on her days off.

196. The pharmacist-manager for Store #17471 was even required to work during a time when her significant other, with whom she resided, was Covid-positive.

197. As a result of the workload and lack of time off, the pharmacist experienced burn-out and compromised mental health. However, the pharmacist's requests for time off were often denied, even though she had accumulated over 200 hours of vacation time.

198. When the pharmacist-manager of Store #17471 reached out to Respondent Corporation on many occasions to express her concerns about the untenable workload and stressful conditions, Respondent Corporation failed to provide any assistance and told the pharmacist-manager to "be patient" and "be a leader."

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199. When the pharmacist-manager reported to Respondent Corporation that staff of Store #17471 did not have time to complete the lab paperwork required for the walk-in Walgreens employee Covid testing, Respondent Corporation's district manager instructed the pharmacist-manager to give the Covid tests to the employees and deal with the paperwork later.

200. The pharmacist-manager for Store #17471 observed there was no ability for social distancing in the store with the number of immunization appointments scheduled, that having waiting rooms full of unvaccinated people was unsafe, and requests to management for reduce appointments or testing were disregarded.

201. The pharmacist-manager for Store #17471 reported that pharmacy staff was not able to answer the phone most days.

202. On September 1, 2021, OPR received a complaint about Store #17471 from a staff member of an external pharmacy.

203. The staff member from the external pharmacy reported that its patient requested a transfer of the patient's prescription for a medication the patient needed immediately from Store #17471 to the external pharmacy.

204. The staff member from the outside pharmacy called Store #17471 and was put on hold for over ten minutes, then the phone was picked up and hung up without addressing the caller. The staff member called Store #17471 again, was placed on hold for ten minutes, and again the phone was picked up and hung up without addressing the caller.

205. In October 2021, the pharmacist-manager for Store #17471 resigned due to the "horrible pharmacy practices" resulting from the lack of resources and support from Respondent Corporation.

206. When the pharmacist-manager gave her notice, Respondent Corporation attempted to retain her as an employee and asked what could be done to make her stay.

207. When the pharmacist manager requested fewer hours, additional compensation, additional staff, and less testing, Respondent Corporation denied those requests and stated they could only reduce testing at the store for two weeks.

208. In November 2021, a floater pharmacist working at Store #17471 informed a caller who called on the phone to inquire if the pharmacy was open that the pharmacy was "barely open" and whatever prescription the caller was looking for "probably wasn't ready" due to lack of pharmacy staff.

209. The floater pharmacist admitted to OPR Investigators that he made mistakes due to the unsafe and untenable workload at Store #17471, including administering two empty vaccinations with no medication in them to patients.

210. When the floater pharmacist reported unsafe workload and lack of staffing issues to Walgreens Corporation District Manager, he was told "figure it out" and "we need to be Netflix, not Blockbuster." Walgreens Corporation provided no assistance in response to the floater pharmacist's plea for help.

211. The floater pharmacist reported that Walgreens previously employed immunization nurses to administer vaccines, but no longer does so.

212. The floater pharmacist reported that conditions at Store #17471 were unsafe.

213. Due to the unsafe conditions, lack of support from Respondent Corporation and the untenable workload, the floater pharmacist gave his notice in November 2021 and quit prior to Thanksgiving.

214. On December 1, 2021, the pharmacist who filled in after the floater pharmacist at Store #17471 resigned was not made aware by Respondent Corporation that the floater pharmacist resigned.

215. When the floater pharmacist resigned from Store #17471, a controlled drug count was not conducted and the pharmacist who temporarily filled the role was not aware of the status of the controlled substance inventory for the store.

216. As of December 1, 2021, Store #17471 had no staff pharmacist and no pharmacist-manager.

C. Store #11526 (Farrell Street, Burlington)

217. In the months leading up to and including November 2021, the Walgreens Store #11526 located at Farrell Street in Burlington experienced unsafe pharmacy conditions.

218. On September 16, 2021, the Pharmacist-Manager of Farrell Street completed a DEA [Drug Enforcement Administration] Form 106 Report of Theft or Loss of Controlled Substances.

219. In the Form 106, the pharmacist-manager reported the suspected employee theft of 100-5mg tablets of Oxycodone HCL, a Schedule II Narcotic, that occurred in July 2021.

220. The Farrell Street Store discovered the loss of the Oxycodone during a monthly Schedule II count on July 27, 2021, but did not ascertain what caused the loss and did not report to the DEA for several months.

221. A pharmacist from the Farrell Street location reported having more than 200 prescriptions each day to fill and 50 to 80 vaccinations to administer each day in addition to other pharmacist duties.

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222. In addition to vaccinations to administer and prescriptions to fill, the Farrell Street location was conducting over 30 Covid tests daily in September and October 2021.

223. Due to being overwhelmed by the workload and dealing with frustrated customers, a pharmacist from Farrell Street reported crying in front of patients on multiple occasions.

224. A pharmacist at the Farrell Street location indicated that she was only able to fill prescriptions for patients who were waiting at the window and was unable to fill prescriptions in advance for patients.

225. A pharmacist at the Farrell Street location indicated that as a result of the workload and understaffing, she was not able to do the prescription verifications that she needed to do.

226. A pharmacist at the Farrell Street location indicated that she has noted an increase in prescription errors and vaccine administration errors due to the workload, including a patient who was given an incorrect dosage of a prescription which resulted in the patient experiencing low blood pressure, dizziness, and fogginess.

D. Store #17518 (Barre)

227. In June 2020, a pharmacist-manager who had just started working in Store #17518 (Barre) reported that the store was experiencing unsafe conditions due to the unsustainable volume of work for the pharmacy staff allotted by Respondent Corporation.

228. The pharmacist-manager also reported the controlled drug inventory was not accurate because staff did not have adequate time to conduct inventories.

229. The pharmacist-manager reported that the workload pressure on pharmacy staff encouraged them to take short cuts and engage in unsafe practice.

230. The pharmacist-manager submitted his immediate resignation and explained that he felt the pharmacy should be shut down.

231. In the months leading up to and including November 2021, Store #17518 experienced unsafe pharmacy conditions due to a lack of adequate staff for the pharmacy workload.

232. During the relevant time, a pharmacy staff member of Store #17518 estimated the pharmacy filled approximately 300 prescriptions per day.

233. Through the online vaccine scheduler, Store #17518 had between 30 and 60 vaccine appointments per day, which, with multiple vaccines per appointment possible, resulted in an additional number of actual vaccines administered each day.

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234. Store #17518 had two pharmacists and three to four pharmacy technicians who worked various parttime hours.

235. Pharmacists for Store #17518 were asked to work come in early for their shifts due to the workload.

236. A pharmacist for Store #17518 reported feeling unsafe and contacted Respondent Corporation to report problems with the workload.

237. A supervisor for Respondent Corporation told the pharmacist to "do the best she could do," but failed to provide help or assistance.

238. In early November 2021, Respondent Corporation's vaccine scheduler allowed vaccine appointments at Store #17518 to be scheduled every ten minutes.

E. Store #17185 (Hardwick)

239. In the months leading up to and including November 2021, Store #17185 (Hardwick) experienced unsafe pharmacy conditions.

240. Store #17185 is closed on the weekends, which increases the workload on Mondays and Fridays.

241. During the relevant time, Store #17185 had one pharmacist.

242. Pharmacy staff for Store #17185 estimated that the pharmacy averaged approximately 300 prescriptions to fill each day and up to 50 or more immunizations to administer each day.

243. Just prior to mid-November 2021, Respondent Corporation reduced the number of vaccine appointments available in the online scheduler from one appointment every ten minutes (which could include more than one immunization) to 30 vaccine appointments each day.

244. The lack of adequate staff for the workload at Store #17185 created unsafe pharmacy conditions.

245. A pharmacy staff member reported that the number of prescriptions to fill and immunization appointments resulted in an increase in pharmacy errors and normal day-to-day pharmacy functions, such as ordering controlled medications, not being performed.

F. Store #07270 (Canal St., Brattleboro)

246. In the months leading up to and including November 2021, Store #07270 (Canal St., Brattleboro) experienced unsafe pharmacy conditions due to inadequate staffing levels for the pharmacy workload and due to the lack of a pharmacy-manager.

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247. During the relevant time, Store #07270 had one pharmacy manager, four full-time pharmacy technicians, one part-time pharmacy technician, and, at times, a floater pharmacist. The staff pharmacist recently quit.

248. A pharmacy staff member estimated that on a daily basis during the relevant time, Store #07270 filled approximately 250 to 500 prescriptions, conducted 30 to 35 vaccine appointments (approximately 50 immunizations) and an estimated 50 Covid tests.

249. A pharmacy staff member reported that on a few days in November 2021, Store #07270 processed an estimated 600 prescriptions with only one pharmacist.

250. A pharmacy staff member reported that between January 1, 2021 and November 15, 2021, Store #07270 reported over 20 medication errors to Respondent Corporation.

251. Store #07270 operated without a Pharmacist-Manager between May 2021 and September 21, 2021.

252. The new pharmacist-manager previously worked for Walgreens in Vermont. He was laid off and then rehired by Respondent Corporation for $2.65 less in per hour pay. He was then offered a $50,000.00 bonus for taking the pharmacist-manager job, but would lose that bonus and have to repay it if he left or was fired within two years.

253. In mid-September 2021, prior to the start of the new Pharmacist-Manager for Store #07270, Patient D.F. attempted to pick up a prescription for Fentanyl transdermal patches ordered by his physician.

254. Patient D.F. received a text message stating that his prescription was ready for pick up.

255. When Patient D.F. arrived to Store #07270, pharmacy staff informed him that his prescription could not be completely filled because the store did not have enough patches and there was not an authorized pharmacist who could order the controlled drug.

256. Pharmacy staff informed Patient D.F. that his physician should submit a prescription for five patches, the number the pharmacy had on hand, which would have required Patient D.F. to pay an additional $40 co-pay.

257. Pharmacy staff attempted to work with the store manager for a solution to compensate Patient D.F. for the additional $40 co-pay that he would have to pay for the smaller number of patches since the store had run out. However, the store manager was not able to fully compensate Patient D.F. for the additional $40 co-pay.

G. Store #19795 (St. Albans)

258. In October and November 2021, Store #19795 (St. Albans) experienced unsafe pharmacy conditions due to inadequate staffing levels for the pharmacy workload and no pharmacist manager.

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259. During the relevant time, Store #19795 was staffed only by a floating pharmacist and pharmacy technicians. The store had no pharmacist-manager.

260. As of mid-November 2021, staff reported that Store #19795 was an estimated two hundred prescriptions behind.

261. The floating pharmacist was the sole pharmacy staff member trained to administer vaccines and administered between 30 and 60 vaccines per day.

H. Store #18090 (St. Johnsbury)

262. In 2021, Store #18090 (St. Johnsbury) operated with one pharmacist and three pharmacy technicians.

263. In the last quarter of 2021, a pharmacy staff member estimated that Store #18090 filled approximately 300 prescriptions per day and had approximately 60 vaccination appointments scheduled per day.

264. Respondent Corporation reduced the number of vaccination appointments to one appointment every thirty minutes and a significant number of those appointments included more than one vaccine.

265. A pharmacy staff member from Store #18090 reported that they often begin the day with prescriptions from the previous day still to fill, at times almost 100 from the prior day.

266. Prescriptions at Store #18090 were primarily filled when the patients come into the store, as the pharmacy staff does not have time to fill prescriptions in advance.

267. A pharmacy staff member reported having a complete lack of guidance or protocols from Respondent Corporation regarding ways to keep vaccine dosages separated and organized to ensure patient safety.

268. On November 13, 2021, three children were scheduled to receive the Children Ages 5-11 dose of the Pfizer-BioNTech Covid vaccine at Store #18090.

269. Pfizer-BioNTech Covid vaccines are normally diluted with sodium chloride sterile diluent at the pharmacy.

270. The vaccines administered to the three children on November 13, 2021 were erroneously mixed with bacteriostatic sodium chloride, a diluent that has not been approved for use with the vaccine.

271. On November 16, 2021, Respondent Corporation notified the parent of two of the children who received incorrect vaccines and advised the parent to reschedule the children for another dose of the vaccine as soon as possible.

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I. Store #18977 (Morrisville)

272. In April and May 2021, Store #18977 (Morrisville) experienced unsafe conditions due to inadequate staffing levels for the pharmacy workload and no pharmacist manager.

273. In the months leading up to April 2021, Store #18977 operated with one pharmacist and one pharmacy technician doing sixty to seventy vaccinations each day (one vaccination approximately every five minutes), in addition to fielding phone calls and the normal workload associated with filling prescriptions and running a pharmacy.

274. On April 9, 2021, pharmacy staff who opened Store #18977 found the safe containing Schedule II Controlled Substances ajar.

275. The same day, pharmacy staff member found a Schedule II Controlled Drug on the main shelves and not in the safe, as well as two discrepancies between the amounts identified on the inventory of Schedule II Controlled Drugs versus the amounts actually in the store.

276. In the following days, more discrepancies were discovered between the Schedule II Controlled Drug inventory versus what was in the store.

277. Due to the untenable workload for the available staff and stressful conditions, the pharmacist-manager of Store #18977 asked to be re-assigned to a floating pharmacist position.

278. The same pharmacist-manager indicated he had been unable to keep up with Schedule II Controlled Drug inventories for some time due to the workload at Store #18977 and that he sometimes left the safe door open because it was tricky and on a three-minute delay between inserting the key and the opening of the safe.

X. Out-of-Stock Medications and Delays in Filling Prescriptions

279. In October 2020, a nurse from Southwestern Vermont Health Care reported that her patient with Type I Diabetes had called Store #17379 (Wilmington) earlier in the week on October 22, 2020 to obtain a refill of his NovoLog, an insulin commonly used for diabetes patients.

280. When the patient went to pick up his NovoLog prescription at Store #17379 on October 23, 2020, pharmacy staff informed him they could not fill the prescription and that he would have to go to the emergency room to get some prior to running out.

281. In November 2020, Patient E.M. attempted to get a refill of her blood pressure/heart medication from Store #17379 (Wilmington).

282. When she went to pick up the prescription two days after it was called in, a pharmacy staff member informed her that they would not be able to refill the prescription for four more days and they did not have a small amount on hand to tide her over when her prescription ran out.

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283. Store #17379 informed Patient E.M. that her prescription could not be transferred. Patient E.M. went three days without her medication and experienced a significant increase in her blood pressure, which distressed her.

284. In April 2021, Patient M.H. attempted to fill a prescription for acetaminophen with codeine #3 at Store #18418 (Putney Road, Brattleboro).

285. Patient M.H.'s oral surgeon called in the prescription on Monday, April 26, 2021.

286. Patient M.H. called Store #18418 each day thereafter asking if her prescription was ready.

287. Each day, pharmacy staff informed Patient M.H. that her prescription was not ready because the pharmacy was "running behind on prescriptions due to Covid vaccines."

288. Patient M.H. was able to pick up her pain reliever on Friday, April 30, 2021.

289. By the time the pharmacy filled Patient M.H.'s prescription, she did not need it anymore because her recovery from the oral surgery went well and she only needed over-the-counter pain reliever.

290. In January 2022, Patient T.P. went to Store #17183 (Colchester) to request a transfer of a prescription to another pharmacy because the medication was over $75 cheaper at a competing pharmacy.

291. Patient T.P. reported that staff at Store #17183 refused to transfer his prescription and he was forced to purchase it for the higher price at Walgreens.

XI. Other Patient/Customer Complaints

A. Store #19233 (Bellows Falls)

292. On January 26, 2021, Patient A.J. filled a prescription for Fluoxetine at Store #19233 (Bellows Falls).

293. In late February 2021, Patient A.J. realized that instead of receiving 10mg pills of the medication, she received 20mg pills, which resulted in Patient A.J. having a higher dosage of the medication than the dosage ordered by her physician for almost an entire month.

294. The pharmacy technician who made the error in filling Patient A.J.'s prescription indicated that due to staff turnover, constant change in pharmacists, and Covid, the work environment at Store #19233 is "very hectic" and stressful.

295. The pharmacist who reviewed the complaint believed the error in filling Patient A.J.'s prescription was caused by a returned-to-stock bottle of 20mg pills being placed in the wrong section of the shelving with the 10mg bottle.

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B. Store #18020 (Manchester)

296. On February 5, 2021, pharmacy staff at Store #18020 (Manchester) filled a prescription for Nortriptyline, an anti-anxiety medication, for Patient A.F., a minor.

297. Patient A.F. had orders for three 10mg tablets, twice daily or 60 mg per day.

298. Because the prescription was for several months of medication, 540 capsules, Patient A.F. received six bottles of medication, five of which were unopened stock bottles with 100 capsules in each.

299. Patient A.F. used the first bottle of medication without incident.

300. In March 2021, Patient A.F. developed significant physical symptoms of unknown origin, including shaky hands, blurred vision, nausea, balance issues, hallucinations, and high blood pressure.

301. Patient A.F. was unable to attend school in person due to the symptoms.

302. After an inconclusive doctor visit, Patient A.F.'s mother inspected the medication and realized the capsules looked different than Patient A.F.'s normal 10 mg capsules.

303. Upon closer inspection, Patient A.F.'s mother discovered "NTP50" printed on each capsule and learned that A.F. had been taking three 50 mg capsules twice each day, or 300 mg per day.

304. After her doctor had her stop taking the medication, Patient A.F. continued to experience significant symptoms for several days, including hallucinations, until the symptoms subsided.

305. The pharmacist at Store #18020 indicated the 50 mg bottle of medication was in the wrong location on the shelf and, rather than scanning each bottle, the pharmacy technician likely scanned the same stock bottle five times to generate the labels.

306. The pharmacy technician who filled the prescription indicated she likely grabbed the wrong bottle off the shelf but did not specifically recall.

307. In March and April 2021, Patient M.Z. received her two Covid vaccines at Store #18020 (Manchester).

308. When Patient M.Z. received her booster vaccine in November 2021, she learned that Store #18020 had not submitted her vaccine information to the Vermont Department of Health.

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XI. Discipline Against Pharmacy Chain

309. 26 V.S.A. § 2053(b) provides:

> Drug outlets under common ownership and control constitute a chain. Discipline against anyone drug outlet in a chain may be imposed against all drug outlets in a chain, provided the State alleges in a specification of charges and the Board subsequently finds:
> (1) unprofessional conduct has occurred at one or more drug outlets;
> (2) the unprofessional conduct is attributable to pharmacy or pharmacy business-related policies, procedures, systems, or practices of the chain whether or not those practices manifested in unprofessional conduct at each location; and
> (3) imposition of disciplinary sanctions or conditions against all drug outlets in the chain is appropriate to protect the public.

310. The multiple instances of unprofessional conduct that have occurred throughout Respondent Walgreens Company's store locations in Vermont have resulted from Respondent Corporation's pharmacy business-related policies, procedures, systems, and practices of the Walgreens chain; therefore, discipline against Respondent Company and all Vermont locations for the violations set forth below is appropriate to protect the public and proper under Vermont law.

Violation One: 26 V.S.A. § 2053(a)(1) Introducing or enforcing policies and procedures related to the provision of pharmacy services in a manner that results in deviation from safe practice.

311. Paragraphs 2 through 310 above are incorporated herein.

312. Vermont law prohibits a licensee from introducing or enforcing policies and procedures related to the provision of pharmacy services in a manner that results in deviation from safe practice.

313. Paragraphs 2 through 310 above demonstrate that Respondent Corporation introduced and enforced policies, practices, and procedures related to the provision of pharmacy services that resulted in deviation from safe practice, including but not limited to: operating pharmacies without a pharmacist-manager; failing to conduct appropriate perpetual and controlled substances inventories; allowing the online scheduling of vaccine appointments by patients without regard for staffing levels or safety in the pharmacies; requiring pharmacies to operate with unsafe staffing levels in light of the number of vaccine appointments scheduled in addition to the regular pharmacy workload; failing to allow staff to use vacation time; not permitting pharmacists to control the number of vaccine appointments; structuring in-store policies/procedures such that non-pharmacist store managers supervise pharmacists, pharmacy staff, and operation of the pharmacy; failing to adequately/appropriately train pharmacy staff regarding storage/organization practices, administration of vaccines, and reverse-billing; and generally failing to provide adequate support and staffing so that pharmacies could operate safely.

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314. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondents have committed unprofessional conduct in violation of 26 V.S.A. § 2053(a)(1) and (b).

Violation Two: 26 V.S.A. § 2053(a)(2) Unreasonably preventing or restricting a patient's timely access to patient records or essential pharmacy services.

315. Paragraphs 2 through 310 above are incorporated herein.

316. Vermont law prohibits Respondents from unreasonably preventing or restricting a patient's timely access to patient records or essential pharmacy services.

317. Paragraphs 2 through 138, 279 through 291 above demonstrate that Respondents unreasonably prevented or restricted patients' timely access to essential pharmacy services when the retail pharmacy locations were closed unexpectedly and without adequate notice to patients.

318. Paragraphs 2 through 138 above demonstrate that Respondents unreasonably prevented or restricted patients' timely access to essential pharmacy services when the phone systems did not function or did not provide current information regarding the location's status.

319. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondents have committed unprofessional conduct in violation of 26 V.S.A. § 2053(a)(2) and (b).

Violation Three: 26 V.S.A. § 2053(a)(3) Failing to identify and resolve conditions that interfere with a pharmacist's ability to practice with competency and safety or create an environment that jeopardizes patient care, including by failing to provide mandated rest periods.

320. Paragraphs 2 through 310 above are incorporated herein.

321. Vermont law requires Respondent Corporation to identify and resolve conditions that interfere with a pharmacist's ability to practice with competency and safety or create an environment that jeopardizes patient care, including by failing to provide mandated rest periods.

322. Paragraphs 2 through 310 above demonstrate that Respondent failed to identify and resolve conditions that interfere with a pharmacist's ability to practice with competency and safety or create an environment that jeopardizes patient care.

323. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondents have committed unprofessional conduct in violation of 26 V.S.A. § 2053(a)(3) and (b).

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Violation Four: 26 V.S.A. § 2053(a)(4) Repeatedly, habitually, or knowingly failing to provide resources appropriate for a pharmacist of reasonable diligence to safely complete professional duties and responsibilities, including: (A) drug utilization review; (B) immunization; (C) counseling; (D) Verification of the accuracy of a prescription; (E) all other duties and responsibilities of a pharmacist under State and federal laws and regulations.

324. Paragraphs 2 through 310 above are incorporated herein.

325. Under Vermont law, Respondent Corporation must provide appropriate resources for a pharmacist of reasonable diligence to safely complete professional duties and responsibilities, including: (A) drug utilization review; (B) immunization; (C) counseling; (D) verification of the accuracy of a prescription; and (E) all other duties and responsibilities of a pharmacist under State and federal laws and regulations.

326. Paragraphs 2 through 310 above demonstrate that Respondent Corporation failed to provide appropriate resources for a pharmacist of reasonable diligence to safely complete professional duties and responsibilities, including: (A) drug utilization review; (B) immunization; (C) counseling; (D) verification of the accuracy of a prescription; and (E) all other duties and responsibilities of a pharmacist under State and federal laws and regulations.

327. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 26 V.S.A. § 2053(a)(4).

Violation Five: 3 V.S.A. § 129a(a)(3) Failing to comply with provisions of federal or State statutes or rules governing the practice of the profession (incorporating Chapter 36 of Title 26 of Vermont Statutes Annotated and the Administrative Rules of the Vermont Board of Pharmacy).

328. Paragraphs 2 through 310 above are incorporated herein.

329. Vermont law requires Respondents to comply with provisions of federal or State statutes or rules governing the practice of the profession, which includes profession-specific statutes set forth in Chapter 36 of Title 26 of Vermont Statutes Annotated and the Administrative Rules of the Vermont Board of Pharmacy ("BOP").

330. Under Vermont law, a retail drug outlet "shall be managed by licensed pharmacists who have held an unrestricted license in this or another state for at least one year. A pharmacist who holds a restricted license may petition the Board for permission to be a pharmacist manager, which may be granted by the Board for good cause shown." 26 V.S.A. § 2061(e).

331. Paragraphs 12, 13, 147 through 181 demonstrate the Vermont Walgreens locations are not managed as required under Vermont law.

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332. Because the Vermont Legislature has imposed by statute the requirement that each retail drug outlet must have a pharmacist manager, the Board of Pharmacy may not waive the requirement.

333. In addition, BOP Rules Part 6 provide that the designated Pharmacist-Manager of a pharmacy is responsible for important pharmacy duties and standards in each retail pharmacy. Pharmacist-Manager must be physically present in the pharmacy a sufficient amount of time to provide supervision and control over the security of and pharmacy practice in the pharmacy. A pharmacist-manager may not serve in that role for more than one pharmacy at a time.

334. BOP Rule 6.1 provides: "Pharmacist-Manager Required. No pharmacy may operate unless its designated pharmacist-manager has been approved by the Board."

335. BOP Rule 6.3 sets for the required duties of the pharmacist-manager, which include: enforcing security standards in the prescription area; assuring pharmacy employees are properly licensed; reporting to the BOP any disciplinary action taken against employees for diversion or violation of BOP rules; and filing reports required by federal and state law, among other required duties.

336. BOP Rule 6.7 also imposes important requirements on retail pharmacies which govern "Change of Pharmacist-Manager," including that the outgoing pharmacist-manager shall conduct a physical written inventory of all controlled drugs, explain any discrepancies in full, certify the inventory as true and correct, ad retain a copy for his or her records."

337. BOP Rule 7.5 provides: "No pharmacy shall be operated without a designated pharmacist-manager approved by the Board."

338. BOP Rules, Part 9 Standards for Pharmacies provide in Rule 9.1(a): "Minimum requirements for a pharmacy: (a) No pharmacy may operate without a designated pharmacist-manager."

339. Paragraphs 147 through 162, 166 through 177 demonstrate that Respondent Corporation failed to comply on an egregious scale with numerous State statutes and Administrative Rules that require each operating pharmacy to have a designated pharmacist-manager.

340. Paragraphs 163 through 177 demonstrate that Respondent Corporation failed to comply with BOP Rule 6.7 requirements for controlled drug inventories conducted with a change in pharmacy-manager.

341. Administrative Rule 8.3 Drug Outlet Closing – If the closing of a drug outlet is not planned, the licensee shall notify the Board of the closing within 48 hours.

342. Paragraphs 28 through 33 demonstrate that Respondent Corporation violated Rule 8.3 by failing to notify the Board of Pharmacy of the extended closure of the Manchester Center store as required by the Administrative Rules.

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343. Administrative Rule 10.33 mandates that a perpetual inventory shall be maintained for at least two years for all Schedule II controlled substances.

344. Paragraphs 214 through 216, 227, 228, and 272 through 278 above demonstrate that Respondents failed to comply with Rule 10.33.

345. Administrative Rule 10.34 requires that all Schedule II Controlled Substances be physically inventoried and documented at least once every thirty days.

346. Paragraphs 214 through 216, 227, 228, and 272 through 278 above demonstrate that Respondents failed to comply with Rule 10.34.

347. Administrative Rule 20.2 requires licensed pharmacists to use their independent professional judgment in the practice of pharmacy.

348. Paragraphs 12, 15, 16, 178 through 278 above demonstrate that the policies, practices, and procedures of Respondent Corporation fail to permit licensed pharmacists to exercise their own independent professional judgment in the performance of licensed activities.

349. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(a)(3) by violating the Board of Pharmacy Administrative Rules referenced above.

Violation Six: 3 V.S.A. § 129a(a)(28) Engaging in conduct of a character likely to deceive, defraud, or harm the Public.

350. Paragraphs 2 through 310 above are incorporated herein.

351. Vermont law prohibits Respondents from engaging in conduct of a character likely to deceive, defraud, or harm the public.

352. Paragraphs 2 through 310 above demonstrate that Respondents engaged in conduct of a character likely to deceive, defraud, or harm the public.

353. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 3 V.S.A. § 129a(a)(28).

Violation Seven: 3 V.S.A. § 129a(b)(1) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient or client care.

354. Paragraphs 2 through 310 above are incorporated herein.

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355. Vermont law requires Respondents to perform safe and acceptable patient and client care.

356. Paragraphs 2 through 310 above demonstrate that Respondents provided unsafe and unacceptable patient and client care.

357. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 3 V.S.A. § 129a(b)(1).

Relief Requested

WHEREFORE, the Vermont Board of Pharmacy should revoke, suspend, reprimand, condition or otherwise discipline the licenses of Respondents.

DATED at Montpelier, Vermont this 15th day of June, 2022.

STATE OF VERMONT
SECRETARY OF STATE

By: _____

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