Nevada State Board of Pharmacy
555 DOUBLE EAGLE COURT • SUITE 1100 • RENO, NEVADA 89521-8991
(775) 850-1440 • 1-800-364-2081 • FAX (775) 850-1444
E-mail: pharmacy@govmail.state.nv.us • Web Page: www.state.nv.us/pharmacy/

QUARTERLY DISCIPLINARY REPORT TO LEGISLATIVE COUNSEL BUREAU

APRIL 20, 2006

1 Marcie B. Mountan Board Meeting 3/1/06 Case No. 05-032-RPH-N
Critical Care Systems, Inc Case No. 05-032-PH-N

Patient T, a 64 year old female, was diagnosed with colon cancer in December of 2004. She was subsequently placed on a chemotherapy regime consisting of a bi-weekly infusion at a medical office, followed by an infusion at her home. The home infusion was normally accomplished via an Eclipse elastomeric pump often referred to as "the ball" because of its shape. This pump is designed to infuse Fluorouracil (5-FU) at 2 ml/hour over a 46 hour period. The home infusion process was administered and monitored by the pharmaceutical and nursing staff at Critical Care Systems (CCS) in Reno.

On May 18, 2005, a CCS pharmaceutical technician inadvertently placed Patient T's bi-weekly chemotherapy preparation of 5-FU into the wrong Eclipse pump. Although similar in appearance to the Eclipse "C" pump, the standard Eclipse Home Pump selected was designed to infuse at 100 ml per hour instead of the 2 ml per hour that was prescribed. This error was not caught by Ms. Mountan or by the administering CCS nurse. Patient T was subsequently connected to the pump at the medical office on the morning of May 18, 2005. One hour later, after returning home, Patient T discovered that the pump was empty.

Within days, Patient T's physical condition deteriorated. Her skin became dark and discolored and pustules resembling chicken pox covered much of her body. Severe nausea developed into uncontrollable vomiting and diarrhea and swollen ulcerations in her throat made it difficult to swallow. Home care continued until May 30, 2005 when Patient T was taken to the hospital. On May 31, 2005 Patient T developed tachypnea, tachycardia, and fluctuating levels of consciousness. Patient T stopped breathing, however was resuscitated and placed on a ventilator. She remained unresponsive until June 7, 2005 when Patient T died. The immediate cause of death was complications of chemotherapy.

Marcie Mountan was fined $6,000, placed on probation for two years, remanded to complete the Your Success Rx evaluation paying for the service with a portion of the $6,000 fine and the remainder of the fine to be paid to the State of Nevada, Office of the Treasurer, and complete ten hours of continuing education in addition to the required 30 units for renewal.

CCS was fined $10,000, placed on probation for two years, required to pay all fees and costs in this matter, prepare policies and procedures and submit to Board staff, and monitor their errors and report them to Med Watch.

2. Felix R. Del Valle Board Meeting 4/19/06 Case No. 05-056-PTT-S

Mr. del Valle did not appear for hearing. Mr. del Valle was registered at Heritage College in its pharmaceutical technician program. Mr. del Valle obtained a technician-in-training registration from the Board. Heritage College performed a routine urine analyses and Mr. del Valle tested positive for marijuana during one of these routine tests.

Mr. del Valle's pharmaceutical technician-in-training registration was revoked

3. Sandra Stevens Board Meeting 4/19/06 Case No. 06-001-RPH-N

Ms. Stevens checked her pharmacist license renewal application indicating she had completed 30 CEU's. During a random continuing education audit a letter was sent to Ms. Stevens requesting copies of her continuing education certificates. A second letter was sent to Ms. Stevens requesting the same information and she provided 14.5 continuing education certificates, including one for Nevada law, and 16.5 continuing education certificates that were dated after October 31, 2005.

Ms. Stevens signed a stipulated agreement that was accepted by the Board requiring Ms. Stevens to take and pass the Nevada jurisprudence written examination, complete 60 hours of continuing education for the renewal period ending October 31, 2007, be audited again at the next renewal period, and pay an administrative fee of $250.

4 Brandon L. Davis Board Meeting 4/19/06 Case No. 06-008-PT-S

Mr. Davis did not appear for hearing. The managing pharmacist, in the pharmacy where Mr. Davis worked, noticed that he was missing certain drugs from his stock. He was missing Oxycodone/APAP 10/325 and Cialis 20 mg. tablets. A surveillance camera was placed in the pharmacy and loss prevention personnel suggested that the managing pharmacist speak with Mr. Davis regarding the missing drugs. When the managing pharmacist spoke with Mr. Davis he admitted to taking one bottle of 30 Cialis 20 mg. tablets and one bottle of 30 Viagra 100 mg. tablets and selling them because he was having personal and financial difficulties and needed money for his rent.

Mr. Davis' pharmaceutical technician registration was revoked. If he ever asks for his registration to be reinstated he must first provide proof of

restitution to his previous employer.

5 Evren Gonzales Board Meeting 4/19/06 Case No. 06-010-PTT-S

Mr. Gonzales did not appear for hearing. Mr. Gonzales was registered at Heritage College in its pharmaceutical technician program. Mr. Gonzales obtained a technician-in-training registration from the Board. Heritage College performed a routine urine analyses and Mr. Gonzales tested positive for amphetamines during one of these routine tests.

Mr. Gonzales' pharmaceutical technician-in-training registration was revoked.

6. Rondall D. Wood Board Meeting 4/19/06 Case No. 06-013-RPH-S

Mr. Wood did not appear for hearing. On or about February 27, 2006 Board staff received a letter from the district pharmacy manager for Rite Aid that he had terminated the employment of Mr. Wood. Mr. Wood came to work under the influence of alcohol and continued drinking alcohol while on duty.

Mr. Wood's pharmacist license was revoked.

7. William Eisler Board Meeting 4/19/06 Case No. 06-014-RPH-S

Mr. Eisler indicated on his renewal application that he had completed 30 hours of continuing education. During a random continuing education audit, a letter was sent to Mr. Eisler requesting copies of his continuing education certificates. Mr. Eisler sent copies of his continuing education certificates. Mr. Eisler could not provide Board staff with a copy of a continuing education certificate for one continuing education unit in a jurisprudence program approved by the Board. On or about January 6, 2006 a letter was sent to Mr. Eisler with a CE law examination requesting completion of the law exam within 30 days of receipt of the examination. Mr. Eisler received the letter and CE law examination on January 7, 2006. On or about February 16, 2006 Board staff sent Mr. Eisler another letter noting that Board staff had still not received his completed CE law examination that was due to the Boar office on February 6, 2006. Mr. Eisler was given until February 24, 2006 to return his completed CE law examination to avoid disciplinary action. Mr. Eisler did not comply.

At hearing Mr. Eisler said the law examination "turned him off" and did not do it. He stated he does not want to practice pharmacy and he did not need a license. Mr. Eisler was advised that he could attend four hours of a Board meeting to comply and the Board generously allowed Mr. Eisler to stay for this Board meeting and the Board would consider that his compliance. Mr. Eisler returned to the Board meeting when it reconvened after lunch, however he left shortly thereafter not fulfilling the four required hours.