Nevada State Board of Pharmacy

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QUARTERLY DISCIPLINARY REPORT TO LEGISLATIVE COUNSEL BUREAU

JULY 20, 2003

1. David C. Curry Board Meeting 4/23/03 Case No. 03-022-RPH-S

   Mr. Curry appeared at hearing late and told the Board he thought the charges against him were 'petty' and almost did not bother to come. Mr. Curry was terminated from employment from Rite Aid for filling prescriptions for his wife without authorization from a physician. At hearing, Mr. Curry admitted that he filled false prescriptions for controlled substances (Lortab) using an emergency room doctor's name that Mrs. Curry had seen once, and an APN Mrs. Curry used to work with in Maryland. Mrs. Curry had never been treated by the APN in a professional manner, however Mr. Curry found it easier to fill his wife's prescriptions by using false methods rather than have Mrs. Curry establish a relationship with a physician in Las Vegas. His justification for what he did was, "That's what they would have prescribed anyway." David Curry's pharmacist license was revoked.

2. John A. Bank Board Meeting 4/23/03 Case No. 03-020-PT-S

   Mr. Bank was terminated from employment at Kindred Hospital and Horizon Specialty Hospital for diversion of controlled substances. Mr. Bank removed morphine, Demerol, Dilaudid, hydromorphone, Lortab, Meperidine, Oxycontin and Percocet from dispensing machines at both hospitals where he worked as a pharmaceutical technician. He joined PRN-PRN before hearing and the PRN-PRN coordinator did not recommend Mr. Bank return to pharmacy at this time. The Board Ordered 6 months suspension, probation with the standard PRN-PRN Order, and administrative fees.

3. Scott W. Parker Board Meeting 4/23/03 Case No. 03-021-PT-S

   Mr. Parker did not appear at hearing. Mr. Parker was terminated from employment at Desert Springs Hospital for diversion of drugs. Mr. Parker removed controlled substances from Pyxis machines throughout the hospital for his personal use. Pharmaceutical Technician registration revoked.

4. Richard R. Thompson Board Meeting 4/23/03 Case No. 03-019-PT-S

   Mr. Thompson did not appear at hearing. While filling a large container of a dispensing machine at Medco Health, Mr. Thompson was observed cupping his hand and putting tablets into his mouth. Mr. Thompson was filling the

machine with Clonazepam 0.5mg. tablets and was behaving erratically. He was found to have been eating tablets while filling the machine. Mr. Thompson made comments to Medco personnel that he spit tablets out of his mouth into the bulk bin containing the Clonazepam 0.5 mg. tablets. Because of his behavior, 194,886 Clonazepam tablets had to be destroyed by Medco Health because of possible contamination. The Board revoked Mr. Thompson's pharmaceutical technician registration.

5. Terrance Rogers, Walgreens #06545
Board Meeting 4/23/03, Case No. 02-102-AB-S

This was a stipulated agreement presented to the Board. A prescription for liquid Zantac was taken to Walgreens #06545 to be filled for an infant. Mr. Rogers filled the prescription with liquid Zyrtec instead. Since it was the first offense by Mr. Rogers and Walgreens #06545, the Board accepted the stipulated agreement for a fine of $100 and administrative fees for both parties.

6. Michael T. Szewczyk, Sav-on Drugs #9096
Board Meeting 4/23/03, Case No. 02-039-AB-S

This was a stipulated agreement presented to the Board. A prescription for Doxazosin Mesylate 4 mg. tablets was transferred to Sav-on #9096 to be filled. Mr. Szewczyk filled the prescription with Doxazosin Mesylate 8 mg. tablets instead. Since it was the first offense by Mr. Szewczyk and Sav-on #9096, the Board accepted the stipulated agreement for a fine of $250 and administrative fees for both parties.

7. Peter Trinh, Walgreens #04197
Board Meeting 4/23/03, Case No. 03-011-AB-S

Ms. Shoemaker's health was deteriorating. She had a history of colon cancer that had metastasized and she had undergone radiation therapy and became too ill to continue the treatments. Ms. Shoemaker lived in a group home. On January 1, 2003, Ms. Shoemaker was hospitalized because of low oxygen/ blood count and pain in her stomach. By January 3, 2003, Ms. Shoemaker had stabilized and was ready to be released back to the group home. The family had arranged for hospice care at the group home. A caregiver from the hospice requested a prescription for Roxanol to help ease Ms. Shoemaker's pain and ensure that she was comfortable. The physician at the hospital gave the family members a prescription and asked one of them to have it filled in case Ms. Shoemaker experienced discomfort during her transport back to the group home. One of the members of the family went to Walgreens #04197 to have the prescription for Roxanol filled. When Ms. Shoemaker's daughter arrived back at the hospital, she found Ms. Shoemaker eating lunch and communicating with her other daughters. While

they waited for the transport, Ms. Shoemaker looked like she was suffering some pain and her daughter administered the prescribed Roxanol. After Ms. Shoemaker took the Roxanol she became unresponsive and her family thought she was having a heart attack. After being granted a waiver of responsibility, the transport took Ms. Shoemaker to the hospice at the group home.

On January 4, 2003, the family met with the hospice nurse. The hospice nurse questioned the dosage of Roxanol for Ms. Shoemaker and contacted the physician that wrote the prescription for clarification. The doctor verified that he had not written a dosage of 1 teaspoon for Ms. Shoemaker. Because of the incorrect dosage directions, Ms. Shoemaker ingested 100 mg. of Roxanol liquid, which is 20 times the amount of morphine sulphate than she was prescribed. Ms. Shoemaker's health deteriorated from the point she took the incorrect dosage of Roxanol, and she died nine days later.

During the hearing Mr. Trinh could not explain how the error occurred, but he testified that whenever he looked at the prescription he saw "5 ml." rather than "5 mg." He said a high dose warning came up on the computer but that they were regularly overridden with just a keystroke. It was never clearly defined regarding the counseling issue. Ms. Shoemaker's daughter testified that he came to her but, in broken English told her something, however nothing about this being a high dosage.

The Board Ordered Mr. Trinh to pay a fine of $3,250, take an ACPE approved CE on pain management and 4 hours of CE on counseling skills. The Board Ordered Walgreens #04197's to extend their probation another year, do the ISMP evaluation by pharmacy personnel, no management, and present the results to the Board at the August Board meeting and pay a fine of $5,000 plus administrative fees.

8. Joseph L. Norris, Sav-on Drugs #185
Board Meeting 6/18/03, Case No. 03-030-AB-N

Ms. Allaire telephoned in a refill for her Toprol XL 100 mg. tablets on the Sav-on automated telephone system. The following evening Mr. Allaire went to Sav-on #185 to pick up his wife's prescription. When he arrived he was told it was not ready and Mr. Allaire voiced his displeasure. Pharmacy staff hurriedly filled the prescription. A pharmaceutical technician pulled a return to stock bottle and a stock bottle to fill the prescription. The PT did not open the return to stock bottle and check the contents, but scanned the stock bottle of Toprol and relabeled the return to stock bottle with Ms. Allaire's information. Mr. Norris dispensed the prescription to Mr. Allaire, and while counseling he looked through the amber vial and the medication looked like Toprol. Mr. Allaire took the medication home to his wife and she began taking it the following morning. Ms. Allaire testified that she noticed a difference in her

medication, however thought they were another generic for Toprol. She drove to work, however claimed she did not remember doing so. She said she felt "dizzy and spacey". Ms. Allaire telephoned the pharmacy and asked about the "new generic" and was told she did not have a new generic, but she had the wrong medication. It was determined that Ms. Allaire had ingested a Topamax 100 mg. tablet that is meant for the treatment of seizures. The Board Ordered Mr. Norris $250 plus administrative fees and fine Sav-on #185 $250 and provide Board staff with a copy of their policies and procedures regarding return to stock drugs.

9. Emmanuel I. Rohani, Wal-Mart Pharmacy #10-2453
Board Meeting 6/18/03, Case No. 03-028-AB-N

This was a stipulated agreement presented to the Board. Ms. B lives in Round Mountain. Ms. B took her son to the doctor and he was diagnosed with an ear infection. Ms. B was given a prescription for Amoxil 125/5 ml. suspension, #200 cc with directions to take 1¼ teaspoons 3 times a day for 10 days. Ms. B took the prescription to Wal-Mart #10-2453, in Fallon, to be filled. After four days Ms. B was almost out of medication. She called the pharmacy and was told that she only received half the medication she should have received for her son. Since Battle Mountain is approximately 160 miles from Fallon and mail time is slow for remote areas, Ms. B's son missed 5 doses of Amoxil. Ms. B asked her physician if she could begin the Amoxil therapy for her son again after having missed so many doses and the doctor advised she needed to bring her son in for his ears to be checked. Ms. B took her son back to the doctor three more times and at the time of the Board hearing her son had an appointment with a specialist since his ears had not improved.

Mr. Rohani and Wal-Mart #10-2453 were both fined $250 plus administrative fees.

10. William A. Grohs, Sav-On Drugs #172
Board Meeting 6/18/03, Case No. 03-009-AB-N

A stipulated agreement was presented to the Board. Patient E was released from the hospital and was given six prescriptions on a chart order. The prescriptions were taken to Sav-On #172 to be filled. Upon a follow-up appointment with her physician, it was determined that Patient E was given Cardura 4 mg. tablets rather than the Avandia 4 mg. tablets that she was prescribed. Patient E ingested approximately 12 Cardura 4 mg. tablets, but fortunately suffered no complications or harm from the error.

Mr. Grohs and Sav-On #172 were both fined $100 plus administrative fees.