Nevada State Board of Pharmacy

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QUARTERLY DISCIPLINARY REPORT TO LEGISLATIVE COUNSEL BUREAU

OCTOBER 20, 2003

1 Steven J. Shaver Board Meeting 8/6/03 Case No. 03-035-RPH-S

Mr. Shaver violated his agreement with PRN-PRN by drinking alcohol. On more than one occasion Mr. Shaver's UA's were positive for alcohol. The Board revoked his license.

2 Robert W. Wasem Board Meeting 8/6/03 Case No. 03-036-RPH-S

Mr. Wasem did not appear at hearing, but the circumstances of this case were that he violated his agreement with PRN-PRN by drinking alcohol. Mr. Espadero, PRN-PRN monitor reported that Mr. Wasem had been in detox twice recently and still failed to remain sober. Mr. Wasem is planning to check into a six-month rehabilitation program. The Board suspended Mr. Wasem's license indefinitely with the requirement that he appear before the Board to request reinstatement.

3 Steven M. Hardy Board Meeting 8/6/03 Case No. 02-090-PT-S

Mr. Hardy did not appear at hearing. The Board had seen Mr. Hardy in October 2002 and suspended his pharmaceutical technician registration at that time for six months. After the six month suspension was completed, Board staff checked with PRN-PRN to see if Mr. Hardy had joined the program and he had not. The Board revoked Mr. Hardy's pharmaceutical technician registration.

4 Andrew Sneed Board Meeting 8/6/03 Case No. 03-039-PT-S

Mr. Sneed did not appear at hearing. Board staff took this action because they had received notice that Mr. Sneed was terminated from employment from Albertson/Sav-On for drug diversion. The Board revoked Mr. Sneed's pharmaceutical technician registration.

5 Sean D. Miller Board Meeting 8/6/03, Case No. 03-037-PT-S

Mr. Miller did not appear at hearing. Board staff took this action because they had received notice that Mr. Miller was terminated from employment from Albertson/Sav-On for drug diversion. The Board revoked Mr. Miller's

pharmaceutical technician in training registration

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Gary L. Horne Board Meeting 8/6/03, Case No. 03-017-RPH-S

Mr. Horne gave a candid report to the Board regarding his behavior. He testified that he began a training schedule at The Gym and began weight training four days a week. His objective was to loose body fat and increase muscle mass but not to become a body builder. He heard talk at The Gym about a doctor who administered steroids and other products and supplements. He stated that he did some research and learned of anti-aging clinics in the area that prescribed and administered male hormones, human growth hormone and other medications that delay the aging process. Mr. Horne got the idea that he could set up a phony clinic in the pharmacy accounts at PharMerica, where he was employed. He would purchase medications and charge them to the clinic and pay for them himself. The accounting person at PharMerica questioned why he was paying cash and why invoices that were sent to the address were returned to PharMerica with a postal stamp 'unknown address.' Mr. Horne bought these medications for his personal use. Mr. Horne found that the deeper he got into his fantasy, the more he had to lie to cover up his behavior. He testified that his wife, his trainer and his employer became suspicious of his alleged clinic and Mr. Horne's behavior. PharMerica found that the amount of products purchased for the fictitious clinic exceeded the amount of accounted for as sold and invoices for the transactions did not exist. Mr. Horne was terminated from employment. He had to tell his wife the truth. Mr. Horne testified that he had begun counseling sessions to address his behavioral problems. The Board suspended Mr. Horne's pharmacist license for six months, stayed five months of the suspension, put him on probation for three years, plus pay all fees and costs and a fine of $2,500 to be due within 60 days, join PRN-PRN and have a psychiatric evaluation, not practice as a managing pharmacist during his probationary period and attend Las Vegas Board meetings for the first year of his probation.

7 Edmund A. Gianan/Walgreens #04086
Board Meeting 8/6/03, Case No. 03-014-S

It was determined that Mr. Gianan was not the responsible pharmacist for this error and in fact it was Christopher G. Weihler. Mr. Weihler appeared and Mr. Gianan was not present. The circumstances of this case turned into a complex series of events for Patient R's prescriptions for potassium chloride. The first prescription was filled with directions to take less than was prescribed by her physician. Also, the physician's name was incorrect. On the second prescription her physicians name was still incorrect and the directions for use were to take a milliliter measurement and she was not given a dropper. After discussion this with the pharmacist she was told that the first

directions were wrong and that an incident report would be made. In the meantime, another pharmacist telephoned her physician for clarification. The nurse and the physician did not have Patient R's chart in front of them so they told the pharmacist to give her what she had the first time, assuming that the prescription was filled correctly. This time Patient R received even less than the first time because of the direction from the physician's office. There was considerable discussion regarding the initials of the pharmacist. Walgreens stated that their system can tell who verified or filled a prescription, but that only one pharmacists initials appear on all labels as the filling pharmacist. Walgreens stated that their policy is that the filling pharmacists initials are printed on labels and the real verifying pharmacist is supposed to hand initial the other pharmacists computer generated initials on the back of the original prescription. This is why Mr. Gianan was thought to be the pharmacist responsible for this error when in fact it was Mr. Weihler. The Board dismissed the charges against Mr. Gianan. Mr. Weihler was to receive a letter of reprimand, do two hours of CE on medication errors in addition to the 30 CE's due at renewal of his license. The Board moved to dismiss the one Cause of Action against Walgreens if they voluntarily do the ISMP survey.

8 Olukunle A. Alabi/Walgreens #03841
Board Meeting 8/6/03, Case No. 03-032-S

The circumstances regarding this complaint revolved around a 2 ½ year old child that was diagnosed with a mild case of conjunctivitis. Patient L was prescribed Rondec for his cough and congestion and the other was Polytrim eye drops for the conjunctivitis. His mother administered the drops to Patient L for two days according to the directions and Patient L appeared to be having an allergic reaction to the drops. Ms. L researched the problem by telephoning Patient L's physician and the pharmacy and it was discovered that she had been instilling ear drops in Patient L's eyes. Mr. Alabi testified that it was a busy day, Ms. L came through the drive through however he failed to notice the discrepancy when he counseled Ms. L. Mr. Alabi said that a pharmaceutical technician pulled the bottle from the shelf however did not scan it. The Board fined Mr. Alabi $250 plus costs and administrative fees, do two hours of CE on counseling in addition to the 30 CE's due at renewal of his license. Walgreens was found guilty of one Cause of Action however it was determined not to impose any discipline.

9 Sayed Haseebullah/Raxo Drugs
Board Meeting 8/6/03, Case No. 03-029-S

The complainant for this case was unable to attend the hearing. It was explained to the Board that the patient had been shorted on his prescriptions and when confronted, Mr. Haseebullah would make determinations whether he felt the patient was in pain and how much medication the patient would

receive. The investigation of this case provided that Mr. Haseebullah and Raxo Drugs handled referrals from a personal injury attorney. Mr. Haseebullah would fill their clients prescriptions and bill the attorney for reimbursement after the legal matter was settled. It was found that Mr. Haseebullah would only do a partial fill and tell the patient to return for the remainder of their medication at a later time. When the patient would return for the remainder of the medication, Mr. Haseebullah would make a personal judgment as to the need of the patient. In this particular matter Patient M was shorted 126 Lortab and 90 Soma after suffering a broken neck in an automobile accident. After testimony by Board investigators and inspectors, numerous violations of Nevada law were found in Mr. Haseebullah's pharmacy. The Board dismissed the Third Cause of Action against Mr. Haseebullah and found him and Raxo Drugs guilty of the 1st, 2nd, 4th, 5th, and 6th Causes of Action. Mr. Haseebullah was fined $2,500 plus costs and administrative fees, he was placed on probation for a period of three years and during that time was not to practice as a managing pharmacist or do his own ordering. Mr. Haseebullah will need to hare a managing pharmacist who will do the record keeping and ordering for Raxo Drugs. Raxo Drugs was placed on probation for three years and ordered to pay a fine of $2,500. Raxo Drugs was ordered to provide an action plan – Policies and Procedures to include partial fill procedures, perpetual inventory procedures for Schedule II controlled substances and for hydrocodone products and Soma. Raxo will be reinspected and Mr. Haseebullah will give a progress report to the Board in six months.

10. Donald C. Gitersonke/Target Pharmacy T-826
Board Meeting 8/6/03, Case No. 03-024-S

Prior to hearing Mr. Gitersonke and Target have taken responsibility for this error and have put new procedures in place to ensure this type error won't recur. This matter involved a labeling error. Baby M was prescribed 2 cc's of Albuterol, however the prescription label indicated that Baby M was to take 2 teaspoons of Albuterol. Baby M consumed five doses of Albuterol with the incorrect dosing instructions. Baby M ingested five times the dosage of Albuterol that was prescribed by Baby M's physician. The Board ordered Mr. Gitersonke to pay a fine of $250 plus costs and administrative fees. Target was found guilty of the charges and will given a letter of reprimand, they were not imposed a fine, however were to review their Policies and Procedures reinforcing the training for high dose alerts.

11. Sam C. Sherman/Longs Drug Store #404
Board Meeting 9/10/03, Case No. 03-012-N

Ms. King is the complainant in this matter on behalf of her son Trevor. Trevor is manic-bipolar and is extremely hyperactive. He regularly takes Adderall XR 70 mg. for hyperactivity, 500 mg. Seroquel nightly for manic behavior and

sleep and he takes a weekly time-release dose of two Prozac 90 mg. capsules. After having Trevor's prescriptions refilled in February, she gave him five 100 mg. tablets of Seroquel that she received from Long's #404. Within a short period of time, Trevor threw up and became very hyperactive. He did not sleep well that night. The following morning he was very calm, however he was hallucinating. Ms. King took the medication she received from Long's #404 to Walgreens and asked the pharmacist to identify it. It was discovered that Trevor had ingested Serzone rather than the prescribed Seroquel. After a brief stay at the hospital, Ms. King returned to Long's #404 and spoke with Mr. Sherman and asked him to identify the tablets in the container that he dispensed to her the previous evening. At first Mr. Sherman could not identify the tablets in the prescription container as Serzone and thought they were Seroquel. He did finally identify them correctly. It was determined at hearing that Mr. Sherman did not have a scanner at Long's #404 and he stated that he hand wrote NDC codes and apparently he did not look at the bottle when he was checking his work. Mr. Sherman claimed that he tried to counsel Ms. King on Trevor's prescriptions, however she refused since Trevor had taken the medication before. The investigation of this matter brought to light that Long's uses inadequate counseling logs. Mr. Sherman was fined $1,000, required to complete four CE's on misfills, pay half of the costs and administrative fees and appear at all Reno Board meetings for one year to report how he has incorporated what he has learned from his continuing education and how he has applied it to his practice of pharmacy. Long's #404 was placed on probation for one year, remanded to pay a fine of $1,000 plus half of the costs and administrative fees, appear at Reno Board meetings for one year and report on the changes they have made to that store to improve, prepare a uniform counseling log for their stores in Nevada that meet the requirements of Nevada law and do the ISMP survey.

12. Jeannie H. Chang/Wal-Mart #10-2453
Board Meeting 9/10/03, Case No. 03-008-N

This was originally a stipulated case that the Board rejected and the reason this hearing is brought forth. It was a misfill of Tussionex for Zithromax for a four year old child. Counseling was provided by a pharmacist other than Ms. Chang who filled the prescription. Ms. Chang testified that she was a fill-in pharmacist at Wal-Mart #10-2453 located in Fallon. Ms. Chang is the managing pharmacist for Wal-Mart in Carson City. She arranged for coverage for her store and drove to Fallon as quickly as she could and arrived there at approximately 10:30 a.m. The store was behind since it was opening late and she was hurriedly filling prescriptions to catch up. Even though she was very busy, Ms. Chang testified that she read the prescription as Tussionex and filled it with Tussionex. Mr. Crisologo, the managing pharmacist for Wal-Mart #10-2453 immediately called a staff meeting upon his return to work. He discussed the circumstances of this case and shared

ideas to improve their pharmacy operation. Mr. Crisologo advised that now show and tell counseling is required on all new prescriptions and that this procedure has been successful. The Board ordered a fine of $250 plus administrative fee for both Ms. Chang and Wal-Mart #10-2453.

13. Charlene C. Rock/Smith's #357
Board Meeting 9/10/03, Case No. 03-043-N

Ms. Dyer appeared on behalf of her son Patrick and described the circumstances of her complaint. Ms. Dyer explained that Patrick has ADHD and takes clonidine at night to help him sleep. Ms. Dyer telephoned the automated system at Smith's for a refill of Patrick's clonidine and Mr. Dyer picked it up from the pharmacy. Ms. Dyer administered two tablets to Patrick and approximately 45 minutes later went to take Patrick to bed. She observed that he was stumbling, he fell down, he was dizzy and having extreme difficulty maintaining his stability. Ms. Dyer called poison control and they identified the tablets as clonazepam. Ms. Dyer took Patrick to the emergency room for evaluation and he was released from the hospital without treatment. Bonnie Brandt, the district manager for Smith's testified that had even one of the procedures followed in this case the error would not have occurred. Ms. Brandt has had several conversations with Ms. Rock and they have shared ideas to improve the procedures in Smith's #357. One of the changes made have been to separate clonazepam and clonidine so they are not side-by-side. The Board ordered Ms. Rock to pay a fine of $500 plus costs and administrative fees plus do two CE's focusing on medication errors. There was no discipline imposed upon Smith's #357.

14. Theodore K. Worswick Board Meeting 9/10/03 Case No. 03-051-N

Mr. Worswick was represented by counsel who explained that in the criminal action against Mr. Worswick he has been remanded to the PRN-PRN program rather than be charged with a felony. He explained that Mr. Worswick suffers from chronic back pain, made the decision to self medicate and took advantage of his position in the pharmacy. He also stated that Bobby Tucker is willing to take Mr. Worswick as a pharmacist in his pharmacy and monitor him. Mr. Tucker is the PRN-PRN representative in the North. After lengthy discussion with the Board, the following was ordered. Mr. Worswick was placed on 90 days suspension to include time served since his arrest since he had not worked, continue in the PRN-PRN program for a period as prescribed in his contract, may only be employed at Tucker's Pharmacy and if he leaves Mr. Tucker's employ he needs to return to the Board for review, that he not fill prescriptions for himself or his family, that he return to the Board prior to being released from probation for a final review of his progress and be assured that Mr. Tucker maintains a perpetual inventory on all controlled substances.

15. John J. Jarzynka/Patricia A. Jarzynka
Board Meeting 9/10/03, Case No. 02-107-N

Both, Mr. and Mrs. Jarzynka were each represented by separate legal counsel. Mr. Bradley, representing Mr. Jarzynka, noted that Mr. Jarzynka would not be giving testimony as his criminal case was still pending. Board legal counsel advised that the two matters would be treated as separate issues. The Jarzynka's moved from Arizona to Nevada in 2001. Mrs. Jarzynka was being treated for diabetes, osteoarthritis and estrogen issues. She wanted to maintain her same treatment therapy and she had Mr. Jarzynka refill her prescriptions as if they had been transferred to Nevada. In 2002 Mrs. Jarzynka obtained a physician in Nevada and continued her therapy with prescriptions from her new physician. Mr. and Mrs. Jarzynka were both employed at Washoe Medical Center Pharmacy and were terminated from employment for filling false prescriptions for themselves. After Mrs. Jarzynka obtained her own physician, Mr. Jarzynka would enter prescriptions from physicians they had not seen in years, did not exist at all, or had not written the prescriptions. Once the false prescriptions were entered into the pharmacy computer, Mr. Jarzynka would generate receipts for the prescriptions which he would then send to their insurance company for reimbursement. Mr. Jarzynka had obtained more than $16,000 in reimbursement for fraudulent prescriptions from their insurance company from May 2001 through November 2002. Mr. Bradley asked the Board to accept the surrender of Mr. Jarzynka's pharmacist license, and by agreement he would never request reinstatement. In the matter of Mrs. Jarzynka the Board ordered a 90 day suspension of her license, the suspension was stayed, she was placed on two years probation with the conditions that she not practice as a managing pharmacist, not fill prescriptions for herself or her family, pay a fine of $1,500 and the costs and administrative fees.

16. Tony L. Huffman Board Meeting 10/15/03 Case No. 03-046-RPH-S

Mr. Huffman was terminated from employment from Smith's for diversion of drugs. Mr. Huffman had neck surgery and took hydrocodone and carisoprodol for approximately nine months. He tried to stop taking the pain medication however he could not withdraw from use. He got help from a pain management doctor to help him get off the pain medications. He testified that he has not used anything since May 26, 2003 and he joined PRN-PRN after he was dismissed from Smith's. Mr. Huffman is now working in a nuclear pharmacy. The PRN-PRN monitor and Mr. Huffman's physician both attested that they were comfortable with Mr. Huffman working – especially in a nuclear pharmacy where there were no common drugs. The Board ordered Mr. Huffman to pay a fine of $1,000 plus administrative fees and continue with the PRN-PRN program.

7. Lisa M. Bowyer Board Meeting 10/15/03 Case No. 03-038-PT-S

Ms. Bowyer was terminated from employment at Sav-On #6044 for unlawfully diverting controlled substances and other legend drugs. She admitted to falsifying a prescription in her sister-in-law's name and giving the prescription to her sister-in-law's brother-in-law who was a personal friend. She also admitted to adding refills on hydrocodone prescriptions for her father, mother, sister-in-law, a friend and her boyfriend. The Board ordered Ms. Bowyer's pharmaceutical technician license be suspended for 30 days, she was placed on probation for two years, she is required to have a PRN-PRN evaluation, inform any future employer of this order and pay the costs and administrative fees.

18. Stacy E. Cronshaw Board Meeting 10/15/03 Case No. 03-057-PT-S

Mr. Cronshaw was terminated from employment from Albertson/Sav-On. He came to hearing and told an incredible tale of how he had been in an automobile accident and had back pain and needed a prescription refill for Lortab 10 #30. He claims to have called his doctor and had them call in a refill. A person named Jennifer claiming to be from Dr. Shelf's office called in a prescription and the information was taken by a pharmaceutical technician. Mr. Cronshaw picked up the prescription, however the pharmacist had concerns about the prescription and telephoned Dr. Shelf's office to verify the refill. The pharmacist learned that he nor none of his staff had approved a refill for Mr. Cronshaw for Lortab, and in fact Jennifer was on vacation. Mr. Cronshaw claimed that Dr. Shelf's office left a message on his answering machine advising him that his prescription was ready. He also stated that he didn't have the prescription filled in the store he worked in because he was going to be in the area of the store that filled the prescription and it would be more convenient. The Board revoked Mr. Cronshaw's pharmaceutical technician registration.

19. Cynthia Blake Board Meeting 10/15/03 Case No. 03-027-PT-S

Ms. Blake did not appear at hearing, however her managing pharmacist, Jeri Raj, appeared and testified that a doctor had called and questioned her regarding who from her pharmacy was filling prescriptions for Lortab for one of his patients without his authorization. After a complete investigation into the circumstances in question, it was determined that Cynthia Blake had been filling the prescriptions for the doctor's patient. The Board revoked Ms. Blake's pharmaceutical technician registration.

20. Andres M. Estrada, Jr Board Meeting 10/15/03 Case No. 03-050-PT-S

Mr. Estrada was terminated from employment from Walgreens after testing positive for marijuana in a random drug screen. Mr. Estrada testified that he

had been to a concert and made a poor choice when he used marijuana with his friends. He has been in touch with PRN-PRN and he has an appointment for an evaluation with Mr. Espadero. Mr. Estrada seemed sincerely remorseful for his behavior. The Board ordered the standard PRN-PRN contract if Mr. Estrada is evaluated and appears to have a problem.

21. Rhonda J. Lehman Board Meeting 10/15/03 Case No. 03-041-PT-S

Legal counsel for the Board advised that Ms. Lehman was not present and that she had been arrested with bail set at $30,000. It could not be determined that the case had gone to trial yet and suggested the Board suspend Ms. Lehman's pharmaceutical technician registration until the criminal matter is handled. The Board suspended Ms. Lehman's pharmaceutical technician registration as suggested.

22. Sherrie L. Winings Board Meeting 10/15/03 Case No. 03-056-PT-S

Ms. Winings was terminated from employment from Valley Hospital and Medical Center for testing positive for marijuana in a random drug screen. Ms. Winings appeared and testified that she worked at Valley Hospital and had seven days on and seven days off. She had friends in from out of town and she partied with them on one of her seven days off and smoked marijuana with them for the entire time. Ms. Winings testified that she had never done that before and that she doesn't intend to do it again, but she got caught up in the moment with her friends. The Board ordered the standard PRN-PRN contract if Ms. Winings is evaluated and appears to have a problem.

23. Dutchess Business Services, Inc/Legend Pharmaceuticals, Inc.
Board Meeting 10/14-15-16/03, Case No. 03-004-WH-S

This case was heard on October 14th, 15th, and 16th, however it was not completed and was continued to the December 2nd, 3rd, and 4th Board meeting in Reno.