Nevada State Board of Pharmacy

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QUARTERLY DISCIPLINARY REPORT TO LEGISLATIVE COUNSEL BUREAU

OCTOBER 20, 2007

1 Pamela S. Goff — Board Meeting 07/25/07 — Case No. 06-069A-RPH-S
Nazanin Rezvan — Case No. 06-069B-RPH-S
Jackson Yu — Case No. 06-069C-RPH-S
Asia I. Cornelius — Case No. 06-069-PT-S
Summerlin Hospital Medical Center Pharmacy — Case No. 06-069-IA-S

Alyssa Shinn was a premature baby born weighing slightly over one pound at birth. She was placed in the Neonatal Intensive Care Unit (NICU) at Summerlin Hospital. On November 8, 2006, Dr. Zenteno created a written order for TPN at 4:30 p.m. for Alyssa Shinn. One of the components included in the TPN order was zinc written for the concentration of 330 mcg./100 ml. At 7:44 p.m. Ms. Goff processed the TPN order into the pharmacy's computer system. Dr. Zenteno's order for the zinc was written in quantity per volume rather than in quantity per patient weight and because Summerlin Pharmacy's automated TPN compounding device, known as a BAXA device, was set up for orders to be placed in quantity per weight, Ms. Goff calculated the total volume for the bag that would contain the finished TPN, and then performed a calculation to convert Dr. Zenteno's zinc order as appropriate for the total volume of the bag. Ms. Goff performed the first calculation correctly, but because there had been concerns raised by the nursing staff regarding the quantity per volume calculations appearing on TPN labels, Ms. Goff recalculated the zinc order to convert it from mcgs./decileter to mcgs./kilogram. In recalculating the zinc order, Ms. Goff selected "mg." for the quantity rather than "mcg" as ordered, thus resulting in a final quantity of zinc of 330 mg. per 100 ml. rather than 330 mcg. per 100 ml. When Ms. Goff printed the two label sets for the preparation of Alyssa Shinn's TPN order per Summerlin Hospital's policies and procedures, the labels contained an incorrect dose of zinc that was one thousand times more than ordered. Ms. Goff presented the label sets to Ms. Rezvan for double-checking of the accuracy of the data entered by Ms. Goff. Ms. Rezvan failed to catch the error and explained at hearing that she did not notice the "mg." instead of the "mcg." that should have been on the zinc component of the order. After completing her check of the order, Ms. Rezvan forwarded the label sets to the compounding room so the order could be filled. Ms. Cornelius was the pharmaceutical technician who performed the compounding. Ms. Cornelius was asked to compound a few products that evening because the usual compounding pharmaceutical technician was unavailable. It was found that

Ms. Cornelius was new to Summerlin Pharmacy and had compounded fewer than 20 products using the BAXA device. Ms. Cornelius compounded Alyssa Shinn's TPN and had to calculate the total volume of the prepared product. She had to use a 500 ml. bag rather than the 250 ml. bag that was usual for neonatal patients. During the filling of the TPN for Alyssa Shinn, Ms. Cornelius replenished the zinc supply in the BAXA device eleven times using 48 vials of zinc. Ms. Cornelius completed the compounding of the TPN order and presented the bag on which one of the two label sets had been placed, the duplicate label set, and the vials and syringes for the two manually-added ingredients to Mr. Yu for his verification. Ms. Cornelius explained that she did not tell Mr. Yu or any other pharmacist about the huge quantity of zinc she had added to Alyssa Shinn's TPN because she did not know or think there was anything wrong with what she had done. Mr. Yu was the verifying pharmacist and was only required by Summerlin Hospital Pharmacy policies and procedures to verify the vials and syringes of the manually added ingredients, but not the completed TPN product. Since the zinc was not manually added, Mr. Yu was unaware of the volume of zinc Ms. Cornelius had added to the TPN. Because Mr. Yu performed only the limited verification required of him by Summerlin Pharmacy, Mr. Yu did not catch that Alyssa Shinn's TPN bag contained a one thousand times overdose of zinc. At approximately 3:00 a.m. on November 9, 2006, the nursing staff at the NICU began administration of the TPN bag that contained the zinc overdose. Neither of the NICU nurses on duty caught the error or questioned why the bag containing the TPN was larger than the baby. At approximately 6:00 a.m. when Ms. Cornelius was going off shift and Rebecca Weiss, a lead pharmaceutical technician, was coming on shift, Ms. Cornelius related the unusual preparation of Alyssa Shinn's TPN. Ms. Weiss immediately rechecked the order and discovered the zinc over dose and took her concerns to Mr. Yu. At approximately 6:15 a.m. Mr. Yu contacted the NICU and ordered that Alyssa Shinn's TPN be immediately discontinued. Mr. Yu contacted poison control to see if he could find an antidote for zinc poisoning. He determined EDTA might help but Summerlin Pharmacy did not have EDTA. Mr. Yu had EDTA compounded from a private retail pharmacy, however unfortunately the EDTA did not reverse Alyssa Shinn's overdose. At approximately 4:20 p.m. Alyssa Shinn was declared dead by the Clark County Coroner from zinc intoxication.

Ms. Goff was fined $5,000.00, required to participate in the Your Success Rx program and be on probation for one year. Ms. Rezvan was fined $2,500.00, required to participate in the Your Success Rx program and was suspended for 30 days. Mr. Yu was fined $2,500.00, required to participate in the Your Success Rx program, do 10 hours of CE on TPN or pharmacy errors due to Board's staff within 90 days of the Board's Order, and was suspended for 30 days. Summerlin Hospital Pharmacy was fined $10,000.00 plus the fees and costs in this matter and required to participate in the Your Success Rx program with follow-up to the Board in one year to report on how the

pharmacy is operating.

2 Wendell C. Weeks Board Meeting 07/25/07 Case No. 06-044-RPH-S
Walgreens #04137 Case No. 06-044-PH-S

This was a stipulated agreement for an ingested misfill accepted by Mr. Weeks and Walgreens #04137 for $200.00 each.

3. Vaughn R. Terry Board Meeting 09/05/07 Case No. 07-056-PT-N

Mr. Terry did not appear at hearing. The Board determined they would move forward with this matter in Mr. Terry's absence. Louis Ling advised the Board that Mr. Terry tested positive for marijuana in a pre-employment drug screen for Smith's. Mr. Terry's pharmaceutical technician registration was revoked.

4. Breanne N. Kephart Board Meeting 09/05/07 Case No. 07-020-PT-N
Raley's Drug Center #105 Case No. 07-020-PH-N

Ms. Kephart failed to renew her pharmaceutical technician registration and worked unregistered for a few days. Raley's headquarters had a miscommunication when verifying Mf. Kephart's registration information at renewal time. Raley's has implemented new policies and procedures to ensure licensure of their pharmacy staff.

Ms. Kephart was fined $250.00 and was mandated to attend a live CE presentation given by Board staff on September 20, 2007. Raley's was fined $250.00 plus costs and fees in this matter.

5. Wal-Mart #10-3408 Board Meeting 09/05/07 Case No. 07-010-PH-N

Mason Rice, a one year old baby, was prescribed Bactrim suspension by his pediatrician, Dr. Philip Schlager, for an ear infection. Jeannie Dey, Mason Rice's mother, had the prescription phoned to Wal-Mart #10-3408 to be filled. David Rice, Mason's father, is an employee of that particular Wal-Mart and would pick up the filled prescription from the pharmacy when he got off work. When Mr. Rice appeared to pick up the prescription he noted that there were pills in the bag he was handed and asked the clerk how he was supposed to give his baby a pill. He was told to crush it and put it in the baby's food. Mr. Rice paid for the prescription and left the pharmacy. When he arrived home he gave the medication to his wife and told her of his conversation with the pharmacy clerk regarding administering the medication. Ms. Dey contacted Dr. Schlager's office the following morning to get clarification on administering the medication because she was under the impression the medication was to be a liquid. She also noticed that the label did not have Dr. Schlager's name on the label, but another name that Ms. Dey was not familiar with. Ms. Dey was advised that Dr. Schlager had ordered a suspension and Mason was not

to be given the pills that were dispensed to Mr. Rice.

The investigation of this case found it impossible to determine who actually was involved in the filling of this prescription. Board staff found that the pharmacist on duty was logged on to more than one computer and anyone in the pharmacy would use the computers under the pharmacist's log-on ID. It was found that it was common practice in that pharmacy. While checking the counseling log, the Board investigator witnessed a pharmaceutical technician asking a patient if they wanted to talk to the pharmacist rather than asking the pharmacist to come to the counter to counsel on a new prescription. There was no record of Mason Rice's prescription in the counseling log. It was determined that the pharmaceutical technician who input the prescription had used a drop-down list that did not have Bactrim suspension on the list and chose the adult dosage of Bactrim pills. Because of all the Nevada law violations found in this pharmacy, Board staff only charged Wal-Mart in this matter.

Wal-Mart #10-3408 was found guilty of all eight Causes of Action, they were placed on probation for one year, required to enhance their computer system to include high dose alerts and take measures to ensure counseling takes place. Wal-Mart representatives will sit down with Board staff to discuss compliance with Nevada law and the referenced requirements. The Board inspector is to audit for counseling compliance and then spot check during the probationary period. Wal-Mart was also fined $3,000.00 plus costs and fees in this matter.