

## Nevada State Board of Pharmacy

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## QUARTERLY DISCIPLINARY REPORT TO LEGISLATIVE COUNSEL BUREAU

**JANUARY 20, 2006** 

1. Julie J. Leavitt CVS Pharmacy #5792

Board Meeting 10/26/05

Case No. 04-043-RPH-S Case No. 04-043-PH-S

Ms. Leavitt filled a prescription for Bactrum DS for a patient that had an allergy to sulfa drugs. Ms. Leavitt overrode the allergy warning that appeared on the computer screen as she was processing the prescription. The patient had seen a new doctor, and after tests it was determined he had a bacterial infection and was prescribed Bactrum DS, the doctor not knowing the patient was allergic to sulfa.

A stipulated agreement of a \$300 fine and \$250 administrative fee was offered to Ms. Leavitt and CVS #5792 that they both signed. The Board accepted the stipulated agreements.

Malinda Cantu

Ms. Cantu did not appear for hearing. Ms. Cantu had been working at K-Mart when it came to the attention of the pharmacy manager that controlled substances were missing. Cameras were installed in the pharmacy and Ms. Cantu was caught on tape stealing. After Ms. Cantu was confronted, she admitted to K-Mart loss prevention personnel and the Las Vegas police, that she had taken approximately \$4,300 worth of drugs from K-Mart.

The Board found Ms. Cantu guilty and revoked her pharmaceutical technician registration with the provision that if she ever requested reinstatement that she appear before the Board and prove that she had paid restitution to K-Mart.

3. John H. Kephardt Board Meeting 10/26/05 Case No. 05-043-PT-S

Mr. Kephardt lied on his original and renewal applications by not disclosing that he had surrendered his license to the Nursing Board. Mr. Kephardt explained that he thought the question related to his pharmacy license and since he had not had an action with the Board of Pharmacy he thought he was answering the question appropriately. On November 21, 2002 Mr. Kephardt signed a document relinquishing his license with the Nursing Board On January 3, 2003 the relinquishment was accepted by the Board of

Nursing. Mr. Kephardt was registered by the Board of Pharmacy in April 2003. He explained that he was accused of diverting drugs and denies that allegation. He advised the Board that he has been working as a pharmaceutical technician at Biotech, a nuclear pharmacy, where there are no controlled substances.

Mr. Kephardt was placed on probation for two years, is responsible for having a PRN-PRN evaluation, notify the Board if he changes employment and pay the Board's administrative fee of \$250.

4. Jason J. Walker Board Meeting 10/26/05 Case No. 05-041-PTT-S

Mr. Walker contacted Board staff and advised that he would not be present at hearing as he had decided to pursue another career path.

Mr. Walker was a student at Heritage College in the pharmaceutical technician training program. He tested positive for marijuana during a random screening. Mr. Walker came before the Board and agreed to join the PRN-PRN program in order to have a second chance. Mr. Walker joined the program, however came to a peer group meeting and appeared to be impaired. He was asked to submit a urine sample and the PRN-PRN group monitor found a bottle of urine in his pocket that he intended to substitute for the sample he was asked to produce. This incident was reported to Board staff.

The Board revoked Mr. Walker's pharmaceutical technician in training registration.

5. Debra K. Dorigatti Board Meeting 10/26/05 Case No. 05-022-RPH-S UMC Inpatient Pharmacy Case No. 05-022-PH-S

The complaint came from Dr. Dua on behalf of one of his patients. On April 21, 2005 Ms. Dorigatti received an order from Dr. Dua for a non-formulary drug. Ms. Dorigatti claimed that she could not identify from the signature who the physician was that wrote the order. Ms. Dorigatti brought the order to the attention of the nurse on duty who told her she would be seeing the physician when he made rounds and would see if the drug could be changed to a formulary drug. Ms. Dorigatti failed to make contact with the physician or the nurse on duty or to follow-up with the physician before the end of her shift. Thus, Dr. Dua's patient did not receive her anti-coagulation therapy for approximately 48 hours, thus exposing the patient to considerable risk that Dr. Dua's order was intended to alleviate.

Ms. Dorigatti was fined \$250 and UMC was placed on probation for six months, was fined \$250 plus the costs and fees in this matter and Board staff would audit them to ensure the new policies and procedures they claim to

have written because of this incident are in place.

6. Cale S. Batt Board Meeting 10/26/05 Case No. 05-027-RPH-S Lins Supermarkets #5 Case No. 05-027-PH-S

Mr. Batt filled a prescription for 1 mg. Coumadin tablets with 5 mg. Coumadin tablets. The patient has a heart problem and he was prescribed 1 mg. Coumadin tablets to ensure his blood flowed properly and did not clot. The patient ingested the misfiled prescription and began noticing his right leg, foot and ankle began to hurt and turn black and blue. His left leg began to hurt, also, and began bruising. The patient began using his arms to lift himself from a sitting position, however this activity caused bruising to his arms. He went to his physician to see what was causing this condition and it was discovered that he had been given the higher dosage of Coumadin.

Mr. Batt was found guilty of the offense and fined \$1,000 to be applied toward a pharmacist practice evaluation program given by Katie Johnson, take 2 hours of anticoagulation product continuing education and report back to the Board after his practice evaluation. Lins #5 was found guilty and is required to install the new computer system they described within six months, train their employees, prepare polices and procedures regarding narrow therapeutic index products, institute show and tell counseling within 120 days, and pay a fine of \$2,000 plus fees and costs. Lins #5 will report their progress within six months at a Las Vegas Board meeting.

7 Kenneth J. Ackerman Board Meeting 12/8/05 Case No. 05-021-RPH-N Walgreens #04789 Case No. 05-021-PH-N

Mr. Ackerman is a pharmacist that was working at a Walgreens in Las Vegas and was asked to be a relief pharmacist in Reno for one day. While he was working in Reno a refill prescription for acetaminophen with codeine was transferred to the store in which he was working. Even though only one refill was authorized by the prescriber, six additional refills were added. While this matter was under investigation, it took two weeks to find out who the pharmacist was that was working at Walgreens #04789 when this incident occurred. Walgreens had a new managing pharmacist in that store that was unfamiliar with Walgreens procedures and was unable to identify the pharmacist who filled the prescription at issue. The information was finally obtained by Walgreens headquarters payroll department.

Mr. Ackerman was found guilty and will receive a letter of reprimand. Walgreens was found guilty and was fined \$250 plus costs and fees.

8. Scott T. Larsen Walgreens #03871 Board Meeting 1/11/06

Case No. 05-033-RPH-S Case No. 05-033-PH-S

Patient G has a heart condition and has had five open heart surgeries and has had three heart valves replaced and she has two pacemakers. Patient G takes Coumadin to ensure her blood does not clot and 10 mg. of Valium at night so she can sleep because of the noise the pacemakers make. Patient G had her prescriptions filled and began taking the medications as directed and as she always had however she was constantly tired and slept a great deal of the time. Patient G had her prescriptions refilled again and noticed as she was going to put the three tablets left from her Coumadin prescription with the new medication that they were not quite the same. It was discovered that Patient G had been given 5 mg. tablets of Valium in the Coumadin bottle and she had taken them for 27 days along with the 10 mg. Valium she normally takes at bedtime. Fortunately Patient G did not suffer a blood clot while she was not taking her Coumadin. For lack of evidence, the Board dismissed the charges against Mr. Larsen and Walgreens #03871.

9. Scott T. Larsen Walgreens #03842

Board Meeting 1/11/06

Case No. 05-034-RPH-S Case No. 05-034-PH-S

Patient T received a prescription from an ER doctor for Zithromax and a second prescription for Flumadine for a mild upper respiratory tract infection. Mr. Larsen misread the Flumadine prescription and filled it with flecainide. Patient T began having heart palpitations and returned to the ER where it was discovered she had been taking an antiarrhythmic drug. Patient T did not have a heart problem. Mr. Larsen and Walgreens #03842 were each fined \$500 and they would split the costs and fees in this matter.

10. Leslie J. Schweizer Walgreens #05646

Board Meeting 1/11/06

Case No. 05-038-RPH-S Case No. 05-038-PH-S

Patient P is a diabetic that takes Novalog 70/30 twice a day to maintain her insulin levels. She had her prescriptions refilled and the pharmacy gave her a partial refill as they had to order more medication. When the medication came in, two boxes were prepared for Patient P to fulfill her original order. A technician taped two boxes together and labeled it and gave it to Ms. Schweizer to check. Ms. Schweizer scanned and checked the top box but did not scan the second box that was taped to the first. Patient P used one of the syringes from the second box and injected it in her stomach prior to dinner. She went to bed after dinner, however awoke and was shaky and had cold sweats. She realized that she was having a reaction but could not understand since she had just taken her insulin. She checked her blood sugar and it was extremely low and went about finding candy, juice or other sweets to raise her sugar level. It was discovered that the box that was attached to the box that was scanned was not Novalog 70/30 that Patient P

regularly takes, but regular Novalog that is a fast acting insulin. Ms. Schweizer and Walgreens #03842 were each fined \$250 and they would split the costs and fees in this matter.

11. Ellery A. Greeley RPH-S Walgreens #05862 Board Meeting 1/11/06

Case No. 05-046-

Case No. 05-046-PH-S

Patient G received a prescription for a penicillin product from a physician that was unaware of her allergy to penicillin. Patient G took the prescription to Walgreens #05862 to have it filled. Ms. Greeley filled the prescription for Patient G and did not notice the allergy warning in their computer system as she was processing the prescription. Ms. Greeley and Walgreens #05862 were each fined \$250 and they would split the costs and fees in this matter.

12. Peoria M. Parikh Board Meeting 1/11/06 Walgreens #06545

Case No. 05-037-RPH-S Case No. 05-037-PH-S

Ms. Parikh filled a prescription for an injectable. When she created the label she inadvertently directed to take 2-6 'vials' rather than 2-6 'mls'. The patient was a nurse and had taken the medication before and knew not to take as directed. Ms. Parikh will receive a letter of admonition and Walgreens will pay the costs and fees in this matter.

13. Dale E. Hawkins Walgreens #03845 Walgreens Co. Board Meeting 1/11/06

Case No. 05-042-RPH-S Case No. 05-042-PH-S Case No. 05-042-PH-S

Patient T is a two-year old child being treated for a hypo thyroid condition. Patient T was prescribed Levoxyl 125 mcg. tablets with directions to take ½ tablet by mouth every day. Mr. Hawkins misread the prescription as being 25 mcg. tablets as the prescription looked like the physician had put parentheses around the dosage. Patient T was only receiving 12.5 mcg. of Levoxyl per day rather than the 62.5 mcg. prescribed by the physician. Mr. Hawkins is required to enroll in and pay half of the Your Success Rx program to help him with his pharmacy practice, Walgreens is to pay the other half of the Your Success Rx program for Mr. Hawkins, and half of the fees and costs to be split with Mr. Hawkins and since Walgreens #03845 is already on probation with the Board another year of probation will be added.