Nevada State Board of Pharmacy

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QUARTERLY DISCIPLINARY REPORT TO LEGISLATIVE COUNSEL BUREAU

JANUARY 20, 2007

1 Atanas K. Stanev — Board Meeting 10/25/06 — Case No. 06-031-RPH-S
CVS Pharmacy #3172 — Case No. 06-031-PH-S

A stipulated agreement was accepted by both parties and presented to the Board. Mr. Stanev filled a prescription for Verapamil 120 mg. tablets with Verapamil ER and did not advise the patient that the substitution had been made. Both parties were fined $100.

2. Trac T. Nguyen — Board Meeting 10/25/06 — Case No. 06-020-RPH-S
Walgreens #05862 — Case No. 06-020-PH-S

There were two patients with the name "James." Both James' had prescriptions for similar products. When one of the prescriptions was filled, Mr. Nguyen called "James" and one of the James' appeared and was sold the wrong prescription.

Mr. Nguyen was fined $500 plus administrative fees and costs, plus complete one hour of continuing education on error prevention. Walgreens #05862 was placed on probation for two years.

3. David Kendrick — Board Meeting 10/25/06 — Case No. 06-051-RPH-S

Mr. Kendrick was not present for hearing even though he received the Notice of Intended Action and Accusation. The Board continued with the hearing in his absence since there was a witness present. There were discrepancies in the CII counts at Summerlin Hospital Pharmacy where Mr. Kendrick was employed. An audit was conducted on controlled substances in schedule II. From that point, the CII's were audited daily. Mr. Kendrick's behavior had been erratic and he was observed with a bag of Fentanyl that he did not have a prescription to fill for. The audit showed discrepancies with Fentanyl in the schedule II cabinet and the Pyxis machines. Hidden video cameras were placed in the pharmacy to see if pharmacy management could determine how the Fentanyl was disappearing from the CII cabinet. After viewing the DVD's it was determined that Mr. Kendrick was removing the drugs. The DVD's clearly showed in one instance Mr. Kendrick hiding the Fentanyl in his sock, in another it showed him hiding Fentanyl in paperwork in his hands and in yet another it showed him removing Fentanyl and hiding it in his pocket.

The Board revoked Mr. Kendrick's license, fined him $5,000 plus fees and costs, and will not allow him to request reinstatement of his license until he has signed another five year agreement with PRN-PRN.

4 Rite Aid #6281 Board Meeting 10/25/06 Case No. 05-053-PH-N

This case was a continuation of the disciplinary action taken at the September 2006 Board meeting that involved a death at this Rite Aid pharmacy. No discipline was imposed upon Rite Aid because of the untimely demise of Jim Krahulic, with whom Mike Dyer, local legal counsel for Rite Aid, had been consulting. Board counsel advised that this was not a rehearing, however presented new facts in this matter that were previously unknown and asked the Board to determine discipline based on these new findings.

The Board fined Rite Aid #6281 $1,000 plus one half of the fees and costs in this matter and placed Rite Aid #6281 on probation for two years.

5 Scott T. James Board Meeting 10/25/06 Case No. 06-048-RPH-S

Mr. James was not present at hearing. Board staff was unsure why he was not present as staff had spoken with Mr. James several times regarding this matter.

In Mr. James' absence Board legal counsel read a handwritten statement Mr. James presented regarding his dismissal from employment at Huntridge Drug into the record. Mr. James left the pharmacy unattended for approximately 45 minutes while he and his brother went upstairs to smoke methamphetamine. Mr. Ling did not present security camera video of those actions by Huntridge Drug since Mr. James admitted guilt.

The Board revoked Mr. James' pharmacist license, fined him $2,000 plus fees and costs and enroll in the PRN-PRN program before he will be allowed to request reinstatement.

6 Lawrence L. Benson Board Meeting 12/6/06 Case No. 06-055-PT-N

Mr. Benson appeared and admitted he had stolen hydrocodone from Walgreens for his personal use. He advised the Board that he did not want his pharmaceutical technician registration because he did not think it would be wise to work in a pharmacy at this time. Larry Espadero, PRN-PRN monitor, testified that he agreed with Mr. Benson – that he did not belong in a pharmacy at this time.

Mr. Benson's pharmaceutical technician registration was revoked.

7 Caitlyn M. Beaubriand Board Meeting 12/6/06 Case No. 06-054-PT-N

Ms. Beaubriand admitted to the Board that she tested positive for marijuana. She stated that she smoked one joint of marijuana on the 4th of July weekend with friends. She stated that she did not use marijuana regularly and that she used poor judgment when she accepted the marijuana from her friend and smoked it. Ms. Beaubriand was randomly drug tested by her employer when she returned to work and tested positive. Larry Espadero, PRN-PRN monitor, testified that Ms. Beaubriand does not appear to display addictive behaviors and advised that he planned to monitor her for three months. When the Board asked Mr. Espadero if he would trust Ms. Beaubriand to work in a pharmacy, he responded that he would. Brett Ramey, Ms. Beaubriand's former managing pharmacist, testified on her behalf that she was an excellent pharmaceutical technician and would work with her again, however company policy would not allow her to return to Smith's.

The Board suspended Ms. Beaubriand's pharmaceutical technician registration, stayed the suspension, placed her on one year probation and required that she continue with PRN-PRN until Mr. Espadero completed her evaluation.

8 Jonathan Corey Ray Board Meeting 12/6/06 Case No. 06-053-RPH-N

Mr. Ray testified that he had maintained his sobriety for over two years and started using again because of family problems. He admitted to taking oxycodone containing drug products from Tucker's Pharmacy for his personal use and substituted saved clean urine samples for his urine analyses for PRN-PRN. After his relapse, Mr. Ray entered an in-patient 28 day program to help him get his life on track again. Mr. Ray advised the Board that he had been looking for work but finds it difficult because after he reveals that he is a pharmacist on his applications he is denied employment because he is over-qualified. Larry Espadero recommended that Mr. Ray not be allowed back into pharmacy at this time and advised that he not be allowed for at least one year. Mr. Ray concurred that this recommendation would be appropriate because part of his PRN-PRN program is to accept responsibility for his actions.

The Board suspended Mr. Ray's pharmacist license for a minimum of one year providing he continue with his PRN-PRN program and appear with Mr. Espadero when Mr. Ray requests reinstatement.

9 Paul L. Hampton Board Meeting 1/10/07 Case No. 06-041A-RPH-N
Thomas E. Danson Case No. 06-041B-RPH-N
John A. Warren Case No. 06-041C-RPH-N
Northern Nevada Medical Center (NNMC) Case No. 06-041-IA-N

Board counsel explained that only the portion of the case regarding Mr. Hampton and Mr. Danson would be heard at this meeting. A continuation for NNMC had been granted until the February 2007 Board meeting and Mr. Warren would appear at that meeting, also.

Mr. Hampton testified that he became depressed while employed at NNMC and tried to "fix" his problem by taking Lortab. He was self medicating by removing Lortab and Oxycontin from Pyxis machines in the hospital. He had a few days off and became sick and realized that he was addicted. He kept taking Oxycontin but realized he needed help. Mr. Hampton advised that he went to a psychiatrist who prescribed a drug to help him detox from the Oxycontin. He was trying to work and detox at the same time when NNMC changed ownership and sent in auditors who found discrepancies with various drugs. Mr. Hampton went into the PRN-PRN program and has been working his program.

Mr. Hampton's pharmacist license was suspended for six months, required him to pay restitution to NNMC and pay one half the fees and costs in this matter. Mr. Hampton will be placed on probation after the suspension is lifted and continue in PRN-PRN.

During that same audit, it was found that Mr. Danson had been "adjusting" injectable inventories. There was no evidence of an order for any of the adjustments. Mr. Danson could not explain his notations in the computer to the Board. The Board found Mr. Danson's testimony to be incredible. His excuses for his behavior were not feasible. Mr. Danson was represented by Hal Taylor. Mr. Taylor was unable to help Mr. Danson produce credible testimony. Mr. Taylor brought up Mr. Danson's past drug problem. Board counsel reviewed Mr. Danson's injectable drug diversion for his personal use history with the Board.

Mr. Danson's pharmacist license was revoked

10. Jodi Hopkins Board Meeting 1/10/07 Case No. 06-067-PT-N

Board staff received notice of termination of employment for Jodi Hopkins. Ms. Hopkins worked for Don's Pharmacy and had been taking cocaine from the pharmacy for her personal use. It was determined that Ms. Hopkins had taken approximately 29.579 grams. Ms. Hopkins paid restitution of $2,100.00 to the pharmacy.

The Board suspended Ms. Hopkins pharmaceutical technician registration until she joined the PRN-PRN program and Larry Espadero felt she would be ready to return to practice pharmacy. Ms. Hopkins will be on probation for the term of her PRN-PRN contract once the suspension is lifted.

11. Marty L. Martins Steven J. Peters Sav-on Drugs #9003	Board Meeting 1/10/07	Case No. 06-023A-RPH-N Case No. 06-023B-RPH-N Case No. 06-023-PH-N

A 7 month old baby was prescribed Reglan syrup in a concentration of 5 mg./1 ml. to be dispensed in 0.7 mg. dosing by mouth three times daily, fifteen minutes before meals. A pharmaceutical technician-in-training entered the prescription information into the computer for metoclopramide, the generic equivalent, but inadvertently typed 7 mg. dosing instead of 0.7 mg. dosing. Mr. Martins had to order the medication, it came in the following day and he filled the prescription without noticing the dosing error. The parents called the pharmacy three different times to check on the dosing instructions and was told each time by Mr. Peters that the directions were correct and, finally after the third call, if they had any questions to call the prescribing doctor. The parents gave what they considered the correct amount of medication but the baby was not improving. Eventually they administered the amount on the label. The baby exhibited signs of lethargy, seizure-like stiffness and lack of coordination. They immediately called their doctor who advised that the baby had been given an overdose and should be taken to the nearest emergency room for observation and treatment. The baby was released from the hospital the same day.

Mr. Martins was fined $500 plus ½ of the fees and costs plus do 6 hours of CE on error prevention and/or pediatric dosing. Mr. Peters was remanded to take the Your Success Rx program and pay for one half of the charges for the training and the Board will pay for half of the charges out of the special educational fund, do 6 hours of CE on error prevention, attend one Reno Board meeting and receive a letter of reprimand. Sav-On #9003 was fined $1,000 plus one half of the fees and costs in this matter.