BOARD OF REGISTRATION IN PHARMACY
PHARMACY BOARD MEETING MINUTES
TUESDAY, AUGUST 27, 2002
239 CAUSEWAY STREET, ROOM 206
BOSTON, MASSACHUSETTS
02114

The meeting was called to order by President Harold B. Sparr 9:30 a.m.

The following Board members were present: Harold B. Sparr, R.Ph. , MS, President, Donna M. Horn, R.Ph., Secretary, Dan Sullivan, R.Ph., Karen M. Ryle, MS, R.Ph., Dr. Robert P. Paone, R.Ph., Pharm. D. (excused at 12 p.m.), and Marilyn M. Barron, MSW, Public Member. (Absent: Jim DeVita)

The following Board staff were present: Charles R. Young, R.Ph., Executive Director, James D. Coffey, R.Ph., Associate Director, Arthur J. Chaput, R.Ph., Pharm. D., Quality Assurance Surveyor, James C. Emery, C.Ph.T., Healthcare Investigator, Alan Van Tassel, Healthcare Investigator, and Leslie S. Doyle, R.Ph., Healthcare Supervisor and Investigator.

AGENDA ITEMS

1. **9:30 a.m. to 10:10 a.m.**
   Call to Order: Investigative Conference & Business Meeting

Investigative Conference: PH-02-109
In the matter of Registrant, Luizo Stark, R.Ph. (License # 16469).

The purpose of the conference was to discuss a complaint filed with the Board alleging the failure to adhere to professional standards of pharmacy practice and unlawful dispensing of controlled substances.

Present for discussion:
Investigator: Leslie S. Doyle
Registrant: Luizo Stark
Brooks Representative: Steve Horn

Recusal: Harold B. Sparr

CEs: Compliant.

Investigator Leslie Doyle reviewed her report of investigation with the Board.

The Registrant said the investigator's report sounded correct. The Registrant stated that no other patients received medications without prescriptions. In addition, the Registrant said that none of the pharmacy customers were related to his family. The

Registrant said that he advised the patients to obtain new prescriptions when refill authorizations expired. The Registrant stated that he advanced a couple of tablets to the patients without a prescription due to the pressure of working in a busy pharmacy. The Registrant said the two patients to whom medication was advanced were under the care of a physician. However, the Registrant said that he was not sure how often the patients were seen by the prescribing physician. The Registrant said that in order to fill the Fioricet without prescriptions he created new prescription numbers with no refills and then deleted the transactions after labels were generated.

The Registrant said he was familiar with the rebound effect associated with the prescriptions at issue. The Registrant stated he did not realize that the patients may have seen other physicians for the same medication. The Registrant said he gave the patients the medication to get them out of store. The Registrant said the patients paid for the medications with cash. The Registrant stated that another staff pharmacist reported his actions to the Brooks Pharmacy Supervisor. The Registrant said that in hindsight he regretted his conduct. The Registrant said that he is no longer employed by Brooks Pharmacy but rather Bouvier Pharmacy in Marlboro. The Registrant stated that only 1 of the 2 patients at issue (the wife) now trades with Bouvier Pharmacy. The Registrant said that he informed Bouvier Pharmacy about the incident and related Brooks Pharmacy termination.

Brooks Supervisor Steve Horn said that he and the Brooks Loss Prevention Supervisor counseled the Registrant about the incident.

Board Decision:
Motion/Paone for discussion purposes to offer the Registrant a Formal Reprimand with stipulations to include a 1 month suspension and 2 hours of pharmacy law CE. Second/Ryle for discussion purposes. The motion did not carry.
Motion/Horn to offer the Registrant a consent agreement with stipulations to include 30 days "stayed" suspension followed by 1 year of probation and 2 hours of pharmacy law CE. Second/Sullivan. The motion carried unanimously. (Recused: Harold Sparr)

2. **10:10 a.m. to 10:50 a.m.**
Investigative Conference: PH-00-106
In the matter of Registrant, Christopher P. Sokol, R.Ph., (License # 18816).

The purpose of the conference was to discuss a complaint filed with the Board alleging unlawful possession of controlled substances.

Present for discussion:
Investigator: Leslie S. Doyle
Registrant: Christopher P. Sokol

CEs: Compliant in 1999 & 2000.

The Registrant declined the Board offer for executive session.

The Registrant advised the Board that he previously appeared before the Board with regard to a disciplinary action. More specifically, the Registrant said the 1991 complaint involved controlled substance theft. The Registrant said that his counsel advised him that representation was not needed for this conference.

Investigator Leslie Doyle reviewed her report of investigation with the Board.

The Registrant stated that the investigator's report sounded accurate. The Registrant said he voluntarily surrendered his license to the Board and prefers to do so on a permanent basis. The Registrant stated that his Rhode Island license is inactive.

The Board advised the Registrant to continue with CE requirements and confer with MPRS if reinstatement is sought in the future. The Board requested the Registrant to return his wall certificate along with the signed consent agreement.

Board Decision:
Motion/Sparr to refer the matter to Board counsel for related consent agreement. Second/Paone. The motion carried.

3. **11:00 a.m. to 11:40 a.m.**
Investigative Conference: DS-02-081 & PH-02-091
In the matter of CVS Pharmacy #1226, 47 Pond Street, Ashland, MA 01721 (Permit # 2022) and Registrant, Sherwin Solomon, R.Ph., (License # 14429).

The purpose of the conference was to discuss a complaint submitted by a consumer alleging the failure to fill a prescription properly. The complainant alleged that on or about January 22, 2002 the Registrant dispensed Lescol 20mg rather than Lescol 40mg as prescribed and labeled, while employed at CVS Pharmacy #1226, 47 Pond St., Ashland, Massachusetts.

Present for discussion:
Investigator: Leslie S. Doyle
Complainant: Present.
Registrant: Sherwin Solomon
CVS Pharmacy Manager of Record: Sherwin Solomon
CVS Representatives: Jim Scanlon

The Registrant (Solomon) advised the Board that he had not previously appeared before the Board with regard to a disciplinary action.

Investigator Leslie S. Doyle reviewed her report of investigation with the Board.

The Registrant acknowledged responsibility for the medication error. The Registrant said that the stock medication was retrieved form the shelf by a pharmacy technician. The Registrant stated that he failed to look closely at the number on the medication capsule.

The Registrant outlined the corrective measures implemented after the incident to include an NDC check (circle/hi-lite), counseling the technician regarding proper filling techniques, red shelf dividers, the basket filling method and utilization of a magnifying glass to review medication ID numbers.

The Registrant said that an apology was extended to the patient. The Registrant stated an incident report was reconciled for the medication error.

CVS Supervisor Jim Scanlon stated that CVS does not barcode the prescription label for cross reference against the manufacturers stock bottle but rather for pill imaging and prescription hardcopy verification.

The complainant stated that this was the second medication error at the Ashland CVS Pharmacy for her father. The complainant said that the pharmacy is too busy and understaffed.

Board Decision:
Motion/Paone to offer the CVS Pharmacy & Registrant (Solomon) an Advisory Letter for the failure to fill a prescription properly with stipulations that 1) the Registrant file a USP Medication Error Report with USP PRN (a copy to the Board), 2) the Registrant complete a two (2) hour home study medication error reduction continuing education program within thirty (30) days and 3) a pharmacy CQI Survey. The motion was not seconded.

Motion/Paone to take the matter under advisement pending Board review of a CQI Survey conducted by Dr. Arthur J. Chaput. Second/Sparr. The motion carried

4. **11:40 a.m. to 12:20 p.m.**
Investigative Conference: DS-02-077 & PH-02-090
In the matter of Spring Street Drug Inc., 121 Spring Street, Springfield, MA 01105 (Permit # 13508) and Registrant, Terese A. Girard-Majka, R.Ph., (License # 19041).

The purpose of the conference was to discuss a complaint submitted by a consumer alleging the failure to fill a prescription properly. The complainant alleged that on or about August 24, 2000 the Registrant dispensed Haloperidol 5mg tablets rather than Clonazepam 0.5mg tablets as prescribed while employed at Spring Street Drug Inc., 121 Spring St., Springfield, Massachusetts.

Present for discussion:

Investigator: Alan Van Tassel
Complainant: Present with counselors Hal Etkin & Travaun Bailey.
Registrant: Teresa A. Girard-Majka
Spring Street Drug Manager of Record: Daryl Schwartz
Spring Street Drug Representatives: Daryl Schwartz

CE: Registrant (Girard-Majka) and Manager of Record (Schwartz) compliant.

The Registrant (Girard-Majka) advised the Board that she had not previously appeared before the Board with regard to a disciplinary action.

Investigator Alan Van Tassel reviewed his report of investigation with the Board.

The Registrant (Girard-Majka) acknowledged responsibility for the medication error. However, the Registrant stipulated that the she did not count the tablets with regard to the reference of 60 dosage units returned to the pharmacy. The Registrant said the tablets were allegedly counted by a pharmacy technician. The Registrant said that an on duty pharmacist did not check the pharmacy technicians count.

The complainant stated that she contacted the pharmacy and advised a male staff member that she received orange / pinkish pills rather than yellow. The complainant told the male that she ingested 2 pills on Saturday night and was admitted to the hospital on Monday due to related adverse effects. The complainant said the incorrect medication was picked up by the pharmacy on August 28, 2002. The complainant stated she was on Clonazepam for about 5-6 years.

Attorney Etkin said the pharmacy initially responded that no medication error occurred. Atty. Etkin said that pharmacy changed their position once his clients insurance company became involved.

The Manager said that the complainants returned medication was not returned to pharmacy stock. The Manager stated that pharmacy policy dictates that returned medication is destroyed. The Manager said that the prescribing practitioner was not contacted by the pharmacy about the incident. The Manager said that the pharmacy staff deeply regrets the error.

The Manager said that an incident report was generated for the error. The Manager verified that the medication returned to the pharmacy was drug picked up by tech did contain Haloperidal.

The Manager stated that pharmacy policies and procedures were reviewed by staff but the review was not documented.

The Manager outlined the corrective measures implemented after the incident to include the basket filling method, meetings with pharmacy staff to discuss the incident

and quality assurance enhancements and utilization of Spanish speaking employees as interpreters for communication and counseling assistance, automation (Autoscript).

The Manager of Record suggested that the basket prescription filling method might reduce the incidence of medication errors.

Dr. Paone suggested that the pharmacy needs to utilize an incident report which references both a root cause analysis and corrective actions.

Board Decision:
Motion/Paone to take the matter under advisement. Second/Sparr. The motion carried.

5. **12:20 p.m. to 1:20 p.m.**
   Lunch

6. **1:20 p.m. to 2:00 p.m.**
   Investigative Conference: PH-02-060
   In the matter of Registrant, Stephen Meyers, R.Ph. (License # 14094).

   The purpose of the conference was to discuss a complaint submitted by a consumer alleging unethical and or unprofessional conduct.

   Present for discussion:
   Investigator: Leslie S. Doyle
   Registrant: Stephen Meyers & Attorney Leon A. Blais

   Attorney Blais requested that any CVS Pharmacy Board member recuse him/herself from the conference.

   CEs: Registrant (Myers) compliant.

   Myers stated that he appeared before the Board for a disciplinary conference in 1983.

   Investigator Leslie Doyle reviewed her report of investigation with the Board. Ms. Doyle stated that a copy of a tape transcript was available for Board review.

   The Registrant said that the investigator's report sounded correct. The Registrant represented that the taped message at issue was unintentionally left out of frustration due to a perceived lack of interest / progress on the part of the police department related to a report filed involving his sons stolen bicycle. The Registrant said his recorded comments were nothing more than stupid mistake.

   Attorney Blais emphasized that at no time did the Registrant intend on making his comments public. Atty. Blais said the taped comments were made in private and were non-threatening. Atty. Blais noted that the tape should not have been reproduced

without his clients consent.

Board Decision:
Motion/Sparr to offer the Registrant a consent agreement with stipulation to include 50 hours of community service at the "Main Spring Coalition in Brockton for Homeless" Second/Horn for discussion purposes. The Board entertained discussion on the motion. Vote: In support; Sparr, Opposed; Sullivan / Horn, Ryle and Marilyn Barron. The motion did not carry.
Motion/Ryle to issue the Registrant (Myers) an Advisory Letter on the basis of unprofessional conduct. Second/Horn for discussion purposes. The Board entertained discussion on the matter. The motion did not carry.
Motion/Sullivan to Dismiss the complaint against the Registrant. Second/ Horn. Vote: In support; Ryle / Sullivan / Horn and Barron, Opposed; Sparr. The motion carried.

7. **2:00 p.m. to 2:40 p.m.**
Investigative Conference: DS-02-118 & PH-02-131
In the matter of Brooks Pharmacy #528, 339 Pond Street, Ashland, MA 01321 (Permit # 3096) and Registrant, Jane Petercuskie, R.Ph., (License # 16621).

The purpose of the conference was to discuss a complaint submitted by a consumer alleging the to fill a prescription properly. The complaint alleged that the Registrant (Petercuskie) failed recognize a drug allergy for Amoxicillin. More specifically, the complainant alleged that on or about June 1, 2002 the Registrant dispensed Amoxicillin to her daughter as a premedication for a dentist appointment although the Brooks Pharmacy system listed Amoxicillin as an allergy for such patient while employed at Brooks Pharmacy #528, 339 Pond Street, Ashland, MA.

Present for Discussion:
Investigator: Leslie S. Doyle
Complainant: Present
Registrant: Jane Petercuskie
Brooks Pharmacy Manager of Record: Thomas Trainor
Brooks Representatives: Steve Horn

Recused: Donna Horn

The Registrant (Petercuskie) advised the Board that she had not previously appeared before the Board with regard to a disciplinary action. The Manager of Record, (Trainor) informed the Board that he had appeared before the Board with regard to another complaint matter.

Investigator Leslie S. Doyle reviewed her report of investigation with the Board.

The Manager of Record (Trainor) stated that he reduced the Amoxicillin prescription to writing. The Manager said that a pharmacy technician named Jill was responsible for prescription data entry. The Manager said that neither he or Jill noticed the medication allergy flagged in the computer system. The Manager stated that pharmacy policy requires technicians to bring DUR and allergy indicators (blinking data) to the attention of a pharmacist for review. The Manager said that the offer to counsel was declined by the patient. The Manager stated that the complainant notified the pharmacy about the allergy concern around 3 p.m. on the same day the medication was dispensed.

The Registrant (Petercuskie) stated that the investigator's report sounded accurate. The Registrant said she was the checking/verification pharmacist for the Amoxicillin Prescription.

The Manager said that no special override authorization was required by the data entry technician to continue with the dispensing process. The technician only needed to hit the enter key to by pass the allergy notification. The Manager said that the Brooks Pharmacy prescription software program is being revised to incorporate greater quality assurance controls.

The complainant voiced concern that neither involved pharmacist recognized the medication allergy noted in both the computer system and on the patient drug literature. The complainant stated that she reconciled the dispensing error before any medication was ingested. The complainant said that the dentist also failed in his responsibility to recognize the documented drug allergy.

Brooks Supervisor Steve Horn stated that with regard to corrective actions Brooks Pharmacy will be utilizing a new computer system in early 2003 which will capture all phases of the data entry prescription filling process. Horn said that certain data entry screens will only accessible to pharmacists.

CEs: Registrant (Petercuskie) compliant.

Board Decision:
Motion/Ryle to issue an Advisory Letter to both the Registrant and Brooks Pharmacy for the failure to fill a prescription properly requiring the filing of a USP Medication Error Report with USP PRN and 2-hour medication error reduction continuing education program and the District Manager shall submit a statement regarding both corrective measures implemented and affirmation that the corrective measures (allergy checks) have been shared with other MA Brooks pharmacists. Second/Sullivan . The motion carried.

8. 2:40 p.m. to 3:20 p.m.

Investigative Conference: DS-02-064 & PH-02-104
In the matter of Walgreens Pharmacy #3649, 369 Plymouth Avenue, Fall River, MA 02721 (Permit # 2593) and Registrant, Manuel Dalomba, R.Ph., (License # 24349).

The purpose of this conference was to discuss a complaint submitted by a consumer alleging the failure to fill a prescription properly. The complainant alleged that on or about September 4, 2001 the Registrant dispensed Topomax 100mg tablets rather than Topomax 200mg tablets as prescribed and labeled while employed at Walgreens Pharmacy # 3649, 369 Plymouth Ave., Fall River, Massachusetts.

Present for Discussion:
Investigator: James C. Emery for Leslie S. Doyle
Complainant: Present.
Registrant: Manuel Dalomba
Walgreens Pharmacy Manager of Record: Jose Pacheco
Walgreens Representatives: Leslie Higgins

CEs: compliant. The Registrant stated that he had not previously appeared before the Board with regard to a disciplinary action. The Manager of Record said that he appeared before the Board with regard to another complaint matter.

Investigator James C. Emery reviewed Ms. Doyle's report of investigation with the Board.

Mr. Dalomba acknowledged responsibility for the medication error. The Registrant recalled filling the prescription because he thought the dose was high.

The Manager of Record outlined the corrective measures implemented after the incident to include bar coding and pill imaging technology.

The complainant said her daughter reconciled the medication error shortly after ingestion. The complainant said the original prescription bottle is at home. The complainant said she had problems filling the prescription correctly after the error was reported to Walgreens Pharmacy.

Board Decision:
Motion/Sparr to offer the Registrant (Dalomba) and Walgreens Pharmacy with an Advisory Letter for the failure to fill a prescription properly with stipulations that Dalomba 1) file a USP Medication Error Report with USP PRN (a copy to the Board) and 2) complete a two (2) hour home study medication error reduction continuing education program within thirty (30) days following receipt of the agreement. Second/Horn. The motion carried.

9. **3:20 p.m. to 4:00 p.m.**

Investigative Conference: PH-02-080
In the matter of Registrant, Robert D'Orlando, R.Ph., (License # 19588).

The purpose of the conference was to discuss a complaint filed with the Board alleging unlawful possession of controlled substances.

Present for discussion:
Investigator: James C. Emery
Registrant: Robert D'Orlando & Attorney Elizabeth A. Turner
MPRS: Tim McCarthy

Motion/Sullivan to enter into Executive Session at 3:20 p.m. Second/ Horn. The motion carried. Motion/Sparr to return to Open Session at 4:00 p.m. Second/Sullivan. The motion carried.

Board Decision:
Motion/Sparr to offer the Registrant a consent agreement with stipulations to include compliance with the MPRS contract, 5 years probation and notification of related disciplinary action to the CA Board of Pharmacy. Second/Horn. The motion carried.

10. **4:00 p.m. to 4:30 p.m.**
Correspondence Review and Actions

A) NABP/AACP District Meeting Officials Memorandum: FYI.
B) Board review of Pharmacy Technician Training Programs and or Pharmacy Technician Assessment Examinations.
Spaulding Rehabilitation Hospital: Approve __X_ Deny ___
Motion/Paone to approve the exam. Second/Sparr . The motion carried.
C) In the matter of PH-02-136, Registrant, Melvin H. Goldfarb, R.Ph., (License # 13120): (Board staff to provide overview).
Discussion and or Vote of Decision: related to August 13, 2002 Board Complaint Committee "File Review" / NABP reciprocal disciplinary actions.
D) NABP notification of licensure transfer application related to applicant David Wayne Kazarian: The Board discussed the matter and requested that a special assignment be generated to contact the FL Board to obtain additional information for subsequent Board review.
E) Georgia State Board of Pharmacy compounding regulations: Karen Ryle provided an overview of the Georgia compounding regulations. Ryle stated that the MA compounding task force would meet in October 2002 to discuss draft regulations.

11. **4:30 p.m.**
Motion/Sparr to adjourn the meeting. Second/Sullivan. The motion carried. Meeting adjourned.

Respectfully submitted by:

1/27/03
Executive Director Date

Charles Young
Printed Name

Reviewed by counsel: December 31, 2002
Draft approved: December 31, 2002
Adopted by the Board: January 07, 2003