BEFORE THE NEVADA STATE BOARD OF PHARMACY

NEVADA STATE BOARD OF PHARMACY, **Petitioner,** **v.** **JESSICA NGUYEN, RPH,** **Certificate of Registration No. 15397,** **MARTIN O. CHIBUEZE, RPH,** **Certificate of Registration No. 17555, and** **SPRING VALLEY PHARMACY,** **Certificate of Registration No. PH02375,** **Respondents.** /	)	**CASE NOS. 16-015-RPH-A-S** **16-015-RPH-B-S** **16-015-PH-S** **FINDINGS OF FACT, CONCLUSION OF LAW AND ORDER** **(All Respondents)**

The Nevada State Board of Pharmacy (Board) heard this matter at its regularly scheduled meeting on Wednesday, May 31, 2017, in Reno, Nevada. S. Paul Edwards, Esq., prosecuted the case on behalf of Board Staff. Respondents JESSICA NGUYEN, RPH, Certificate of Registration No. 15397 (Ms. Nguyen), MARTIN O. CHIBUEZE, RPH, Certificate of Registration No. 17555 (Mr. Chibueze), and SPRING VALLEY PHARMACY, Certificate of Registration No. PH02375 (Spring Valley), did not appear at the hearing. They were represented at the hearing by their counsel of record, Jude Nazareth, Esq., of the law firm Montez Nazareth Law.

Based on the evidence presented during the hearing, including testimonial and documentary evidence, the Board issues the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. On May 30, 2017, Respondents, and each of them, entered into a set of *Stipulated Facts*, a copy of which is attached hereto as **Exhibit 1** and incorporated herein by reference. The facts to which Respondents admitted in the *Stipulated Facts* are as follows:

a. In February 2016, patient L.T. saw an APRN, M.G., at the Mind Body Solutions Clinic.

b. M.G. prescribed a quantity of #120 Adderall 10 mg. tablets for L.T. with instructions to take one tablet four times daily.

c. L.T. tendered the prescription to Spring Valley the day she received it.

d. Spring Valley assigned the order prescription number 26542 and dispensed the medication the same day.

e. L.T. alleges that later that evening, when she opened the medication bottle, she discovered that it contained only thirty (30) tablets of Adderall, instead of the one hundred and twenty (120) tablets as prescribed.

f. L.T. later contacted Spring Valley to report the Adderall shortage.

g. Respondent Mr. Chibueze accepted L.T.'s complaint and informed L.T. that he checked the pharmacy's Adderall 10 mg. tablet inventory.

h. In a written statement, Mr. Chibueze states that he conducted a physical count of Spring Valley's Adderall 10 mg. tablets and reported that he found no discrepancies.

i. Mr. Chibueze also stated that he would view the video of L.T.'s prescription being filled.

j. Spring Valley's video system overwrites recorded video every forty-eight hours, so Mr. Chibueze was not able to view the filling of L.T.'s prescription.

k. L.T. was unable to resolve the medication shortage with Spring Valley.

l. While investigating L.T.'s complaint regarding Prescription Number 26542, the Board Investigator discovered that Spring Valley's pharmacy workflow software does not depict the required data elements of a lawful prescription.

m. The Investigator found substantial discrepancies in Spring Valley's electronic Schedule II perpetual inventory recordkeeping.

n. Examples of the discrepancies the investigator found include:

i. **Amphetamine Salts 10 mg NDC 00555-0972-02**: Prescription No. 26542 appears on this inventory four times, once on February 5, 2016, and three times on February 8. Two of those entries show that Spring Valley dispensed the medication, and two show that Spring Valley added the same amount (120 tablets) back into its inventory. The inventory showed that Spring Valley should have had 86 tablets in its inventory on March 15, 2016. The Board Investigator conducted a count of the Amphetamine Salts 10 mg tablets on March 15, 2016, and counted 94.

ii. **Amphetamine 10 mg ER, NDC 000555-07870-2**: Prescription No. 26542 appears on this inventory twice. It shows that Spring Valley dispensed 120 tablets on February 8, 2016, and then received the same amount back into its inventory. The inventory showed that Spring Valley should have had 195 tablets in its inventory on March 15, 2016. The Board Investigator counted and documented 215 tablets.

iii. **Amphetamine 10 mg NDC 45963-0745-11**: Prescription No. 26542 appears on this inventory once, when Spring Valley purportedly dispensed 120 tablets. The inventory shows that Spring Valley should have had a count of -75 tablets. The Board Investigator counted 23 tablets.

o. According to Spring Valley's workflow records for Prescription No. 26542, pharmaceutical technician Rolando (Mr. Urrutia) entered the prescription data.

p. Spring Valley provided the Board Investigator a copy of the workflow screen, "Rx's Checked", for Prescription No. 26542, on March 15, 2016.

q. The record failed to capture the fill technician, verifying pharmacist, prescription verification date/time, counseling pharmacist, and counseling date/time.

r. On March 24, 2016, Spring Valley provided a second copy of the "Rx's Checked" record for Prescription No. 26542. That copy was identical to the March 15th copy except for an additional entry, "Martin Chibueze", in data field "IOU Pharmacist".[i]

[i] "IOU" indicates a remaining medication fill from a prior partial fill.

s. The information in Spring Valley's records reflect an inconsistency as to the NDC for Prescription No. 26542. The NDC on L.T.'s patient profile is 45963-0745-11. The NDC on the label of the bottle dispensed to L.T. is 00555-0972-02.

t. The label on the bottle did not include an expiration date for the medication.

u. Spring Valley's electronic perpetual inventories on March 15, 2016, showed an inventory of negative counts for Amphetamine 10 mg. tablets. Those negative counts were not consistent with the Board Inspector's physical counts of that medication at the pharmacy.

v. Spring Valley's records do not accurately show who was working at the time the pharmacy filled Prescription No. 26542. Respondent Ms. Nguyen purportedly worked from 8:00 AM until 12:00 PM, which includes the time the pharmacy filled Prescription No. 26542. The pharmacy's Time Clock Report does not reflect that Ms. Nguyen worked in the pharmacy during those times.

w. At the time Spring Valley filled Prescription No. 26542, pharmaceutical technician Rolando Urrutia worked at the pharmacy and participated in at least the data entry process. Urrutia left Spring Valley a short time later. Spring Valley and Ms. Nguyen failed to report Mr. Urrutia's employment with and termination from the pharmacy.

x. Pharmacy records show that Mr. Chibueze verified Prescription No. 26542 and sold the medication to L.T.

y. Spring Valley could not initially provide a counseling log for the prescription. Ms. Nguyen later faxed over a duplicate of the patient's signature with the words "Counseling Log" handwritten in the margin.

z. In the absence of critical records, the Board Investigator was unable to reliably determine whether Spring Valley accurately filled Prescription No. 26542.

2. In addition to the foregoing stipulated facts, the Board finds that neither Ms. Nguyen, Mr. Chibueze nor Spring Valley could provide records to show that Mr. Chibueze provided adequate counseling to L.T.

3. The evidence Respondents did provide, and which the Board admitted into evidence, shows that Mr. Chibueze did not adequately counsel L.T. Mr. Chibueze merely offered to counsel and inquired whether L.T. had any questions.

4. During the hearing, the Board admitted into evidence documents from both the prosecution and from Respondent's counsel. The Board also heard testimony from witnesses.

5. Based on the evidence presented at the hearing, the Board finds that evidence exists to support each of the factual allegations stated in the Accusation.

CONCLUSIONS OF LAW

6. During the hearing, Respondents, through their counsel, stipulated that the facts set forth in the *Stipulated Facts* satisfy each of the elements of the First through Seventh, the Tenth and the Eleventh Causes of Action. Only the Eighth and Ninth Causes of Action remained in dispute.

7. Those admissions notwithstanding, and taking under consideration the facts set forth in the Stipulated Facts, the Board hereby concludes as a matter of law:

a. The Board has jurisdiction over this matter and these Respondents because at the time of the alleged events, Ms. Nguyen, Certificate of Registration No. 15397, and Respondent Mr. Chibueze, Certificate of Registration No. 17555, were pharmacists licensed by the Board, and Spring Valley, Certificate of Registration No. PH02375, was a pharmacy licensed by the Board.

b. Spring Valley's computer system does not accurately capture and retain the information required by NAC 639.751, NAC 639.930(3) and (4), and NAC 639.935(g), as demonstrated by the system's failure to capture, retain, and print the required information for Prescription No. 26542. Spring Valley therefore violated each of those regulations.

c. By failing to maintain adequate safeguards in its computer system to identify the information required by NAC 639.751(1)(b) and (2) and NAC 639.930(3) as to Prescription No. 26542, and by failing to prevent the removal of that information as required by NAC 639.930(4) and (5), Spring Valley violated each of those regulations.

d. By failing to properly label the container for Prescription No. 26542 to include the accurate manufacturer name, NDC number and expiration date, Spring Valley violated NRS 639.2801.

e. By placing the NDC 00555-0972-02 on the label of the bottle it dispensed to L.T., and recording a different NDC (45963-0745-11) in L.T.'s patient profile, Spring Valley engaged in unprofessional conduct and violated NRS 585.520.

f. Spring Valley violated NRS 453.246 and NAC 639.485(1) and (2) by failing to maintain an accurate perpetual inventory of its schedule II controlled substances, in particular Amphetamine Salts, Amphetamine 10 mg ER and Amphetamine 10 mg, as alleged in the *Accusation* and as admitted in the *Stipulated Facts*. The pharmacy's inventory records on March 15, 2016, showed negative numbers of each of those substances, which also did not match the Board Investigator's physical account of those substances, and which discrepancies Respondents could not explain.

g. Additionally, Prescription No. 26542 appeared on three separate Spring Valley inventories, further indicating Spring Valley's failure to keep an accurate perpetual inventory of its schedule II controlled substances.

h. By failing to keep a written record that reflects when Ms. Nguyen is on duty at Spring Valley, Spring Valley violated NAC 639.245.

i. By failing to give the Board written notice of pharmaceutical technician Roland Urrutia's employment and subsequent termination, Spring Valley violated NAC 639.540.

j. By failing to provide adequate counseling for L.T.'s new prescription, and to create and maintain clear documentation indicating that counseling occurred, Mr. Chibueze

violated NRS 639.266(1), NAC 639.707(1), (2) and (6), NAC 639.930(3), (4) and (5), as well as NAC 639.945(1)(i).

k. As the managing pharmacist/pharmacist in charge of Spring Valley at the time of each of the violations alleged herein, Respondent Ms. Nguyen is responsible for each violation, including those of her employees. *See* NRS 639.0087, NRS 639.210(15), NRS 639.220(3)(c), NAC 639.510(2), NAC 639.702; and NAC 639.910(2).

l. Ms. Nguyen's pharmacist license, Certificate of Registration No. 15397, is therefore subject to discipline, suspension, or revocation pursuant to those statutes and regulations, NRS 639.210(4), (9), (11) - (12), (15) and/or (17), as well as NRS 639.230(5) and/or NRS 639.255.

m. As the pharmacy and owner of the pharmacy in which the violations alleged herein occurred, Respondents Spring Valley and Ms. Nguyen, respectively, are each responsible for the violations set forth above pursuant to NAC 639.702 and NAC 639.945(2). Each of their licenses, Certificate of Registration No. 15397 (Ms. Nguyen), and Certificate of Registration No. PH02375 (Spring Valley) are therefore subject to discipline pursuant to NRS 639.210(4), (9), (11) - (12), (15) and/or (17), as well as NRS 639.230(5) and/or NRS 639.255.

8. For each of the violations found herein, the licenses of each the Respondents is subject to discipline pursuant to the provisions of NRS 639.210, and well as NRS 639.255, unless otherwise specified herein.

ORDER

9. Related to the violation(s) set forth in the Eighth Cause of Action for failure to adequately counsel patient L.T., Respondent Mr. Chibueze shall:

a. Receive a letter of reprimand from the Board's Executive Secretary reminding him of his duties regarding adequate patient counseling and reprimanding him for his failure to satisfy those duties as to patient L.T.,

b. Pay a fine of Seven Hundred and Fifty Dollars ($750.00),

c. Pay an administrative fee of Four Hundred and Ninety-Five Dollars ($495.00) to partially reimburse the Board for the costs and expenses it incurred investigating and prosecuting this matter,

d. Complete two (2) extra hours of continuing education (CE) on topics related to proper counseling techniques. Those extra hours of CE are in addition to the continuing education hours Mr. Chibueze must otherwise complete to maintain his licensure, and

e. Appear personally at two (2) of the next three Pharmacy Board meetings in Las Vegas, Nevada on disciplinary day—generally the first day of the Board's two-day meeting. At the first of those two meetings, Mr. Chibueze's name shall appear on the agenda and Mr. Chibueze shall appear in person before the Board to explain his failure to attend the hearing in this action.

10. Related to the violations set forth in each of the Causes of Action in the Accusation, for which Ms. Nguyen is responsible either directly, or as the owner and pharmacist in charge/pharmacy manager of Spring Valley, and for which Spring Valley is responsible as the facility in which the violations occurred:

a. Ms. Nguyen shall pay a combined fine of Five Thousand Dollars ($5,000.00),

b. Spring Valley shall pay a combined fine of Ten Thousand Dollars ($10,000.00),

c. Spring Valley shall pay an administrative fee of One Thousand Five Hundred Dollars ($1,500) to partially offset the Board's costs and expenses associated with investigating and prosecuting this action.

d. Ms. Nguyen's pharmacist license, Certificate of Registration No. 15397, is suspended immediately upon the execution of this order,

e. Spring Valley's pharmacy license, Certificate of Registration No. PH02375, is suspended immediately upon execution of this order.

f. The fines imposed on Ms. Nguyen and Spring Valley, and the suspension of Spring Valley's and Ms. Nguyen's respective licenses, are hereby stayed. The administrative fee is not stayed. Both licenses are placed on probation with the following terms and conditions:

i. Ms. Nguyen's pharmacist license shall be on probation for a minimum of eighteen (18) months.

ii. Spring Valley's pharmacy license shall be on probation for a minimum of eighteen (18) months.

iii. During the probationary period, Spring Valley and Ms. Nguyen shall engage and shall each participate in an independent remediation and compliance monitoring program designed by the independent monitor Affiliated Monitors, Inc. (Affiliated Monitors). Affiliated Monitors, in consultation with Board Staff, shall design, implement, and monitor Spring Valley's and Ms. Nguyen's compliance with a program that Affiliated Monitors and Board Staff deem appropriate to address the deficiencies in Spring Valley's and Ms. Nguyen's pharmacy operations and compliance with federal and Nevada law. Affiliated Monitor's monitoring and compliance program must start within ninety (90) days of the execution of this order, and the eighteen-month probationary period shall begin once Affiliated Monitors starts its monitoring program with Spring Valley and Ms. Nguyen.

iv. Affiliated Monitors shall provide Board Staff with regular updates regarding Spring Valley's and Ms. Nguyen's participation and compliance with its monitoring program.

v. Spring Valley and Ms. Nguyen shall bear all costs and fees associated with participating in Affiliated Monitors' program.

vi. Ms. Nguyen may not be designated as, and may not work as, a pharmacist in charge/pharmacy manager in any Nevada-licensed facility during the probationary period.

vii. Spring Valley may not engage in any form of sterile or nonsterile compounding until approved to do so by Affiliated Monitors, in consultation with Board Staff.

viii. Ms. Nguyen must complete ten (10) extra hours of continuing education (CE) on topics related to pharmacy law, proper counseling techniques, patient safety and pharmacy business operations. Those extra hours of CE are in addition to, and do not count toward, the continuing education hours Ms. Nguyen must otherwise complete to maintain her pharmacist license. They may, however, be used to satisfy the extra CE requirements ordered by the Board in Case No. 16-022-RPH-S.

ix. Ms. Nguyen shall appear personally at two of the next three Pharmacy Board Meetings in Las Vegas on discipline day, which is generally the first day of the Board's two-day meeting. At the first of those two meetings, Ms. Nguyen's name shall appear on the agenda and Ms. Nguyen shall appear in person before the Board to explain her failure to attend the hearing in this action.

x. Spring Valley and Ms. Nguyen shall comply with all federal and state statutes and regulations regarding controlled substances, dangerous drugs and the practice of pharmacy, and they shall have no additional complaints filed against them.

g. After not less than eighteen months into the probationary period, Ms. Nguyen shall appear before the Board, both personally and in her capacity as owner of Spring Valley, along with Spring Valley's managing pharmacist at the time and with representatives from Affiliated Monitors, to report and discuss Spring Valley's and Ms. Nguyen's compliance with Affiliated Monitors' program. The Board will determine at that time, and at its sole discretion, whether the probationary period on Spring Valley's and Ms. Nguyen's respective license will end, and whether to waive the fees imposed herein.

h. In the event that Spring Valley and/or Ms. Nguyen fail to participate fully with Affiliated Monitors and Board Staff, or otherwise fail to comply with the terms of this Order, the stay of suspension on each of their licenses and the stay of the fines set forth above shall lift. Spring Valley and Ms. Nguyen's licenses shall then be suspended and the fines set forth above shall become due and payable immediately.

11. Respondents shall pay the fines ordered herein when due, and by *cashier's check* or *certified check* or *money order* made payable to "State of Nevada, Office of the Treasurer" to be received by the Board's Reno office located at 431 W. Plumb Lane, Reno, NV 89509, within 90 days of the effective date of the Board's Order.

12. Respondents shall pay the administrative fees ordered herein by *cashier's check*, *certified check* or *money order* made payable to the "Nevada State Board of Pharmacy" to be received by the Board's Reno office located at 431 W. Plumb Lane, Reno, NV 89509, within thirty (30) days of the effective date of the Board's Order.

13. Any failure by any Respondent to satisfy the obligations stated herein may result in additional discipline, up to and including suspension or revocation of each Respondent's respective registration/license, until all terms have been satisfied.

14. This Order is effective on the date it is executed below.

IT IS SO ORDERED.

Signed and effective this 9 day of June, 2017.

Leo Basch, President
Nevada State Board of Pharmacy

BEFORE THE NEVADA STATE BOARD OF PHARMACY

NEVADA STATE BOARD OF PHARMACY, **Petitioner,** **v.** **JESSICA NGUYEN, RPH,** **Certificate of Registration No. 15397,** **MARTIN O. CHIBUEZE, RPH,** **Certificate of Registration No. 17555, and** **SPRING VALLEY PHARMACY,** **Certificate of Registration No. PH02375,** **Respondents.** /	**CASE NO. 16-015-RPH-A-S** **16-015-RPH-B-S** **16-015-PH-S** **STIPULATED FACTS** **(All Respondents)**

S. PAUL EDWARDS, Esq., General Counsel for petitioner the Nevada State Board of Pharmacy ("Board"), and respondents Jessica Nguyen, RPh, Certificate of Registration No. 15397 ("Ms. Nguyen"); Martin O. Chibueze, RPh., Certificate of Registration No. 17555 ("Mr. Chibueze"); and Spring Valley Pharmacy, Certificate of Registration No. PH02375 ("Spring Valley") (collectively "Respondents"), by and through their counsel, Jude Edward Nazareth, Esq., of Montez Nazareth Law,

HEREBY STIPULATE AND AGREE THAT:

1. The Nevada State Board of Pharmacy (Board) has jurisdiction over this matter and these Respondents because at the time of the alleged events, Respondents Ms. Nguyen, Mr. Chibueze and Spring Valley were each licensed by the Board.

2. In February 2016, patient L.T. saw an APRN, M.G., at the Mind Body Solutions Clinic.

3. M.G. prescribed a quantity of #120 Adderall 10 mg. tablets for L.T. with instructions to take one tablet four times daily.

4. L.T. tendered the prescription to Spring Valley the day she received it.

5. Spring Valley assigned the order prescription number 26542 and dispensed the medication the same day.

6. L.T. alleges that later that evening, when she opened the medication bottle, she discovered that it contained only thirty (30) tablets of Adderall, instead of the one-hundred and twenty (120) tablets as prescribed.

7. L.T. later contacted Spring Valley to report the Adderall shortage.

8. Respondent Mr. Chibueze accepted L.T.'s complaint and informed L.T. that he checked the pharmacy's Adderall 10 mg. tablet inventory.

9. In a written statement, Mr. Chibueze states that he conducted a physical count of Spring Valley's Adderall 10 mg. tablets and reported that he found no discrepancies.

10. Mr. Chibueze also said that he would view the video of L.T.'s prescription being filled.

11. Spring Valley's video system overwrites recorded video every forty-eight hours, so Mr. Chibueze was not able to view the filling of L.T.'s prescription.

12. L.T. was unable to resolve the medication shortage with Spring Valley.

13. While investigating L.T.'s complaint regarding Presecription Number 26542, the the Board Investigator discovered that Spring Valley's pharmacy workflow software does not depict the required data elements of a lawful prescription.

14. The Investigator found substantial discrepancies in Spring Valley's electronic Schedule II perpetual inventory recordkeeping.

15. Examples of the discripencies the investigator found include:

a. Amphetamine Salts 10 mg NDC 00555-0972-02: Prescription No. 26542 appears on this inventory four times, once on February 5, 2016, and three times on February 8. Two of those entries show that Spring Valley dispensed the medication, and two show that Spring Valley added the same amount (120 tablets) back into its inventory. The inventory showed that Spring Valley should have had 86 tablets in its inventory on March 15, 2016. The Board Investigator conducted a count of the Amphetamine Salts 10 mg tablets on March 15, 2016, and counted 94.

b. Amphetamine 10 mg ER, NDC 000555-07870-2: Prescription No. 26542 appears on this inventory twice. It shows that Spring Valley dispensed 120 tablets on February 8, 2016, and then received the same amount back into its inventory. The inventory showed that Spring Valley should have had 195 tablets in its inventory on March 15, 2016. The Board Investigator counted and documented 215 tablets.

c. Amphetamine 10 mg NDC 45963-0745-11: Prescription No. 26542 appears on this inventory once, when Spring Valley purportedly dispensed 120 tablets. The inventory shows that Spring Valley should have had count of -75 tablets. The Board Investigator counted 23 tablets.

16. According to Spring Valley's workflow records for Prescription No. 26542, pharmaceutical technician Rolando (Mr. Urrutia) entered the prescription data.

17. Spring Valley provided the Board Investigator a copy of the workflow screen, "Rx's Checked", for Prescription No. 26542, on March 15, 2016.

18. The record failed to capture the fill technician, verifying pharmacist, prescription verification date/time, counseling pharmacist, and counseling date/time.

19. On March 24, 2016, Spring Valley provided a second copy of the "Rx's Checked" record for Prescription No. 26542. That copy was identical to the March 15th copy except for an additional entry, "Martin Chibueze", in data field "IOU Pharmacist".[1]

20. The information in Spring Valley's records reflect an inconsistency as to the NDC for Prescription No. 26542. The NDC on L.T.'s patient profile is 45963-0745-11. The NDC on the label of the bottle dispensed to L.T. is 00555-0972-02.

21. The label on the bottle did not include an expiration date for the medication.

22. Spring Valley's electronic perpetual inventories on March 15, 2016, showed an inventory of negative counts for Amphetamine 10 mg. tablets. Those negative counts were not consistent with the Board Inspector's physical counts of that medication at the pharmacy.

23. Spring Valley's records do not accurately show who was working at the time the pharmacy filled Prescription No. 26542. Respondent Ms. Nguyen purportedly worked from 8:00 AM until 12:00 PM, which includes the time the pharmacy filled Prescription No. 26542. The pharmacy's Time Clock Report does not reflect that Ms. Nguyen worked in the pharmacy during those times.

24. At the time Spring Valley filled Prescription No. 26542, pharmaceutical technician Rolando Urrutia worked at the pharmacy and participated in at least the data entry process. Urrutia left Spring Valley at short time later. Spring Valley and Ms. Nguyen failed to report Mr. Urrutia's employment with and termination from the pharmacy.

25. Pharmacy records show that Mr. Chibueze verified Prescription No. 26542 and sold the medication to L.T.

26. Spring Valley could not initially provide a counseling log for the prescription. Ms. Nguyen later faxed over a duplicate of the patient's signature with the words "Counseling Log" handwritten in the margin.

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[1] "IOU" indicates a remaining medication fill from a prior partial fill.

27. In the absence of critical records, the Board Investigator was unable to reliably determine whether Spring Valley accurately filled Prescription No. 26542.

Respondents, and each of them, have fully considered the factual allegations contained in the Notice of Intended Action and Accusation in this matter, and the terms of this Stipulation, and have freely and voluntarily agreed to the factual statements set forth herein.

Signed this 30TH day of May, 2017

Jessica Nguyen, RPh.,
Certificate of Registration No. 15397

Signed this ___ day of May, 2017

Martin O. Chibueze, RPh.,
Certificate of Registration No. 17555

Signed this 30TH day of May, 2017

Authorized Representative of
Spring Valley Pharmacy
Certificate of Registration No. PH02375

27. In the absence of critical records, the Board Investigator was unable to reliably determine whether Spring Valley accurately filled Prescription No. 26542.

Respondents, and each of them, have fully considered the factual allegations contained in the Notice of Intended Action and Accusation in this matter, and the terms of this Stipulation, and have freely and voluntarily agreed to the factual statements set forth herein.

Signed this ___ day of May, 2017

Jessica Nguyen, RPh.,
Certificate of Registration No. 15397

Signed this 30th day of May, 2017

Martin O. Chibueze, RPh.,
Certificate of Registration No. 17555

Signed this ___ day of May, 2017

Authorized Representative of
Spring Valley Pharmacy
Certificate of Registration No. PH02375

BEFORE THE NEVADA STATE BOARD OF PHARMACY

NEVADA STATE BOARD OF PHARMACY, **Petitioner,** **v.** **JESSICA NGUYEN, RPH** **Certificate of Registration No. 15397, and** **SPRING VALLEY PHARMACY** **Certificate of Registration No. PH02375** **Respondents.** /	**CASE NO. 16-022-RPH-S** **16-022-PH-S** **FINDINGS OF FACT, CONCLUSION OF LAW AND ORDER** **(All Respondents)**

The Nevada State Board of Pharmacy (Board) heard this matter at its regularly scheduled meeting on Wednesday, May 31, 2017, in Reno, Nevada. S. Paul Edwards, Esq., prosecuted the case on behalf of Board Staff. Respondents JESSICA NGUYEN, RPH, Certificate of Registration No. 15397 (Ms. Nguyen) and SPRING VALLEY PHARMACY, Certificate of Registration No. PH02375 (Spring Valley), did not appear at the hearing. They were represented at the hearing by their counsel of record, Jude Nazareth, Esq., of the law firm Montez Nazareth Law.

Based on the evidence presented during the hearing, including testimonial and documentary evidence, the Board issues the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. On May 30th, 2017, Respondents, and each of them, entered into a set of *Stipulated Facts*, a copy of which is attached hereto as **Exhibit 1** and incorporated herein by reference. The facts to which Respondents admitted in the *Stipulated Facts* are as follows:

a. This case involves three prescriptions for one-year-old patient A.G. One prescription for Methotrexate compounded liquid, with refills, designated as Prescription No. 676992, and two prescriptions for Flagyl suspension, designated Prescription Nos. 675133 and 678825.

b. In March 2016, a Board Inspector conducted Spring Valley's annual pharmacy inspection.

c. The Board Inspector requested to see the prescription and records related to four (4) vials of Methotrexate 250mg/10ml injection on the pharmacy shelf.

d. The pharmacy manager, Respondent Ms. Nguyen, presented the prescription, Prescription No. 676992, and all available records to the Board Inspector.

e. The records show that:

i. A.G.'s physician transmitted what would become Prescription No. 676992 to Spring Valley electronically on February 23, 2016.

ii. Spring Valley's computer system shows that Ms. Nguyen entered the prescription data into the computer.

iii. The system did not capture the signature, initials, or the name of each pharmacist or pharmaceutical technician who played a role in processing or filling Prescription No. 676992.

iv. The computer system also failed to record which pharmacist verified the medication as accurate before dispensing it.

f. In April 2016, Ms. Nguyen provided the Board Inspector a duplicate label for Prescription No. 676992.

g. The duplicate label shows that Spring Valley dispensed the prescription initially on February 23, 2016, with the instructions: "GIVE *0.4* ML BY MOUTH EVERY WEEK ON MONDAY (25MG/*ML*)." (Emphasis added.)

h. Ms. Nguyen also provided the Board Inspector a copy of the prescription from the pharmacy's archived paper records. That copy included the back label from the February 23, 2016 initial fill. That copy of the back label did not match the duplicate label Ms. Nguyen provided to the Board Inspectors. The instructions on that copy of the back label are: "GIVE *4ML* BY MOUTH EVERY WEEK ON MONDAY (GIVE 25MG/*10*ML)." (Emphasis added.)

i. The instructions on the duplicate label and on the back label should match. Ms. Nguyen could not explain why the records she provided were inconsistent.

j. The label on the bottle included the direction to give 4mL, rather than 0.4 mL.

k. Despite the inconsistency, there is no evidence that A.G. ingested an incorrect dose or experienced adverse effects from the incident.

l. A.G.'s physician sent Spring Valley a clarified prescription on March 15, 2016, for a 20 count of "Methotrexate 2.5 MG Oral Tablet." The SIG for the prescription was "10 Milligram (25mg/*10*ml) Milligram, Oral *4*ml once a week on Monday." (Emphasis added.) The notes to the pharmacist similarly stated: "Compound to Methotrexate 25mg/*10*ml every Monday." The prescription allowed for six refills. (Emphasis added.)

m. Spring Valley was unable to produce any record of this e-prescription. The Board Inspector obtained a copy from A.G.'s physician.

n. The label on the bottle that Spring Valley dispensed pursuant to that clarified prescription, which Spring Valley continued to designate as Prescription No. 676992, has instructions to "GIVE *0.4* ML BY MOUTH EVERY WEEK ON MONDAY (25MG/*ML*). (Emphasis added.) That label failed to include: (1) the medication's strength/concentration, or (2) the required warning labels.

o. Spring Valley's records show that Respondent Ms. Nguyen input the prescription data in Spring Valley's computer system. They also show that Ms. Nguyen verified the medication before the pharmacy dispensed it.

p. Spring Valley could not produce records to show who processed the prescription and filled the medication.

q. Spring Valley could not produce evidence to show that anyone contacted A.G.'s physician for approval to change the compound from "(25mg/*10*ml) Milligram, Oral *4*ml once a week on Monday" to "GIVE *0.4* ML BY MOUTH EVERY WEEK ON MONDAY (25MG/*ML*)."

r. Both the duplicate labels for Prescription No. 676992 for fill dates February 23, 2016 and refill date March 15, 2016, show Mylan as the medication manufacturer. The NDC on the label is 51079-0670-05. Neither Mylan nor that NDC number appears on any invoice for Methotrexate purchased by Spring Valley.

s. Respondent Ms. Nguyen verbally admitted to the Board Investigator that she changed the NDC numbers on medications in Spring Valley's system so that they would qualify for payment by insurance companies.

t. The Board investigator requested a copy of Spring Valley's billing records for the medications dispensed for A.G. Neither Respondent Spring Valley nor respondent Ms. Nguyen provided a copy of those records as requested. They offered no explanation for that failure to provide the requested records.

u. During the March 15, 2016 inspection, the Board's Inspectors requested a copy of Spring Valley's policies and procedures for compounding nonsterile compounded drug products. Neither Spring Valley nor Ms. Nguyen could provide those written policies and procedures.

v. In a separate filling error, the Board investigator found, during the investigation on January 13, 2016, A.G.'s physician sent an e-prescription for "Flagyl 250 MG Oral tablet" with notes to compound for "Flagyl Suspension 20 mg per mL, to take 4mL by mouth every 6 hours, for a dosage of 80 mg 4 times a day for 10 days." Spring Valley designated it Prescription No. 675133.

w. On April 25, 2016, Respondent Ms. Nguyen provided a duplicate label for Prescription No. 675133. That duplicate label revealed that Spring Valley dispensed a medication with directions to take "3ML BY MOUTH EVERY 6 HOURS UNTIL GONE." The label also stated "15 Tab METRONIDAZOLE 500MG."

x. The label shows that Respondent Ms. Nguyen, initials "JTN", verified the medication.

y. A copy of the prescription the Board Inspector obtained from the pharmacy's archived paper records contained a back label showing the directions "TAKE HALF TABLET BY MOUTH EVERY SIX HOURS UNTIL GONE."

z. The pharmacy has none of the compounding records required to show that it compounded the medication correctly. Neither the labels nor the archived paper records for Prescription No. 675133 reveal the medication's concentration.

aa. Ms. Nguyen input the prescription data into Spring Valley's computer system, and she verified the medication was accurate prior to sale. Spring Valley's records are missing all information regarding the person who filled the medication.

bb. The Board Inspector found a second instance where Spring Valley failed to adequately label a Flagyl prescription for A.G. in March 2016.

cc. On March 28, 2016, A.G.'s physician transmitted to Spring Valley an e-prescription, Prescription No. #678825, for "Flagyl 250 MG Oral Tablet". The prescription notes called for "Flagyl Suspension 20 mg per mL, to take 4 mL by mouth every 6 hours, for a dose of 80 mg 4 times a day for 10 days."

dd. The duplicate label for that prescription shows directions to take "80 MG (4ML) BY MOUTH EVERY 6 HOURS FOR 10 Days" and "160 MI METRONIDAZOLE 500/ML."

ee. The duplicate label shows Ms. Nguyen's initials "JTN", verified the medication.

ff. Spring Valley did not have a copy of the back label in its records.

gg. The workflow records for Prescription No. #678825 show that Ms. Nguyen input the date of the prescription in the pharmacy computer system. They show a fill time of March 28, 2016, at 11:59 AM. They further show that pharmacist Martin Chibueze verified the medication as accurate the same day, at 4:46 PM.

hh. Respondent Ms. Nguyen could not explain to the Board Investigator the meaning of "160 MI METRONIDAZOLE 500/ML."

ii. The label did not indicate the concentration of the medication, so Spring Valley was unable to provide verification that it compounded the medication correctly.

jj. On March 15, 2016, Ms. Nguyen provided a statement to the Board's Reno Office stating that Spring Valley would no longer provide non-sterile compounded products to its patients.

kk. Pharmacy records indicate the pharmacy continued to make compounded nonsterile medication, including an additional methotrexate compound on April 12, 2016.

2. Based on the evidence presented at the hearing, the Board finds that evidence exists to support each of the factual allegations stated in the Accusation.

CONCLUSIONS OF LAW

3. During the hearing, Respondents, through their counsel, stipulated that the facts set forth in the *Stipulated Facts* satisfy each of the elements of the First through Tenth Causes of Action. After Counsel's opening arguments, no Causes of Action remained in dispute.

4. Those admissions notwithstanding, and taking under consideration the facts set forth in the Stipulated Facts, the Board hereby concludes as a matter of law:

a. The Board has jurisdiction over this matter and these Respondents because at the time of the alleged events, Ms. Nguyen, Certificate of Registration No. 15397, was a pharmacist licensed by the Board and Spring Valley, Certificate of Registration No. PH02375, was a pharmacy licensed by the Board.

b. Spring Valley violated NAC 639.945(1)(d) when, without first contacting A.G.'s prescriber for approval to make an adjustment, it dispensed Prescription No. 676992 to A.G. with instructions to "GIVE *4ML* BY MOUTH EVERY WEEK ON MONDAY (GIVE 25MG/*10*ML)," instead of "*0.4* ML BY MOUTH EVERY WEEK ON MONDAY (25MG/*ML*)" as directed by A.G.'s physician.

c. Spring Valley's computer system does not accurately capture and retain the information required by NAC 639.751, NAC 639.930(3) and (4), and NAC 639.935(g), as demonstrated by the system's failure to capture, retain, and print the required information for

Prescription Nos. 676992, 675133 and 678825. Spring Valley therefore violated each of those regulations.

d. By failing to maintain adequate safeguards in its computer system to identify the information required by NAC 639.751(1)(b) and (2) and NAC 639.930(3) as to Prescription Nos. 676992, 675133 and 678825, and by failing to prevent the removal of that information as required by NAC 639.930(4) and (5), Spring Valley violated each of those regulations.

e. By producing inaccurate records of Prescription No. 676992 to the Board Investigator during the investigation, in particular, by producing a duplicate label for Prescription No. 676992 with the directions "give 0.4mL by mouth every week on Monday (25mg/mL)" and a subsequent copy of the prescription paperwork with different instructions—"give 4mL by mouth every week on Monday (give 25mg/10mL)"—Spring Valley is guilty of violating NRS 454.291(1) and NAC 639.930(1) and (2).

f. By failing to properly label the container for Prescription No. 676992 and Prescription No. 675133 to include an accurate manufacturer name, NDC number, the expiration date or BUD, the strength/concentration of the drug, the proper warning labels and the specific directions for use set by the practitioner, Spring Valley violated NRS 639.2801 and NAC 639.6703.

g. By failing to produce and provide to the Board Investigator the billing records for A.G.'s medications, as required by NAC 639.482(1), Spring Valley violated that regulation.

h. By failing to maintain complete and accurate records of all dangerous drugs it purchased and the dangerous drugs it sold, Spring Valley violated NRS 454.286.

i. By failing to have, and by failing to produce to the Board Investigator, policies and procedures as described above, Spring Valley violated NAC 639.247, NAC 639.67015, NAC 639.67035 and NAC 639.67037.

j. As the managing pharmacist/pharmacist in charge of Spring Valley at the time of each of the violations found above, Respondent Ms. Nguyen is responsible for those violations, including those of her employees. *See* NRS 639.0087, NRS 639.210(15), NRS 639.220(3)(c), NAC 639.510(2), NAC 639.702, and NAC 639.910(2). Ms. Nguyen's pharmacist license, Certificate of Registration No. 15397, is therefore subject to discipline, suspension, or revocation pursuant to those statutes and regulations, NRS 639.210(4), (9), (11) - (12), (15) and/or (17), as well as NRS 639.230(5) and/or NRS 639.255.

k. As the pharmacy and owner of the pharmacy in which the violations alleged herein occurred, Respondents Spring Valley and Ms. Nguyen, respectively, are each responsible for the violations found above pursuant to NAC 639.702 and NAC 639.945(2). Each of their licenses, Certificate of Registration No. 15397 (Ms. Nguyen), and Certificate of Registration No. PH02375 (Spring Valley) are therefore subject to discipline pursuant to NRS 639.210(4), (9), (11) - (12), (15) and/or (17), as well as NRS 639.230(5) and/or NRS 639.255.

5. For each of the violations found herein, the licenses of each of the Respondents is subject to discipline pursuant to the provisions of NRS 639.210, and well as NRS 639.255, unless otherwise specified herein.

ORDER

6. Related to the violations set forth in each of the Causes of Action in the Accusation, and found herein, for which Ms. Nguyen is responsible either directly, or as the owner and pharmacist in charge/pharmacy manager of Spring Valley, and for which Spring Valley is responsible as the facility in which the violations occurred:

a. Ms. Nguyen shall pay a combined fine of Five Thousand Dollars ($5,000.00),

b. Spring Valley shall pay a combined fine of Ten Thousand Dollars ($10,000.00),

c. Spring Valley shall pay an administrative fee of One Thousand Five Hundred Dollars ($1,500) to partially offset the Board's costs and expenses associated with investigating and prosecuting this action.

d. Ms. Nguyen's pharmacist license, Certificate of Registration No. 15397, is suspended immediately upon the execution of this order,

e. Spring Valley's pharmacy license, Certificate of Registration No. PH02375, is suspended immediately upon execution of this order.

f. The fines imposed on Ms. Nguyen and Spring Valley, and the suspension of Spring Valley's and Ms. Nguyen's respective licenses, are hereby stayed. The administrative fee is not stayed. Both licenses are placed on probation with the following terms and conditions:

i. Ms. Nguyen's pharmacist license shall be on probation for a minimum of eighteen (18) months,

ii. Spring Valley's pharmacy license shall be on probation for a minimum of eighteen (18) months,

iii. During the probationary period, Spring Valley and Ms. Nguyen shall engage and shall each participate in an independent remediation and compliance monitoring program designed by the independent monitor Affiliated Monitors, Inc. (Affiliated Monitors). Affiliated Monitors, in consultation with Board Staff, shall design, implement, and monitor Spring Valley's and Ms. Nguyen's compliance with a program that Affiliated Monitors and Board Staff deem appropriate to address the deficiencies in Spring Valley's and Ms. Nguyen's pharmacy operations and compliance with federal and Nevada law. Affiliated Monitors' monitoring and compliance program must start within ninety (90) days of the execution of this order, and the eighteen-month probationary period shall begin once Affiliated Monitors starts its monitoring program with Spring Valley and Ms. Nguyen.

iv. Affiliated Monitors shall provide Board Staff with regular updates regarding Spring Valley's and Ms. Nguyen's participation and compliance with its monitoring program.

v. Spring Valley and Ms. Nguyen shall pay all costs and fees associated with participating in Affiliated Monitors' program.

vi. Ms. Nguyen may not be designated as, and may not work as, a pharmacist in charge/pharmacy manager in any Nevada-licensed facility during the probationary period.

vii. Spring Valley and Ms. Nguyen shall not engage in any form of sterile or nonsterile compounding until Spring Valley's compounding policies and procedures are reviewed and approved by Affiliated Monitors in consultation with Board Staff.

viii. Ms. Nguyen must complete ten (10) extra hours of continuing education (CE) on topics related to pharmacy law, proper counseling techniques, patient safety and pharmacy business operations. Those extra hours of CE are in addition to, and do not count toward, the continuing education hours Ms. Nguyen must otherwise complete to maintain her pharmacist license. They may, however, be used to satisfy the extra CE requirements ordered by the Board in Case No. 16-015-RPH-S.

ix. Ms. Nguyen shall appear personally at two of the next three Pharmacy Board Meetings in Las Vegas on discipline day, which is generally the first day of the Board's two-day meetings. At the first of those two meetings, Ms. Nguyen's name shall appear on the agenda and Ms. Nguyen shall appear in person before the Board to explain her failure to attend the hearing in this action.

x. Spring Valley and Ms. Nguyen shall comply with all federal and state statutes and regulations regarding controlled substances, dangerous drugs, and the practice of pharmacy, and they shall have no additional complaints filed against them.

g. After not less than eighteen months into the probationary period, Ms. Nguyen shall appear before the Board, both personally and in her capacity as owner of Spring Valley, along with Spring Valley's managing pharmacist at the time and with representatives from Affiliated Monitors, to report and discuss Spring Valley's and Ms. Nguyen's compliance with Affiliated Monitors' program. The Board will determine at that time, and at its sole

discretion, whether the probationary period on Spring Valley's and Ms. Nguyen's respective license will end, and whether to waive the fees imposed herein.

h. In the event that Spring Valley and/or Ms. Nguyen fail to participate fully with Affiliated Monitors and Board Staff, or otherwise fail to comply with the terms of this Order, the stay of suspension on each of their licenses and the stay of the fines set forth above shall lift. Spring Valley and Ms. Nguyen's licenses shall then be suspended and the fines set forth above shall become due and payable immediately.

7. Respondents shall pay the fines ordered herein when due, and by *cashier's check* or *certified check* or *money order* made payable to "State of Nevada, Office of the Treasurer" to be received by the Board's Reno office located at 431 W. Plumb Lane, Reno, NV 89509, within 90 days of the effective date of the Board's Order.

8. Respondents shall pay the administrative fees ordered herein by *cashier's check*, *certified check* or *money order* made payable to the "Nevada State Board of Pharmacy" to be received by the Board's Reno office located at 431 W. Plumb Lane, Reno, NV 89509, within thirty (30) days of the effective date of the Board's Order.

9. Any failure by any Respondent to satisfy the obligations stated herein may result in additional discipline, up to and including suspension or revocation of each Respondent's respective registration/license, until all terms have been satisfied.

10. This Order is effective on the date it is executed below.

IT IS SO ORDERED.

Signed and effective this 9 day of June, 2017.

Leo Basch, President
Nevada State Board of Pharmacy

BEFORE THE NEVADA STATE BOARD OF PHARMACY

NEVADA STATE BOARD OF PHARMACY,	)	**CASE NO. 16-022-RPH-S**
	)	**16-022-PH-S**
Petitioner,	)	
v.	)	**STIPULATED FACTS**
	)	**(All Respondents)**
JESSICA NGUYEN, RPH,	)	
Certificate of Registration No. 15397, and	)	
	)	
SPRING VALLEY PHARMACY,	)	
Certificate of Registration No. PH02375,	)	
	)	
Respondents.	/	

S. PAUL EDWARDS, Esq., General Counsel for petitioner the Nevada State Board of Pharmacy ("Board"), and respondents Jessica Nguyen, RPh, Certificate of Registration No. 15397 ("Ms. Nguyen"); and Spring Valley Pharmacy, Certificate of Registration No. PH02375 ("Spring Valley") (collectively "Respondents"), by and through their counsel, Jude Edward Nazareth, Esq., of Montez Nazareth Law,

HEREBY STIPULATE AND AGREE THAT:

1. The Nevada State Board of Pharmacy (Board) has jurisdiction over this matter and these Respondents because at the time of the alleged events, Respondents Ms. Nguyen and Spring Valley were each licensed by the Board.

2. This case involves three prescriptions for one-year-old patient A.G. One prescription for Methotrexate compounded liquid, with refills, designated as Prescription No. 676992, and two prescriptions for Flagyl suspension, designated Prescription Nos. 675133 and 678825.

3. In March 2016, a Board Inspector conducted Spring Valley's annual pharmacy inspection.

4. The Board Inspector requested to see the prescription and records related to four (4) vials of Methotrexate 250mg/10ml injection on the pharmacy shelf.

5. The pharmacy manager, Respondent Ms. Nguyen, presented the prescription, Prescription No. 676992, and all available records to the Board Inspector.

6. The records show that:

a. A.G.'s physician transmitted what would become Prescription No. 676992 to Spring Valley electronically on February 23, 2016.

b. Spring Valley's computer system shows that Ms. Nguyen entered the prescription data into the computer.

c. The system did not capture the signature, initials, or the name of each pharmacist or pharmaceutical technician who played a role in processing or filling Prescription No. 676992.

d. The computer system also failed to record which pharmacist verified the medication as accurate before dispensing it.

7. In April 2016, Ms. Nguyen provided the Board Inspector a duplicate label for Prescription No. 676992.

8. The duplicate label shows that Spring Valley dispensed the prescription initially on February 23, 2016, with the instructions: "GIVE *0.4* ML BY MOUTH EVERY WEEK ON MONDAY (25MG/*ML*)." (Emphasis added.)

9. Ms. Nguyen also provided the Board Inspector a copy of the prescription from the pharmacy's archived paper records. That copy included the back label from the February 23, 2016 initial fill. That copy of the back label did not match the duplicate label Ms. Nguyen provided to the Board Inspectors. The instructions on that copy of the back label are: "GIVE *4ML* BY MOUTH EVERY WEEK ON MONDAY (GIVE 25MG/*10*ML)." (Emphasis added.)

10. The instructions on the duplicate label and on the back label should match. Ms. Nguyen could not explain why the records she provided were inconsistent.

11. The label on the bottle included the direction to give 4mL, rather than 0.4 mL.

12. Despite the inconsistency, there is no evidence that A.G. ingested an correct dose or experienced adverse effects from the incident.

13. A.G.'s physician sent Spring Valley a clarified prescription on March 15, 2016 for a 20 count of "Methotrexate 2.5 MG Oral Tablet." The SIG for the prescription was "10 Milligram (25mg/*10*ml) Milligram, Oral *4*ml once a week on Monday." (Emphasis added.) The notes to the pharmacist similarly stated: "Compound to Methotrexate 25mg/*10*ml every Monday." The prescription allowed for six refills. (Emphasis added.)

14. Spring Valley was unable to produce any record of this e-prescription. The Board Inspector obtained a copy from A.G.'s physician.

15. The label on the bottle that Spring Valley dispensed pursuant to that clarified prescription, which Spring Valley continued to designate as Prescription No. 676992, has instructions to "GIVE *0.4* ML BY MOUTH EVERY WEEK ON MONDAY (25MG/*ML*). (Emphasis added.) That label failed to include: (1) the medication's strength/concentration, or (2) the required warning labels.

16. Spring Valley's records show that Respondent Ms. Nguyen input the prescription data in Spring Valley's computer system. They also show that Ms. Nguyen verified the medication before the pharmacy dispensed it.

17. Spring Valley could not produce records to show who processed the prescription and filled the medication.

18. Spring Valley could not produce evidence to show that anyone contacted A.G.'s physician for approval to change the compound from "(25mg/*10*ml) Milligram, Oral *4*ml once a

week on Monday" to "GIVE *0.4* ML BY MOUTH EVERY WEEK ON MONDAY (25MG/*ML*)."

19. Both the duplicate labels for Prescription No. 676992 for fill dates February 23, 2017 and refill date March 15, 2016, show Mylan as the medication manufacturer. The NDC on the label is 51079-0670-05. Neither Mylan nor that NDC number appears on any invoice for Methotrexate purchased by Spring Valley.

20. Respondent Ms. Nguyen verbally admitted to the Board Investigator that she changed the NDC numbers on medications in Spring Valley's system so that they would qualify for payment by insurance companies.

21. The Board investigator requested a copy of Spring Valley's billing records for the medications dispensed for A.G. Neither Respondent Spring Valley nor respondent Ms. Nguyen provided a copy of those records as requested. They offered no explanation for that failure to provide the requested records.

22. During the March 15, 2016 inspection, the Board's Inspectors requested a copy of Spring Valley's policies and procedures for compounding nonsterile compounded drug products. Neither Spring Valley nor Ms. Nguyen could provide those written policies and procedures.

23. In a separate filling error the Board investigater found during the investigation, on January 13, 2016, A.G.'s physician sent an e-prescription for "Flagyl 250 MG Oral tablet" with notes to compound for "Flagyl Suspension 20 mg per mL, to take 4mL by mouth every 6 hours, for a dosage of 80 mg 4 times a day for 10 days." Spring Valley designated it Prescription No. 675133.

24. On April 25, 2016, Respondent Ms. Nguyen provided a duplicate label for Prescription No. 675133. That duplicate label revealed that Spring Valley dispensed a medication with directions to take "3ML BY MOUTH EVERY 6 HOURS UNTIL GONE." The label also stated "15 Tab METRONIDAZOLE 500MG."

25. The label shows that Respondent Ms. Nguyen, initials "JTN", verified the medication.

26. A copy of the prescription the Board Inspector obtained from the pharmacy's archived paper records contained a back label showing the directions "TAKE HALF TABLET BY MOUTH EVERY SIX HOURS UNTIL GONE."

27. The pharmacy has none of the compounding records required to show that it compounded the medication correctly. Neither the labels nor the archived paper records for Prescription No. 675133 reveal the medication's concentration.

28. Ms. Nguyen input the prescription data into Spring Valley's computer system, and she verified the medication was accurate prior to sale. Spring Valley's records are missing all information regarding the person who filled the medication.

29. The Board Inspector found a second instance where Spring Valley failed to adequately label a Flagyl prescription for A.G. in March 2016.

30. On March 28, 2016, A.G.'s physician transmitted to Spring Valley an e-prescription, Prescription No. #678825, for "Flagyl 250 MG Oral Tablet". The prescription notes called for "Flagyl Suspension 20 mg per mL, to take 4 mL by mouth every 6 hours, for a dose of 80 mg 4 times a day for 10 days."

31. The duplicate label for that prescription shows directions to take "80 MG (4ML) BY MOUTH EVERY 6 HOURS FOR 10 Days" and "160 MI METRONIDAZOLE 500/ML."

32. The duplicate label shows Ms. Nguyen's initials "JTN", verified the medication.

33. Spring Valley did not have a copy of the back label in its records.

34. The workflow records for Prescription No. #678825 show that Ms. Nguyen input the date of the prescription in the pharmacy computer system. They show a fill time of March 28, 2016, at 11:59 AM. They further show that pharmacist Martin Chibueze verified the medication as accurate the same day, at 4:46 PM.

35. Respondent Ms. Nguyen could not explain to the Board Investigator the meaning of "160 MI METRONIDAZOLE 500/ML."

36. The label did not indicate the concentration of the medication, so Spring Valley was unable to provide verification that it compounded the medication correctly.

37. On March 15, 2016, Ms. Nguyen provided a statement to the Board's Reno Office stating that Spring Valley would no longer provide non-sterile compounded products to its patients.

38. Pharmacy records indicate the that pharmacy continued to make compounded nonsterile medication, including an additional methotrexate compound on April 12, 2016.

Respondents, and each of them, have fully considered the factual allegations contained in the Notice of Intended Action and Accusation in this matter, and the terms of this Stipulation, and have freely and voluntarily agreed to the factual statements set forth herein.

Signed this 30 day of May, 2017

Jessica Nguyen, RPh.,
Certificate of Registration No. 15397

Signed this 30TH day of May, 2017

Authorized Representative of
Spring Valley Pharmacy,
Certificate of Registration No. PH02375