

BEFORE THE PHARMACY BOARD OF THE STATE OF IOWA

IN THE MATTER OF

Greenville Pharmacy, Inc.
License No. 667
CSA Registration No. 1102280

RESPONDENT

**CASE NOs.: 2023-0159, 2024-0118, and
2024-0188**

**COMBINED NOTICE OF HEARING,
STATEMENT OF CHARGES, AND
EMERGENCY ADJUDICATIVE ORDER**

COMES NOW the Iowa Board of Pharmacy (“Board”) and files this Notice of Hearing, Statement of Charges, and Emergency Adjudicative Order against Greenville Pharmacy, Inc. (“Respondent”), pursuant to Iowa Code sections 17A.12(2), 17A.18(3), 17A.18A, 272C.3(1)(e), and 657 Iowa Administrative Code (“IAC”) 35.35.

A. TIME, PLACE AND NATURE OF HEARING

1. **Hearing.** A contested case hearing shall be held on December 2, 2024, before the Board. The hearing shall begin at 8:00 a.m. and shall be located in the conference room at the office of the Iowa Board of Pharmacy, 6200 Park Avenue, Ste. 100, Des Moines, Iowa 50321.
2. **Scheduling Conference.** Any party may request a prehearing conference in accordance with 657 IAC 35.22.
3. **Answer.** Within twenty (20) days of the date you are served this Notice of Hearing and Statement of Charges you are permitted by 657 IAC 36.16 to file an Answer. Should you file an Answer, please note whether you will request a continuance of the date and time of the hearing.
4. **Filing of Pleadings.** Pleadings shall be filed with the Board at the following address: Iowa Board of Pharmacy, 6200 Park Avenue, Ste. 100, Des Moines, Iowa 50321, by email to lacy.hepp@dia.iowa.gov, or electronically using the Administrative Electronic Document Management System (adminhearings.iowa.gov/efile/).

5. **Presiding Officer**. The Board shall serve as presiding officer at the contested case hearing, but the Board hereby delegates to an Administrative Law Judge from the Department of Inspections, Appeals and Licensing, the authority to make initial rulings on prehearing matters, and requests the Administrative Law Judge be present to assist and advise the Board at hearing.

6. **Prehearing Conference**. Any party may request a prehearing conference to discuss evidentiary issues related to the hearing in accordance with 657 IAC 35.22.

7. **Hearing Procedures**. The procedural rules governing the conduct of the hearing are found at 657 IAC 35.35. At the hearing, you may appear personally or be represented by legal counsel at your own expense. You will be allowed the opportunity to respond to the charges against you, to produce evidence on your behalf on issues of material fact, cross-examine witnesses present at the hearing, and examine and respond to any documents introduced at hearing. If you need to request an alternative time or date for hearing, you must comply with the requirements of 657 IAC 35.23. The hearing may be open to the public or closed to the public at the discretion of the Respondent.

8. **Prosecution**. The Office of the Attorney General is responsible for representing the public interest (the State) in this proceeding. Pleadings shall be filed with the Board and copies should be provided to counsel for the State at the following address: Lindsey L. Browning, Assistant Attorney General, Office of the Iowa Attorney General 1305 E. Walnut Street, 2nd Floor, Des Moines, Iowa 50319.

9. **Communications**. You may not contact Board members in any manner, including by phone, letter, facsimile, in person or e-mail, about this Notice of Hearing and Statement of Charges. Board members may only receive information about the case when all parties have notice and an opportunity to participate, such as at the hearing or in pleadings you file with the Board and serve upon all parties in the case. You may contact Amanda Woltz, Executive Officer, Iowa Board of

Pharmacy, at 515-281-6674 or Amanda.Woltz@dia.iowa.gov, or Assistant Attorney General Lindsey L. Browning at 515-281-3441 or lindsey.browning@ag.iowa.gov.

B. LEGAL AUTHORITY AND JURISDICTION

10. **Iowa License**. Respondent maintains an Iowa Pharmacy License # 667 that was originally issued on November 7, 2017, and is set to expire on December 31, 2024. This license is currently under probation from a previous Order of this Board issued on March 5, 2024. Respondent also maintains an Iowa CSA-Business Registration #1102280.

11. **Jurisdiction**. The Board has jurisdiction in this matter pursuant to Iowa Code § 155A and 657 IAC 35.35.

12. **Legal Authority**. If any of the allegations against you are founded, the Board has authority to take disciplinary action against you under Iowa Code § 155A and 657 IAC 36.

13. **Default**. The Board may enter a default decision or proceed with the hearing and render a decision in your absence, in accordance with Iowa Code §17A.12(3) and 657 IAC 35.27.

C. STATEMENT OF CHARGES

COUNT I

14. Respondent is charged under 657 IAC 36.6(2) with professional incompetency.

COUNT II

15. Respondent is charged under 657 IAC 36.6(3) with engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established.

COUNT III

16. Respondent is charged under 657 IAC 36.6(18) for willful or repeated malpractice.

COUNT IV

17. Respondent is charged under 657 IAC 36.6(19) for willful or gross negligence.

COUNT V

18. Respondent is charged under 657 IAC 36.6(28) for failing to create and maintain complete and accurate records as required by state or federal law or regulation or rule of the board.

COUNT VI

19. Respondent is charged under 657 IAC 36.6(41) for dispensing, or contributing to the dispensing of, an incorrect prescription, which includes, but is not limited to, the incorrect drug, the incorrect strength, the incorrect patient or prescriber, or the incorrect or incomplete directions.

COUNT VII

20. Respondent is charged under 657 IAC 36.6(9) for violating a lawful order of the Board.

D. FINDINGS OF FACT

21. **Practice Setting**. Respondent is an Iowa licensed pharmacy practicing in the area of Sioux City, Iowa, during the time period relevant to these allegations.

22. **Factual Circumstances**. Respondent's pharmacy license is currently on probation in Case Number 2023-0159. The facts giving rise to this settlement agreement were that on October 4, 2023, Respondent incorrectly filled a patient's prescription. D.K. began taking medication from this fill on or about October 11, 2023. On or about the date of October 25, 2023, D.K. presented to the emergency room and was hospitalized with a life-threatening condition resulting from this medication error. Respondent has failed to comply with the settlement agreement in 2023-0159 by failing to provide adequate documentation in support of its Continuous Quality Improvement ("CQI") program. Expressly, Respondent failed to document reportable program events including the following elements: the date and time the program event was discovered, the name of the staff person who discovered the event, and the names of the individuals recording or analyzing the

program event information. Notably, Respondent's CQI supporting documentation failed to include any analysis of the reportable event and the process for prevention of future events.

On or about the date of May 1, 2024, patient #1 picked up what he thought was his prescription medication. Patient #1 noticed this was the incorrect medication prior to ingesting it and returned it to the pharmacy on May 6, 2024. Despite the owner and staff pharmacist learning that patient #1 received the wrong medication, he did not submit a CQI entry. The owner and staff pharmacist also did not alert the pharmacist in charge ("PIC") of his error. Respondent's owner and staff pharmacist knew that patient #1's prescription was likely in a different patient's medication bag ("Patient #2") and that this error would cause Patient #2 to receive the incorrect medication, but he could not locate patient #2's prescription bag.

On or about the date of May 26, 2024, patient #2 picked up what she believed to be her prescription. She took the medication as instructed on the prescription bottle and by May 29, 2024, experienced an adverse reaction after ingesting the medication. The patient #2 then realized she had received a prescription which should have been dispensed to patient #1. Patient #2 ultimately required an emergency room treatment.

On April 30, 2024, the PIC was the pharmacist who checked the prescriptions for patients #1 and #2 before they were placed in medication bags by a pharmacy technician trainee. Patient #1's medication was placed in a bag labeled with patient #2's receipt and vice versa. Additionally, at this time, the PIC failed to write an "N" on the receipt as is the normal process utilized by this pharmacy for new prescriptions. Respondent's owner was the staff pharmacist who dispensed the prescription to patient #2 on May 26, 2024. A CQI entry was submitted on May 30, 2024, detailing the mix-up of prescriptions between patient #1 and #2.

On or about the date of August 15, 2024, patient #3 received two prescriptions from Respondent, both of which were verified by the PIC. One prescription was misfilled. At 6:00 p.m. that evening, patient took both medications as prescribed. Immediately, patient #3 began to experience adverse symptoms. Subsequent investigation revealed one prescription dispensed to patient #3 was incorrect.

E. SETTLEMENT

23. This matter may be resolved by settlement agreement. The procedural rules governing the Board's settlement process are found at 657 Iowa Administrative Code 35.24. If you are interested in pursuing settlement of this matter, please contact the Assistant Attorney General identified above.

F. PROBABLE CAUSE FINDING

24. On November 14, 2024, the Iowa Board of Pharmacy found probable cause to file this Notice of Hearing and Statement of Charges and Emergency Adjudicative Order.

G. CONCLUSIONS OF LAW

25. Iowa Code § 155A.12 states in pertinent part,

The Board may . . . suspend a license . . . if the board finds that the applicant or licensee has done any of the following: 1) violated any provision of this chapter or any rules of the board adopted under this chapter, and 3) violated any of the provisions for licensee discipline set forth in section 147.55.

26. Additionally, pursuant to statute, the Board may take emergency action “as is necessary to prevent or avoid the immediate danger to the public health, safety, or welfare...”. Iowa Code § 17A.18A(2).

H. ORDER

IT IS THEREFORE ORDERED:

A. The Board finds:

- a. Respondent has repeatedly dispensed incorrect prescriptions, including but not limited to the incidents in October 2023, May 2024, and August 2024;
- b. Respondent has failed to improve their dispensing protocol to ensure prevention of medication errors as directed by its probationary order of March 2024;
- c. Respondent's submitted CQI documentation did not include the required elements outlined in the administrative rule 8.26 of the Board; and
- d. Respondent has failed to comply with the previous Board order in case no. 2023-0159.

B. For the foregoing reasons, the Board finds the Respondent is an immediate danger to the public health, safety and welfare.

C. Accordingly, Respondent's Iowa Pharmacy license shall be INDEFINITELY SUSPENDED five (5) days after the date of service of this Order: November 22, 2024,

D. Respondent shall have thirty (30) days to transfer all patient records in compliance with the Board's rules.



Kathryn Stone, Chairperson
Iowa Board of Pharmacy

Copy to:
Lindsey L. Browning
Katrina Phillip
Assistant Attorneys General
Office of the Iowa Attorney General
1305 E. Walnut Street, Ste. 100
Des Moines, Iowa 50319

Lindsey.browning@ag.iowa.gov
Katrina.phillip@ag.iowa.gov

PLEASE NOTE: If you require the assistance of auxiliary aids or services to participate in this matter because of a disability, immediately call 515-281-0233. (If you are hearing impaired, call Relay Iowa TTY at 1-800-735-2942).