

**BEFORE THE BOARD OF PHARMACY EXAMINERS  
OF THE STATE OF IOWA**

Re:	)	Case No. 2004-13
Pharmacist License of	)	
<b>JOAN L. FARLEY,</b>	)	<b>STATEMENT OF CHARGES</b>
License No. 15645,	)	
Respondent.	)	

**COMES NOW**, the Complainant, Lloyd K. Jessen, and states:

1. He is the Executive Secretary/Director for the Iowa Board of Pharmacy Examiners (hereinafter referred to as the "Board") and files this Statement of Charges solely in his official capacity.
2. The Board has jurisdiction in this matter pursuant to Iowa Code Chapters 155A and 272C (2003).
3. On February 20, 1980, the Board issued Respondent, Joan L. Farley, by examination, a license to engage in the practice of pharmacy as evidenced by license number 15645, subject to the laws of the State of Iowa and the rules of the Board.
4. Respondent's pharmacist license is current and active until June 30, 2005.
5. Respondent's current address is 711 Hearthside Drive, Cedar Falls, Iowa 50613.
6. Respondent was employed, at all times material to this statement of charges, as the pharmacist at Hy-Vee Pharmacy 4, 4000 University Avenue, Waterloo, Iowa 50701.

**A. CHARGES**

**COUNT I – LACK OF PROFESSIONAL COMPETENCY**

Respondent is charged under Iowa Code § 155A.12(1) (2003) and 657 Iowa Administrative Code § 36.1(4) with a lack of professional competency, as demonstrated by willful departure from, and a failure to conform to, the minimal standard and acceptable and prevailing practice of pharmacy in the state of Iowa, specifically the commission of a dispensing error followed by an attempt to cover up the error.

## COUNT II – MAKING DECEPTIVE AND UNETHICAL REPRESENTATIONS

Respondent is charged under Iowa Code §§ 155A.12(1) and 155A.12(2) (2003) and 657 Iowa Administrative Code 8.11(1) and 36.1(4)(c) with making misleading, deceptive and unethical and untrue representations in the practice of pharmacy, specifically representing to a customer that a medication – which had been incorrectly dispensed – was the subject of a recall, thereby failing to disclose to the customer that three doses of the wrong medication had been ingested.

### B. CIRCUMSTANCES

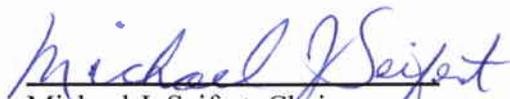
On or about February 18, 2004, an investigation was commenced which revealed the following:

1. Respondent mis-filled a prescription for Acyclovir with Acebutolol. The customer took three doses of Acebutolol, a medication to regulate blood pressure. The customer was also taking another medication for regulation of blood pressure.
2. After discovering the dispensing error, Respondent called the home of the customer and stated that the manufacturer of Acebutolol had recalled the medication which had been dispensed. Respondent left a phone message asking the customer to return the remaining medication to the pharmacy, to be exchanged.
3. When the customer's daughter returned to the pharmacy to exchange the medication, she inquired about medication recalls and was told by Respondent that the Acebutolol was the subject of a recall that required immediate return of the medication. The customer's daughter received a new prescription fill, consisting of Acyclovir.
4. Subsequently, the customer's daughter compared the information provided with each of the prescription fills and noticed that the medications were different. The customer's daughter believes Respondent attempted to cover up the dispensing error, rather than informing the customer of the error and giving the customer an opportunity to consult a physician as to whether ingestion of the incorrect medication posed a health risk.
5. Respondent admits that no recall of Acebutolol occurred.

WHEREFORE, the Complainant prays that a hearing be held in this matter and that the Board take such action as it may deem to be appropriate under the law.

  
Lloyd K. Jessen  
Executive Secretary/Director

On this 7 day of October 2004, the Iowa Board of Pharmacy Examiners found probable cause to file this Statement of Charges and to order a hearing in this case.

  
Michael J. Seifert, Chairperson  
Iowa Board of Pharmacy Examiners  
400 SW Eighth Street, Suite E  
Des Moines, Iowa 50309-4688

cc: Scott M. Galenbeck  
Assistant Attorney General  
Hoover State Office Building  
Des Moines, Iowa

Farley, Joan-SOC.doc

BEFORE THE BOARD OF PHARMACY EXAMINERS  
OF THE STATE OF IOWA

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Re:	)	DIA NO: 04PHB017
	)	CASE NO: 2004-13
Pharmacist License of	)	
<b>Joan L. Farley,</b>	)	
License No. 15645,	)	<b>FINDINGS of FACT,</b>
	)	<b>CONCLUSIONS of LAW,</b>
Respondent.	)	<b>and ORDER</b>

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On October 7, 2004, the Iowa Board of Pharmacy Examiners (the Board) filed a statement of charges filed against Joan L. Farley (Respondent), a licensed pharmacist. The Board charged Respondent with two violations: 1) committing a medication dispensing error, and 2) attempting to cover up the error by making deceptive representations.

The case was set for hearing on March 7, 2006. The following Board members were present for the hearing: Katherine Linder, Vernon Benjamin, Michael Seifert, Leman Olson, Paul Abramowitz, and Kathleen Halloran. Jeffrey Farrell, an administrative law judge from the Iowa Department of Inspections and Appeals, assisted the Board. Scott Galenbeck, an assistant attorney general, represented the public interest. Attorney Thomas Crabb represented Respondent.

**THE RECORD**

The state's exhibits A and C-E were admitted.<sup>1</sup> Jackie Devine and Dennis Dobesh testified on the state's behalf. Respondent testified on her own behalf. Robert Goodloe also testified.

**FINDINGS OF FACT**

On February 7, 2004, Respondent was working in her capacity as a staff pharmacist at Hy-Vee Pharmacy 4 in Waterloo, Iowa. Marilyn Heald was a new customer at the pharmacy. Respondent filled several prescriptions for Ms. Heald that day. Most of the prescriptions consisted of transfers from another pharmacy. The prescription in question was the only new prescription presented.

The new prescription was for 800 mg of acyclovir. (Exhibit E.) Respondent stated that she checked her inventory by computer. The computer database reported that the pharmacy did not have 800 mg in stock, but it did have 400 mg tablets. Respondent stated that she supplied 400 mg tablets with an instruction to take two 400 mg tablets,

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<sup>1</sup> This case was consolidated with another case with common facts. Exhibit B is only relevant to the other case.

as otherwise directed by the prescription. Respondent testified that she confirmed the instructions when she talked to Ms. Heald's daughter, who picked up the medication. Respondent testified that this was the last prescription she filled on February 7. (Respondent testimony.)

Respondent testified that she is certain she dispensed the correct drug. However, the label on the bottle stated that the bottle contained 400 mg of acebutolol. (Respondent testimony; Exhibits C, E.)

Respondent testified that she arrived at work on February 8, 2004, to find a fax from a drug manufacturer concerning a recall on acyclovir. She testified that she recalled filling the prescription for Ms. Heald the day before, so she called Ms. Heald to ask her to return the medication to the pharmacy so it could be exchanged. Ms. Heald's daughter returned the drugs. The new label identified the drug as acyclovir. (Respondent testimony.)

Respondent testified that she packaged the returned drugs and sent them to the address designated on the fax. She said she sent the fax with the drugs. She stated she did not make a copy of the fax. (Respondent testimony.)

Ms. Heald's daughter had some concern after taking the prescription home. She noticed that the bottle listed a different drug name than the first label. The medication also looked different in shape and color. She filed complaints with Hy-Vee and the Board. (Exhibit C.)

Hy-Vee conducted an internal investigation. The investigation was done, in part, by Robert Goodloe. Mr. Goodloe was the supervising pharmacist at Hy-Vee. Mr. Goodloe is also Respondent's husband. (Exhibit C.)

The Board assigned Jackie Devine to initially conduct its investigation. The investigation was later handed off to Dennis Dobesh to accommodate Ms. Devine's approaching retirement. (Exhibits C, D.)

Respondent's drug recall story is not corroborated by any evidence uncovered by the Board or Hy-Vee. There is no copy of the fax that Respondent allegedly received. There is no evidence in Hy-Vee's records that it received a recall notice. Hy-Vee contacted the manufacturer and found no evidence of a recall. There are no documents to show that Respondent sent the drugs back to the manufacturer. There is no evidence that the manufacturer sent a refund to the pharmacy. (Exhibits C, D.)

Respondent's account is refuted by other evidence established in the investigations. Ms. Heald's daughter stated that the first drug was a dark, two-toned capsule, whereas the second drug was a white, six-sided tablet. Hy-Vee employees reported that a 400 mg dosage of acebutolol is a lavender and orange capsule. A 400 mg dosage of acyclovir is a white 5-sided tablet. The description strongly suggests that Ms. Heald was supplied with the wrong drug. (Exhibits C, D.)

Mr. Goodloe checked the inventory of each drug after he learned about the complaint. He stated that the pharmacy had acyclovir in 800 mg dosages, which led him to question why Respondent would sell the drug in 400 mg dosages.<sup>2</sup> Their pharmacy did not have 400 mg dosages of acebutolol, even though records showed the pharmacy should have had 83 capsules on the shelf. Ms. Heald received 70 capsules in the first bottle she received from Respondent. Mr. Goodloe could not otherwise account for the missing acebutolol. (Exhibit C.)

### **CONCLUSIONS OF LAW**

**Regulatory framework:** The Board was created for the express purpose to promote, preserve and protect the public health, safety, and welfare through the effective regulation of the practice of pharmacy.<sup>3</sup> The Board regulates the practice, in part, through the licensing of pharmacies, pharmacists, and others engaged in the sale, delivery, or distribution of prescription drugs and devices.

The Board has the authority to grant licenses to pharmacists, adopt regulations creating standards for licensure, and to enforce compliance with those standards.<sup>4</sup> The Board may impose discipline against the license holder, including revoking or suspending a license, putting a licensee on probation, imposing a civil penalty up to \$25,000, issuing a citation and warning, and requiring professional education.<sup>5</sup>

**Statement of charges:** The two counts are related and will be considered together. The state claims in count I that Respondent violated the ordinary standard of learning and skill possessed and applied by a pharmacist in Iowa when she dispensed acebutolol to Ms. Heald instead of acyclovir.<sup>6</sup> The state claims in counts I and II that Respondent made misleading and deceptive statements to the customer, her employer, and the Board by creating an untrue recall story to cover up her mistake.<sup>7</sup>

The record established that Respondent committed a dispensing error. Respondent was asked to fill a prescription for acyclovir. The label stated that the bottle contained acebutolol. Ms. Heald's daughter described medication that was consistent with a description for acebutolol, and far from a description for acyclovir. The pharmacy's review of its medication showed that it did not have 400 mg capsules for acebutolol, even though its computer data base stated that the pharmacy should have had 83 capsules. The combination of evidence in the record outweighs Respondent's assertions that she sold the correct drug.

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<sup>2</sup> Respondent testified that the store computer showed no 800 mg dosages available. She did not physically check the pharmacy inventory.

<sup>3</sup> Iowa Code section 155A.2.

<sup>4</sup> Iowa Code section 272C.1(6)(q), 272C.3.

<sup>5</sup> Iowa Code sections 155A.12, 155A.18, 272C.3(2).

<sup>6</sup> 657 IAC 36.1(4)(b).

<sup>7</sup> 657 IAC 36.1(4)(c).

The record also established the more serious violation that Respondent lied to attempt to cover up her dispensing error. There is absolutely no evidence to support her recall claim. Neither Respondent nor the pharmacy located any evidence to show the existence of a recall, that Respondent had mailed the drugs back to the manufacturer, or that the pharmacy had received a refund for the allegedly recalled drugs. Further, no party obtained evidence from the manufacturer that it issued a recall; if a manufacturer issued a recall, it should not be difficult to obtain that evidence. Respondent has no evidence to support her testimony. The Board does not believe Respondent's testimony over the overwhelming evidence against her.

### SANCTION

The Board judges dispensing errors in the context which they occur. The Board does not condone dispensing mistakes. However, a significant penalty may not be required in all cases involving dispensing errors. The Board could consider many factors, including, but not limited to the number of mistakes, the egregiousness of an error, whether a patient suffered harm, and whether the pharmacist attempted to remedy any mistake.

There are some factors in Respondent's favor. The dispensing error created a risk of harm to Ms. Heald, but there is no evidence she suffered actual harm. After discovering the error, Respondent did call Ms. Heald rather than let the mistake continue. There are some references to additional dispensing errors in the pharmacy, but there is no detailed evidence in this regard.

The really troubling aspect to this case is that Respondent fabricated a phony recall story to attempt to cover up her mistake. If Respondent had owned up to her mistake, the Board would have considered a minimal sanction based on other mitigating factors. However, Respondent was not truthful to the customer, her employer, or the Board.

Respondent's misrepresentations are disturbing for two reasons. First, Respondent's failure to tell Ms. Heald about the mistake robbed Ms. Heald of the opportunity to talk to her physician about the mistake. Respondent led Ms. Heald to believe that she took the drug that was prescribed; in reality, she had taken a totally different drug. If Ms. Heald had suffered some side effects or harm from the acebutolol, Ms. Heald's physician would have been in a better position to remedy the mistake. Respondent's action disregarded the welfare of her customer.

Second, Respondent's misrepresentation hurts the profession as a whole. There is a strong state interest in assuring the public that the people who dispense prescription drugs are honest and trustworthy. Respondent violated the public trust. The Board is charged with the responsibility of taking disciplinary action to assure the public that such conduct is not tolerated. The Board must take action here to remedy the harm she caused to the integrity of the profession.

conduct is not tolerated. The Board must take action here to remedy the harm she caused to the integrity of the profession.

The Board considered suspending Respondent's license. After considerable discussion, the Board decided to impose a combination of lesser sanctions, with the hope that Respondent will learn from this experience. The Board believes these sanctions will be sufficient to deter similar violations in the future and otherwise protect the public interest.

### **DECISION AND ORDER**

**IT IS THEREFORE ORDERED** that pharmacist license no. 15645, issued to Respondent Joan L. Farley, shall be placed on **PROBATION** for a period of three (3) years from the date of this Order. The Board advises Respondent that any violation of the governing statutes or regulations will be grounds for additional discipline, potentially including revocation of her license.

Respondent shall also pay a civil penalty of \$2,000.00. Respondent shall pay the civil penalty to the Board at the following address: Iowa Board of Pharmacy Examiners, 400 SW 8<sup>th</sup> St., Suite E, Des Moines, Iowa 50309-4688. Respondent shall pay the civil penalty within 30 days from the date of this Order.

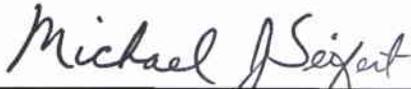
Respondent shall prepare written personal policy and procedures which describe how she will handle follow-up on dispensing errors that have been made and avoid dispensing errors in the future. The policy and procedures shall be thoughtful and detailed. Respondent shall submit the policy and procedures to the Board's executive secretary within 60 days from the date of this Order. The Board authorizes the executive secretary to direct Respondent to revise or make additions to the policy and procedures. Once approved by the executive secretary, Respondent shall comply with all terms of her policy and procedures.

Respondent shall take eight (8) additional hours of continuing education in the area of quality improvement or ethics. Respondent must obtain preapproval from the executive secretary/director before credit is given for this requirement. This requirement is in addition to the 30 hours of continuing education required each year renewal period. Respondent shall complete and submit a report detailing her compliance with this requirement by December 31, 2006.

Respondent shall file written, sworn quarterly reports with the Board attesting to her compliance with all the terms and conditions of the order. The reports shall be filed not later than March 5, June 5, September 5, and December 5 of each year of the Respondent's probation. The quarterly reports shall include the Respondent's place of employment, current home address, home telephone number or work telephone number, and any further information deemed necessary by the Board from time to time.

Violation of any of the provisions of this Order may be the subject of additional disciplinary action.

Dated this 25 day of April, 2006.



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Michael J. Seifert, Chairperson  
Iowa Board of Pharmacy Examiners

cc: Scott Galenbeck, Assistant Attorney General  
Thomas Crabb, Respondent's Attorney

**Notice**

Any aggrieved or adversely affected party may seek judicial review of this decision and Order of the Board, pursuant to Iowa Code section 17A.19.

**BEFORE THE BOARD OF PHARMACY STATE OF IOWA**

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**IN THE MATTER OF THE FINDINGS OF FACT, CONCLUSIONS OF LAW,  
AND ORDER AGAINST**

**JOAN L. FARLEY, R.Ph., RESPONDENT**

**2004-13**

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**TERMINATION ORDER**

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**DATE: June 5, 2009**

1. On April 25, 2006, a Findings of Fact, Conclusions of Law, and Order was issued by the Iowa Board of Pharmacy placing the license to practice pharmacy, number 15645 issued to Joan L. Farley on February 20, 1980, on probation for a period of three years under certain terms and conditions.

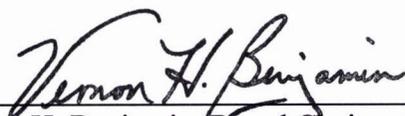
2. Respondent successfully completed the probation on April 25, 2009, as directed.

3. The Board directed that the probation placed upon the Respondent's license to practice pharmacy should be terminated.

**IT IS HEREBY ORDERED:**

That the probation placed upon the Respondent's license to practice pharmacy is terminated, and the license is returned to its full privileges free and clear of all restrictions.

**IOWA BOARD OF PHARAMCY**



Vernon H. Benjamin, Board Chairperson  
400 SW 8<sup>th</sup> Street, Suite E  
Des Moines, Iowa 50309-4688