WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

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STATE OF WISCONSIN
BEFORE THE PHARMACY EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
KATHLEEN M. LIND, R.PH., RESPONDENT.	:	ORDER 0001006

[Division of Enforcement Case # 10 PHM 015]

The parties to this action for the purposes of Wis. Stats. § 227.53 are:

Kathleen M. Lind, R.Ph.
N217 Barberry Lane
Appleton, WI 54915

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Wisconsin Pharmacy Examining Board
Department of Regulation and Licensing
1400 East Washington Avenue
Division of Enforcement
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Board. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Kathleen M. Lind, R.Ph. ("Respondent") was born on August 12, 1963 and is licensed to practice as a registered pharmacist in the State of Wisconsin, under license number 10968-40. This license was granted on June 9, 1987.

2. Respondent's most recent address on file with the Wisconsin Pharmacy Examining Board is N217 Barberry Lane, Appleton, Wisconsin 54915.

3. Patient "J.Z." had been taking the medication Cardizem for some time, but she could not take the generic form of Cardizem, which is Diltiazem. When J.Z. took Diltiazem, it caused her to suffer tachycardia, shortness of breath, dizziness and lightheadedness.

4. On January 2, 2010, J.Z. picked up her prescription for Cardizem from Respondent. Respondent informed J.Z. that the pills were going to look different because they had changed suppliers, but it was the same medication. J.Z. and her husband asked the Respondent numerous times if Respondent was sure that the medication was Cardizem. Respondent told J.Z. numerous times that it was the same medication. J.Z. called the pharmacy prior to taking the medication to verify one more time that it was the correct prescription and was assured over the phone it was the correct prescription.

5. On Monday, January 4, 2010, J.Z. started taking the medication, and by Tuesday, January 5, was already having small episodes that included shortness of breath, exhaustion, and dizziness. By Friday, January 8, J.Z. had a severe episode at a basketball game and was unable to leave without the help of her family.

6. J.Z. continued to take her prescribed medicine daily, and continued to experience shortness of breath, exhaustion, and dizziness. After a month of experiencing these symptoms, she went back to the pharmacy and inquired once again if the right medication had been dispensed to her. After speaking with a different pharmacist, it was discovered that J.Z. had been taking the generic form of the drug, Diltiazem instead of the brand name drug Cardizem. The pharmacy's patient records clearly state that J.Z. has problems with taking Diltiazem and should only receive Cardizem.

7. When Respondent dispensed the medication to J.Z., both the name Cardizem and the National Drug Code ("NDC") number for Cardizem were on the receipt. The NDC number for Cardizem had been crossed off the receipt, and the NDC number for Diltiazem was written above it. The bottle was labeled Cardizem, instead of what was actually in the bottle; Diltiazem. Although Cardizem and Diltiazem are considered to be equivalent medications, they are not the same product.

CONCLUSIONS OF LAW

1. The Wisconsin Pharmacy Examining Board has jurisdiction over this matter and authority to take disciplinary action against the Respondent pursuant to Wis. Stat. § 450.10(1).

2. The Wisconsin Pharmacy Examining Board is authorized to enter into the attached Stipulation pursuant to Wis. Stat. § 227.44(5).

3. Respondent's conduct of dispensing the generic version of a medication to a patient that was known to have adverse reactions when she took the generic version of the

medication, as described in paragraphs 3 and 7, above, constitutes a violation of Wis. Admin. Code § PHM 10.03(2).

4. Respondent's conduct of mislabeling the prescription medication, as described above in paragraph 3 through 7, above, constitutes a violation of Wis. Admin. Code § PHM 10.03(2).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that:

1. Kathleen M. Lind., (License # 10968-40) is hereby REPRIMANDED.

2. Respondent shall, within ninety (90) days from the date of this Order, pay to the Department of Regulation and Licensing a forfeiture in the amount of ONE THOUSAND DOLLARS ($1,000.00).

3. Respondent shall, within ninety (90) days from the date for this Order, pay COSTS of this proceeding in the amount of FIVE HUNDRED DOLLARS ($500.00). Payment shall be made payable to the Wisconsin Department of Regulation and Licensing, and mailed to:

Department Monitor
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935
Telephone (608) 267-3817
Fax (608) 266-2264

4. Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to timely submit any payment of the forfeiture as set forth above, or fails to pay the costs as ordered, the Respondent's license (# 10968-40) may, in the discretion of the board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with this Order.

5. This Order is effective on the date of its signing.

PHARMACY EXAMINING BOARD

By: _____ 7/27/11
A Member of the Board Date