SETTLEMENT AGREEMENT BETWEEN STATE BOARD OF PHARMACY AND KENNETH V. APPLEGATE

Come now Kenneth V. Applegate ("Licensee" or "Respondent") and the Missouri Board of Pharmacy ("Board" or "Petitioner") and enter into this Settlement Agreement for the purpose of resolving the question of whether Licensee's license as a pharmacist will be subject to discipline.

Pursuant to the terms of Section 536.060, RSMo, the parties hereto waive the right to a hearing by the Administrative Hearing Commission of the State of Missouri ("AHC") regarding cause to discipline the Licensee's license, and, additionally, the right to a disciplinary hearing before the Board under Section 621.110, RSMo.

Licensee acknowledges that he understands the various rights and privileges afforded him by law, including the right to a hearing of the charges against him; the right to appear and be represented by legal counsel; the right to have all charges against him proven upon the record by competent and substantial evidence; the right to cross-examine any witnesses appearing at the hearing against him; the right to a decision upon the record by a fair and impartial administrative hearing commissioner concerning the charges pending against him and, subsequently, the right to a disciplinary hearing before the Board at which time it may present evidence in mitigation of discipline; and the right to recover attorney's fees incurred in defending this action against his license. Being aware of these rights provided him by operation of law, Licensee knowingly and voluntarily waives each and every one of these rights and freely enters into this Settlement Agreement and agrees to abide by the terms of this document, as they pertain to him.

Licensee acknowledges that he has received a copy of the draft complaint, the investigative report, and other documents relied upon by the Board in determining there was cause to discipline his license.

For the purpose of settling this dispute, Licensee stipulates that the factual allegations contained in this Settlement Agreement are true and stipulates with the Board that Licensee's license, numbered 040253, is subject to disciplinary action by the Board in accordance with the provisions of Chapter 621 and Chapter 338, RSMo.

JOINT STIPULATION OF FACTS

1. The Missouri Board of Pharmacy ("the Board"), is an agency of the State of Missouri created and established by Section 338.110, RSMo, for the purpose of administering and enforcing the provisions of Chapter 338, RSMo.

2. Respondent, Kenneth V. Applegate, is licensed by the Missouri Board of Pharmacy as a pharmacist, as defined in Section 338.010 RSMo. Respondent's license, numbered 040253, is current and active and was so at all times material herein.

3. At the time of the events alleged herein, Respondent was a staff pharmacist ("PV1") of Omnicare Pharmacy of the Midwest (hereinafter referred to as "Omnicare" or the "Pharmacy"), 453 E. 111th Street, Kansas City, MO 64131, Permit No. 2006009026.

4. On or about December 2, 2008, the Board received a written Complaint from David R. Rush, B.S., PharmD., BCPS signed on November 28, 2008 which alleged that Respondent was responsible for a dispensing error which caused or contributed to cause the death of a pharmacy patient: S.M.

5. On or about December 24, 2008, Board Inspector Frank Van Fleet was assigned

to investigate the complaint against Respondent.

6. Inspector VanFleet prepared an Investigation Report dated January 30, 2009 which was received by the Board on February 3, 2009.

7. Inspector Van Fleet prepared an Addendum to his original Investigation Report dated February 9, 2009 which was received by the Board on February 17, 2009.

8. Respondent was invited to and attended a fact finding meeting on or about April 30, 2009 wherein he responded to the Board's inquiries regarding a dispensing error occurring on or about May 2, 2006.

9. The Board met to review investigative information and allegations concerning the acts and conduct of Respondent set forth in Inspector Van Fleet's Investigation Report dated January 30, 2009 and his Addendum report dated February 9, 2009 and Respondent's admissions made at the April 30, 2009 fact finding meeting.

10. Based upon its review of investigative information and allegations concerning the acts and conduct of Respondent and, pursuant to Section 338.055.3, RSMo, (2000), the Board concluded that Respondent engaged in conduct which would be grounds for disciplinary action by the Board.

Fatal Dispensing Error

11. In late April and early May of 2006, patient S.M. was hospitalized at St. Luke's South Hospital, 12300 Metcalf, Overland Park, Kansas 66213.

12. During her hospitalization, S.M. was prescribed Methotrexate at a dose of 7.5mg (3 tablets) on Thursday morning, once a week.

13. Methotrexate is a folic acid antagonist used in the treatment of many medical

conditions including, but not limited to rheumatoid arthritis, psoriasis, and ectopic pregnancy. The drug has also been used in treating several forms of cancer.

14. Patient S.M. was discharged from St. Luke's South Hospital on or about May 2, 2006 with prescription orders from her treating physician to take three (3) Methotrexate 2.5mg tablets every Thursday morning, ie, once a week.

15. In conjunction with S.M.'s hospital discharge, a "Discharge Disposition" sheet was drafted by a social worker which incorrectly transcribed S.M.'s prescription orders for Methotrexate.

16. The "Discharge Disposition" dated May 2, 2006, directs that S.M. receive a prescription for Methotrexate 2.5mg as follows: 3 tablets (7.5mg) daily.

17. After leaving the hospital, S.M. was transferred to a skilled nursing facility known as "The Greens at Creekside" in Kansas City, Missouri.

18. A physician at the nursing home signed prescription orders in S.M.'s chart authorizing a prescription to be filled for three (3) Methotrexate 2.5mg tablets taken once daily.

19. On or about May 2, 2006, Omnicare (the "Pharmacy") received S.M.'s prescription for Methotrexate 2.5mg by fax from the nursing home.

20. Respondent Kenneth V. Applegate, R.Ph. was a staff pharmacist or "PV1 pharmacist" at Omnicare at the time S.M.'s prescription for Methotrexate was received on May 2, 2006.

21. At Omnicare, the "PV1 pharmacist" is responsible for verifying the prescription order entered into the Pharmacy's computer and verifying the hard copy of the prescription order.

22. On or about May 2, 2006, Respondent filled and dispensed a prescription for Methotrexate 2.5mg with instructions for S.M. to take 3 tablets "daily". (Prescription number 9349426).

23. It is well known by trained and competent pharmacists that Methotrexate 2.5mg should never be given in daily doses and that the common and proper dosage of Methotrexate 2.5mg is once a week as either a single dose or in divided does given over a restricted period.

24. It is further well known and recognized by trained and competent pharmacists that an overdose of Methotrexate may result in a health condition known as "pancytopenia" and potentially, patient death by sepsis.

25. Patient S.M. ingested three (3) tablets of Methotrexate 2.5mg daily for nine (9) days.

26. On or about May 19, 2006, patient S.M. died of coronary vascular disease with an underlying complication of "severe" pancytopenia and sepsis.

Respondent's Interview with Inspector VanFleet

27. On or about January 21,2009, Board Inspector Van Fleet interviewed Respondent Kenneth V. Applegate who admitted:

A. That Respondent was the responsible pharmacist for the dispensing error.

B. That Respondent completely overlooked the dosage and quantity of Methotrexate written for patient S.M. prior to filling prescription no. 9349426.

C. That Respondent knows that Methotrexate is typically written for either a weekly dose or a dosage of every twelve (12) hours for three (3) doses.

D. That there was "no excuse" for failing to question prescription no.

9349426's dosage instructions at the time the prescription was filled and dispensed to patient S.M.

Written Response from Respondent

28. On or about January 28, 2009, Respondent submitted a written explanation of his dispensing error which was received by Board Inspector Frank VanFleet on January 28, 2009.

29. In his January 28, 2009 letter, Respondent admits that he, "mistakenly allowed an order of methotrexate, written daily, pass my work station without intervention."

30. In his January 28, 2009 letter, Respondent admits that he "knew then, as I know now, that methotrexate for these patients is almost always to be dosed weekly and not daily."

31. In his January 28, 2009 letter, Respondent acknowledges, "How this horrible med error got by everybody involved, I do not know. I do know, however, that my involvement in this terrible accident has made me much more diligent in making sure that another accident like this won't happen again".

Fact Finding Meeting

32. On or about April 30, 2009, Respondent was invited to attend a fact finding meeting before the Board to discuss the dispensing error involving patient S.M. from May 2, 2006.

33. Respondent attended the April 30, 2009 meeting, and made the following admissions to the Board:

A. Respondent was responsible for verifying prescription no. 9349426 for patient S.M.;

B. Pharmacists at Omnicare were instructed to read the prescription and the medication label for dosage instructions;

C. Respondent knew then, as he knows now, that the written prescription for patient S.M. was incorrect, as written, and that he should have questioned it;

D. The dosage instructions for prescription no. 9349426 should have been noticeable on the label; and that

E. Respondent should have intervened upon noting the dosage instructions on the hard copy of prescription no. 9349426.

Incompetence, Misconduct, Gross Negligence, Violation of Professional Trust

34. A trained and competent pharmacist exercising due care and diligence would have recognized that prescription no. 9349426 which called for the dispensing and ingesting of three (3) Methotrexate 2.5mg tablets (ie, 7.5 mg) on a daily basis was in error.

35. A trained and competent pharmacist exercising due care and diligence would have recognized that prescription no. 9349426 as written, as filled, and as dispensed to patient S.M. would have harmful and potentially fatal consequences to the patient.

36. Respondent's failure to question a written prescription order for Methotrexate 2.5mg to be dispensed with dosage instructions for three (3) tablets (ie, 7.5mg) daily, is a serious error which demonstrates incompetence, misconduct, and gross negligence in the performance of the functions and duties of a professional pharmacist licensed by the Board in the State of Missouri.

37. Respondent's actual dispensing of a written prescription order for Methotrexate 2.5mg with dosage instructions for the patient to ingest three (3) tablets (ie, 7.5mg) daily, is as serious error which demonstrates incompetence, misconduct, and gross negligence in the performance of the functions and duties of a professional pharmacist licensed by the Board in the State of Missouri.

38. Pharmacy patients, including patient S.M. (deceased), enjoy a relationship of professional trust and confidence with pharmacists, such as Respondent, who are licensed by the State of Missouri.

39. If licensed by the State of Missouri, Pharmacy patients expect that a pharmacist will possesses sufficient training, competence and abilities to question written prescription orders which appear to be issued in error.

40. Patient S.M. had a right to expect that Respondent possessed sufficient training, competence and abilities to question a written prescription order which appeared to be in error and refrain from dispensing same until the prescription could be otherwise verified and/or corrected.

41. Respondent's actions in failing to identify a dosing error present in S.M.'s written prescription and Respondent's failure to intervene and refrain from filling prescription no. 9349426 pending further investigation or verification with S.M's treating physician is a violation of the professional trust and confident placed in him by pharmacy patients, including but not limited to patient S.M. (deceased).

JOINT CONCLUSIONS OF LAW

42. Cause exists for Petitioner to take disciplinary action against Respondent's license under Section 338.055 RSMo (Supp. 2002), which states in pertinent parts:

> 2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit or license required by this chapter or any person who has failed to renew or has surrendered his certificate of

registration or authority, permit or license for any one or any combination of the following causes:

* * *

(5) Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by this chapter.

* * *

(13) Violation of any professional trust or confidence.

JOINT AGREED DISCIPLINARY ORDER

Based upon the foregoing, the parties mutually agree and stipulate that the following shall constitute the disciplinary order entered by the Board in this matter under the authority of Section 621.045.3, RSMo (2000):

1. Respondent's pharmacist license, License No. 040253, is hereby PUBLICLY CENSURED.

2. The terms of this Settlement Agreement are contractual, legally enforceable, binding, and not merely recitals. Except as otherwise contained herein, neither this Settlement Agreement nor any of its provisions may be changed, waived, discharged, or terminated, except by an instrument in writing signed by the party against whom the enforcement of the change, waiver, discharge, or termination is sought.

3. Respondent, together with his heirs and assigns, and his attorneys, does hereby waive and release the Board, its members and any of its employees, agents, or attorneys, including any former board members, employees, agents, and attorneys, of, or from, any liability,

claim, actions, causes of action, fees, costs and expenses, and compensation, including, but not limited to, any claims for attorney's fees and expenses, including any claims pursuant to Section 536.087, RSMo, or any claim arising under 42 U.S.C. Section 1983, which may be based upon, arise out of, or relate to any of the matters raised in this litigation, or from the negotiation or execution of this Settlement Agreement. The parties acknowledge that this paragraph is severable from the remaining portions of this Settlement Agreement in that it survives in perpetuity even in the event that any court of law deems this Settlement Agreement or any portion thereof void or unenforceable.

RESPONDENT, AS EVIDENCED BY THE INITIALS ON THE APPROPRIATE LINE,

_____ REQUESTS

_____ DOES NOT REQUEST

THE ADMINISTRATIVE HEARING COMMISSION TO DETERMINE IF THE FACTS SET FORTH HEREIN ARE GROUNDS FOR DISCIPLINING RESPONDENT'S LICENSE.

If Respondent has requested review, Respondent and Board jointly request that the Administrative Hearing Commission determine whether the facts set forth herein are grounds for disciplining Respondent's license and issue findings of fact and conclusions of law stating that the facts agreed to by the parties are grounds for disciplining Respondent's license. Effective fifteen (15) days from the date the Administrative Hearing Commission determines that the Settlement Agreement sets forth cause for disciplining Respondent's license, the agreed upon discipline set forth herein shall go into effect.

If Respondent has not requested review by the Administrative Hearing Commission, the Settlement agreement goes into effect fifteen (15) days after the document is signed by the Board's Executive Director.

RESPONDENT

Kenneth V. Applegate
KENNETH V. APPLEGATE

Date: 09/29/2009

PETITIONER

MISSOURI BOARD OF PHARMACY

By: Kimberly Grinston
KIMBLERY GRINSTON
Executive Director

Date: 10/8/09

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