SETTLEMENT AGREEMENT BETWEEN MISSOURI DENTAL BOARD
AND TALVA G. JOOST, D.M.D.

Come now Tava G. Joost, D.M.D. ("Licensee") and the Missouri Dental Board ("Board") and enter into
this settlement agreement for the purpose of resolving the question of whether Licensee's license as a dentist
will be subject to discipline.

Pursuant to the terms of § 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 § 621.113,
RSMo.

Licensee acknowledges that she understands the various rights and privileges afforded her by law,
including the right to a hearing of the charges against her; the right to appear and be represented by legal
counsel; the right to have all charges against her proven upon the record by a preponderance of the evidence;
the right to cross-examine any witnesses appearing at the hearing against her; the right to present evidence on
her own behalf at the hearing; the right to a decision upon the record by a fair and impartial administrative
hearing commissioner concerning the charges pending against her and, subsequently, the right to a disciplinary
hearing before the Board at which time she may present evidence in mitigation of discipline; and the right to
recover attorney's fees incurred in defending this action against her license. Being aware of these rights
provided her 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 her.

Licensee acknowledges that she has received a copy of the investigative report and/or other documents
relied upon by the Board in determining there was cause to discipline her license, along with citations to law
and/or regulations the Board believes was violated.

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 014579 is
subject to disciplinary action by the Board in accordance with the provisions of Chapters 621 and 332, RSMo.

1 All statutory references are to Missouri Revised Statutes 2000, as amended, unless otherwise indicated.
Joint Stipulation of Fact and Conclusions of Law

1. The Missouri Dental Board ("Board") is an agency of the State of Missouri created and established pursuant to § 332.021, RSMo, for the purpose of executing and enforcing the provisions of Chapter 332.

2. Licensee Talva G. Joost, D.M.D. is licensed by the Board as a dentist, License No. 014579. Licensee's Missouri license is and was at all times relevant herein, current and active.

3. On or about January 30, 2017, the Board received a complaint against Licensee from H.R. H.R. stated that she was "sedated to the point of being non-coherent." H.R. stated that she had an appointment with Licensee to get "six or seven" cavities filled and Licensee prescribed her two different kinds of pills - "one to calm her down and the other to make her drowsy." H.R. stated in her complaint that there were three "drowsy pills." H.R. stated that her mother asked the opinion of the pharmacist when they picked up the prescriptions. The pharmacist recommended that H.R. take only one pill "due to her size." H.R. stated that she took a "drowsy pill" before they left home for the appointment. She stated she remembered leaving the house and walking [in]to the dental office." H.R. stated that she "thought the assistant put a gas mask on her and told her to take deep breaths." H.R. stated she was "knocked out completely" and remembers throwing up in a trashcan. She stated she "felt the dentist digging into her left side and started moaning." She stated the dentist asked if she needed to use the restroom and she "moaned yes so the dentist would stop." She stated the assistant helped her to the restroom and on and off the toilet. She stated that since the procedure, she has "had a lot of pain and sensitivity in her teeth."

4. As part of H.R.'s complaint, H.R.'s mother, M.R., who accompanied her to the appointment and to the pharmacy, also submitted a written statement. M.R. stated that she made the appointment for H.R.'s extractions and asked Licensee to "give her daughter something because she was nervous." M.R. stated that Licensee started "mocking her daughter for being scared." M.R. stated that Licensee gave them a prescription for 3 tablets of .25 mg Triazolam and 1 10 mg tablet of Diazepam. M.R. stated the triazolam bottle's instructions said to take all three pills. M.R. stated they just gave H.R. one pill as a result of the pharmacist's recommendation to just give one and more if needed. M.R. stated that when they arrived and H.R. was seated in the chair, M.R. told Licensee they had only given H.R. one tablet and Licensee became "beyond livid" and
“started screaming at her.” M.R. stated Licensee “was going off big time” and “screaming like a crazy person.”
M.R. stated that Licensee “ordered her assistant to get the pills and crush one and put it under [H.R.’s] tongue.”
M.R. stated that Licensee later came and apologized and said she was “an aggressive person” and that was “just the way she is.” M.R. stated that after about three hours, “a lady brought [H.R.] out in a wheelchair and told M.R. they had taken her to the restroom during the procedure. M.R. stated that at the time of the complaint, over a month after the incident, H.R. still “had tooth pain and sensitivity” and that when M.R. asked Licensee for H.R.’s records, Licensee would only provide H.R.’s x-rays.

5. As a result of H.R.’s complaint and the accompanying documents discussed above, the Board initiated an investigation of Licensee. As part of the Board’s investigation, Board Investigator Joshua Fisher conducted a check of the Division of Professional Registration licensure system to verify that Licensee had a current and valid sedation permit. Licensee had an Enteral Moderate Sedation Permit which expired June 1, 2016.

6. As part of the Board’s investigation, Investigator Fisher also conducted an audit of local pharmacies for Licensee’s prescribing history and to identify prescriptions Licensee commonly used for sedation purposes. Investigator Fisher identified five patients for whom Licensee prescribed three tablets of .25 mg triazolam including H.R.

7. Investigator Fisher’s audit of the Walgreens pharmacy revealed that Licensee prescribed patient C.L. a total of 390 tablets of Diazepam 10 mg and 60 tablets of Oxycodone/Acetaminophen 10-325 mg over the course of one year. The records also showed that C.L. filled a prescription for 30 10 mg tablets of Diazepam in February, March and April, 2016. Licensee appeared to have written the March and April prescriptions on March 25, 2016. C.L. filled a prescription from Licensee for 60 10-325 tablets of Oxycodone/Acetaminophen in June 2016. Licensee wrote C.L. a prescription for 60 10 mg tablets of Diazepam which Licensee filled in July, October, November and December, 2016 and January 2017. This prescription yielded a total of 300 10 mg tablets.

8. As part of the Board’s investigation, Investigator Fisher visited Licensee at her office. Licensee stated that the complaint “sounds a lot more dramatic than it actually was.” She stated that she did not yell at H.R.’s mother, M.R. and if M.R. thought that she was yelling “she has never had an ass chewing.” She stated she does not sedate patients, including H.R., she “treats anxiolysis.” She stated that H.R. came in for seven
fillings, was nervous about the procedure and “didn’t want to remember anything.” Licensee stated she prescribed H.R. one 10 mg valium to take the night before and three .25 mg triazolam to take before the procedure. Licensee stated H.R. showed up having taken only one triazolam. Licensee stated she may have “been firm” with M.R. telling her why she prescribed what she did but did not yell at them. Licensee stated that “even if she did yell they had the right to walk out the door anytime.” Licensee stated she “had [H.R.] take another triazolam before the procedure and gave her nitrous oxide because "the triazolam was wearing off and it made the patient sick." Licensee stated it is standard operating procedure for staff to take a patient to the restroom if needed because they are “her responsibility” and her staff is “trained to handle emergencies.” She stated it is also standard to take the patient out in a wheelchair. Licensee stated that neither H.R. nor her parents complained. Investigator Fisher asked Licensee if she still had a sedation permit and she stated that she did not and “did not need one to treat anxiolysis.” Licensee stated “she decided not to renew her permit when the sedation rules changed.” She stated she could give 1.5 times the maximum recommended dose because “she was monitoring them.” When Investigator Fisher informed her she could not give 1.5 times the recommended dose without a sedation permit, she stated she thought she could because she was monitoring the patients.

9. During the visit, Investigator Fisher spoke with Licensee about patient C.L. Licensee stated she prescribed C.L. valium as C.L. is receiving treatment for TMJ and muscle spasms. Licensee stated that she thought 390 10 mg tablets in a year was “a reasonable amount for what she was treating.” Licensee stated she originally prescribed C.L. 30 tablets of 10 mg valium and when C.L. said it was not enough, Licensee “upped it to 60 tablets of 10 mg” valium. She stated she prescribed 60 tablets of 10 mg valium with 6 refills and instructions to take one tablet daily. When asked for C.L.’s chart, Licensee stated that she was “negligent in documenting the prescription in the patient record” and that C.L. is “seeing Dr. Steven Huber for orthodontic issues.” C.L.’s patient record showed no documentation for the 390 10 mg tablets or the 60 tablets of 10-325 Oxycodone/Acetaminophen identified in the pharmacy audit. There did appear to be an entry on January 12, 2017, that stated “Rx valium” that was added after January, 2017.

10. During the visit, Investigator Fisher also obtained patient files for H.R., K.F., I.G., A.T. and C.W. These records all showed prescriptions for three .25 mg traizolam to take one hour before the appointment.
11. As part of the investigation, Investigator Fisher also spoke with C.L. C.L. stated she had a lot of orthodontic work done and “could barely open her mouth” so Licensee wrote her the prescriptions. She stated she “only occasionally uses the valium since her issues have gotten a little better.” She stated that the reason it shows she filled all prescriptions is because it is on auto fill at Walgreens and her husband picks up the prescriptions.

12. As part of the investigation, Investigator Fisher also completed an infection control inspection and continuing education audit. Licensee successfully completed both.

13. On or about August 3, 2017, Licensee appeared before the Board. Licensee testified that:

a. Her sedation permit expired in 2016 and she did not renew it. She stated she did not renew it because “the only difference between anxiolysis and conscious sedation” according to the “the lawyers at Doctors of Conscious Sedation (DOCS),” is I cannot titrate in or add other medication the same day. Otherwise, I could give them one dose, three tablets.” She stated she “read the rule at that time” but “didn’t quite understand ... the verbiage.” She stated she did not think she needed her permit to give three pills and “I guess I apparently misinterpreted” that.

b. She stated she understood now that anxiolysis is not a level of sedation. She stated that she had five patients for whom she wrote prescriptions for sedation medication after her sedation permit expired. Those prescriptions were for three Triazolam. She stated she now understands the law to be she can give two Triazolam and she learned that when Investigator Fisher visited her office “a couple of months ago.”

c. With regard to patient C.L., she stated that she “eventually just referred [C.L.] ... to Dr. Huber to see if it was a misalignment of her occlusion and maybe to correct some stuff with that.” She stated that every time she saw Dr. Huber, she’d have “terrible pain and miss work” and “call me crying” so I called her in Valium as a muscle relaxer.” She stated the 5-milligram “did some, but the 10-milligram did better.”

d. With regard to the fact that she prescribed a total of 390 10-milligram tablets to C.L. over the course of a year, Licensee testified “she didn’t take all of those” but she did prescribe them. She testified that she called in the Valium “usually in the evening.” She stated she was “neglectful” in not documenting that into her chart. She stated she “had been treating” the
condition for which she prescribed the Valium prior to referring C.L. to Dr. Huber and that she remained C.L.'s "primary care dentist." She stated she was not currently treating C.L. but that "I had been treating the condition prior to that."

e. She stated she also prescribed C.L. Oxycodone in addition to the 390 10-mg tablets of Valium. She stated she prescribed 60 tablets of Oxycodone with no refills because "I don't think you can do refills on Oxycodone." She stated that the orthodontist had prescribed ibuprofen but it "didn't touch the pain at all," so she prescribed the Valium and Oxycodone.

f. Licensee stated she was "negligent in not documenting that I was treating her for pain for the TMJ while she was being seen by the orthodontist." She also stated "Yes, 390 pills — when I read that, I thought wow. I didn't realize that she had been prescribed that many because it was, you know, it was over a course of time and with refills[.]

g. She stated her prescriptions for C.L. "seemed okay at the time" but do not now.

h. She stated she realizes now that she was sedating patients and has "changed her office protocol."

14. Section 332.052, RSMo, states, in relevant part:

   1. Dentists shall maintain an adequate and complete patient record for each patient and may maintain electronic records provided the record-keeping format is capable of being printed for review by the board.

15. Regulation 20 CSR 2110-4.010 states, in relevant part:

   (1) The following words and terms, when used in this chapter, shall have the following meanings.

   (S) Maximum recommended does (MRD) — Maximum United States Food and Drug Administration (FDA) recommended dose, as printed in the FDA-approved labeling for unmonitored home use. Drugs used for moderate sedation shall not exceed one and one-half (1.5) times the maximum recommended does (MRD) for a period of twelve (12) hours before and after the patient appointment (i.e., MRD for Triazolam is one-half milligram (.5 mg). One and one-half (1.5) times the MRD for Triazolam is three-fourths (.75 mg) total does for one (1) appointment).

   (T) Minimal sedation (Anxiolysis) — A minimally depressed level of consciousness produced by a pharmacological method, which retains the patient's ability to independently and continuously
maintain an airway and respond normal to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilator and cardiovascular functions are unaffected.

Note: In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation. When the intent it minimal sedation for adults, the appropriate initial dosing of a single enteral drug is no more than the maximum recommended dose (MRD) that can be prescribed for unmonitored home use.

16. Regulation 20 CSR 2110-4.020(2) states:

No dentist shall administer enteral and/or parenteral moderate sedation unless the dentist possesses a moderate sedation permit issued by the Missouri Dental Board. (A dentist is not required to possess a moderate sedation permit for the prescription or administration of drugs prescribed for minimal sedation and/or pain control.) This permit shall be renewed by June 1 every five (5) years from the year of issuance.

17. Regulation 19 CSR 30-1.048(2) states:

Each individual practitioner shall maintain a record of the date, full name and address of the patient, the drug name, strength, dosage form and quantity for all controlled substances prescribed or administered. This record may be maintained in the patient’s record. When the controlled substance record is maintained in the patient’s medical record and the practitioner is not the custodian of the medical record, the practitioner shall make the controlled substance record available as required in 19 CSR 30-1.041 and 19 CSR 30-1.044.

18. Licensee’s conduct, as described in paragraphs 3 through 13 above, constitutes cause to discipline Licensee’s license.

19. Cause exists for the Board to take disciplinary action against Licensee’s license under § 332.321.2(5), (6), (13), (15), RSMo, which states in pertinent part:

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 permit or license required by this chapter or any person who has failed to renew or has surrendered his or her 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;
(6) Violation of, assisting, or enabling any person to violate, any provision of this chapter, or any lawful rule or regulation adopted pursuant to this chapter;

...

(13) Violation of any professional trust or confidence;

...

(15) Violation of the drug laws or rules and regulations of this state, any other state or the federal government[.]

Joint Agreed Disciplinary Order

20. 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 § 621.045.3, RSMo:

21. The terms of discipline shall include that Licensee’s licensee shall be placed on PROBATION for a period of three (3) years (“disciplinary period”). During Licensee’s probation, Licensee shall be entitled to engage in the practice of dentistry under Chapter 332, RSMo, provided she adheres to all of the terms of this Settlement Agreement.

I. SPECIFIC REQUIREMENTS

A. Licensee shall not reapply for any sedation permit or site certificate during the disciplinary period. Licensee shall not perform any level of enteral and/or parenteral sedation for which a permit is required pursuant to Chapter 332 and 20 CSR 2110.

II. EDUCATIONAL REQUIREMENTS

A. Licensee shall successfully complete fifteen (15) hours of in-person continuing education in the area of prescribing within 180 days of this Agreement becoming effective. Licensee shall submit written proof of the completion of the continuing education to the Board no more than thirty (30) days after completing the course. Online courses shall not count toward fulfilling this requirement. Completion of these hours shall not count toward the continuing education requirements for the next renewal period. Failure to complete the education within 180 days shall constitute a violation of this Agreement.

B. Licensee shall take and pass the Board’s jurisprudence examination within twelve (12) months of this Agreement becoming effective. Licensee shall contact the Board office to request a current law packet and permission to sit for the jurisprudence examination no less than thirty (30) days prior to the date Licensee desires to take the examination. Licensee shall submit the required re-examination fee to the Board prior to taking the examination. Failure to take and pass the examination during the first twelve (12) months of the disciplinary period shall constitute a violation of this Agreement.
III. GENERAL REQUIREMENTS

A. Licensee shall meet with the Board or its representatives at such times and places as required by the Board after notification of a required meeting.

B. Licensee shall submit reports to the Missouri Dental Board, P.O. Box 1367, Jefferson City, Missouri 65102, stating truthfully whether she has complied with all the terms and conditions of this Settlement Agreement by no later than January 1 and July 1 during each year of the disciplinary period.

C. Licensee shall keep the Board apprised of her current home and work addresses and telephone numbers. Licensee shall inform the Board within ten days of any change of home or work address and home or work telephone number.

D. Licensee shall comply with all provisions of the Dental Practice Act, Chapter 332, RSMo; all applicable federal and state drug laws, rules, and regulations; and all federal and state criminal laws. "State" here includes the state of Missouri and all other states and territories of the United States.

E. During the disciplinary period, Licensee shall timely renew her license and timely pay all fees required for licensing and comply with all other board requirements necessary to maintain Licensee’s license in a current and active state.

F. If at any time during the disciplinary period, Licensee removes herself from the state of Missouri, ceases to be currently licensed under provisions of Chapter 332, or fails to advise the Board of her current place of business and residence, the time of her absence, unlicensed status, or unknown whereabouts shall not be deemed as any part of the time of discipline so imposed in accordance with § 332.321.6, RSMo.

G. During the disciplinary period, Licensee shall accept and comply with unannounced visits from the Board’s representatives to monitor her compliance with the terms and conditions of this Settlement Agreement.

H. If Licensee fails to comply with the terms of this Settlement Agreement, in any respect, the Board may impose such additional or other discipline that it deems appropriate, (including imposition of the revocation).

I. This Settlement Agreement does not bind the Board or restrict the remedies available to it concerning any other violation of Chapter 332, RSMo, by Licensee not specifically mentioned in this document.

IV. ADDITIONAL REQUIREMENTS

A. Licensee shall not allow her license to lapse.

B. Licensee shall notify, within 15 days of the effective date of this Settlement Agreement, all hospitals, nursing homes, out-patient centers, surgical centers, clinics, and all other facilities where Licensee practices or has privileges of Licensee’s disciplinary status. Notification shall be in writing and Licensee shall, contemporaneously with the giving of such notice, submit a copy of the notice to the Board for verification by the Board or its designated representative.
22. The parties to this Agreement understand that the Missouri Dental Board will maintain this Agreement as an open record of the Board as provided in Chapters 332, 610 and 324, RSMo.

23. The terms of this settlement agreement are contractual, legally enforceable, and binding, not merely recital. Except as otherwise provided 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.

24. Licensee, together with her heirs and assigns, and her attorneys, do hereby waive, release, acquit and forever discharge the Board, its respective 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 § 536.087, RSMo, or any claim arising under 42 U.S.C. § 1983, which may be based upon, arise out of, or relate to any of the matters raised in this case, its settlement, 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 to be void or unenforceable.

25. If no contested case has been filed against Licensee, Licensee has the right, either at the time the settlement agreement is signed by all parties or within fifteen days thereafter, to submit the agreement to the Administrative Hearing Commission for determination that the facts agreed to by the parties to the settlement agreement constitute grounds for denying or disciplining the license of the licensee. If Licensee desires the Administrative Hearing Commission to review this Agreement, Licensee may submit this request to:

Administrative Hearing Commission, Truman State Office Building, Room 640, 301 W. High Street, P.O. Box 1557, Jefferson City, Missouri 65101.

26. If Licensee has requested review, Licensee and Board jointly request that the Administrative Hearing Commission determine whether the facts set forth herein are grounds for disciplining Licensee's license and issue findings of fact and conclusions of law stating that the facts agreed to by the parties are grounds for disciplining Licensee's license. Effective the date the Administrative Hearing Commission determines that the agreement sets forth cause for disciplining Licensee's license, the agreed upon discipline set forth herein shall
go into effect. If Licensee does not request review by the Administrative Hearing Commission, the settlement agreement goes into effect 15 days after the document is signed by the Executive Director of the Board.

**LICENSEE**

[Taliva G. Joost, D.M.D.]

Date 11/28/2017

**BOARD**

[Brian Barnett, Executive Director
Missouri Dental Board]

Date 12/4/2017