STATE OF NEW HAMPSHIRE
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

BOARD OF NURSING

In Re: Eryn Daly,
LNA License # 055231-24

Docket No.: 2023-NUR-0013

FINAL DECISION AND ORDER – 05/25/23

I. ATTENDEES

Samantha O'Neill, Board Chair
Joni Menard, Board Vice-Chair
Melissa Tuttle, Board Member
Melissa Underhill, Board Member
Matthew Kitsis, Board Member
Maureen Murtagh, Board Member
Dwayne Thibeault, Board Member
Michele Melanson-Schmitt, Board Member
Jennifer Thibeault, Board Member
Attorney Rahkiya Medley, OPLC Board Counsel
Attorney Elizabeth Eaton, OPLC Board Counsel
Michael Gianunzio, OPLC Board Administrator
Jeanne Webber, OPLC Board Administrator
Attorney John Garrigan, OPLC Hearing Counsel
Attorney Nikolas K. Frye, OPLC Hearings Examiner and Presiding Officer
Jessica Reeves, OPLC Investigator and as Witness
Eryn Daly, Licensee

II. CASE SUMMARY/PROCEDURAL HISTORY

On or about 01/15/2021, the New Hampshire Board of Nursing (“Board”) received a complaint from Bedford Nursing and Rehab of 480 Donald St., Bedford, NH. The complaint alleges that Eryn Daly ("Licensee") forcibly cut the nails of resident (Jeanette Miller) against the resident’s will. After investigation, the Board voted on 01/26/2023 to commence an adjudicative/disciplinary proceeding in this matter. A Notice of Adjudicative Hearing followed, and the Board then held the adjudicatory hearing on 05/25/23. This Final Decision and Order follows.

III. SUMMARY OF THE EVIDENCE

The Board received the following evidence pursuant to RSA 541-A:33 and Rule 207.09:

a. Exhibits were filed by Hearing Counsel, numbered as follows:

1. Complaint from Bedford Nursing and Rehabilitation Center, dated 01/19/21 (Bates #HC005-HC015); ***Note: Patient identifiers redacted pursuant to RSA 91-A:5, IV.***
2. Respondent written statement, dated November 15, 2021 (Bates HC023-026); ***Note: Internal Division of Enforcement communications redacted as privileged***.
3. Resident Health Records Agency, dated January 15, 2021-January 29, 2021 (Bates HC031-057); ***Filed under seal as containing protected health information pursuant to RSA 91-A:5, IV.*** **SEALED**
4. Jessica Reeves Report of Investigation, dated December 12, 2022, (Bates HC061-063); ***Note: Patient identifiers redacted pursuant to RSA 91-A:5, IV.***
5. Recording of Interview with Eryn Daly, dated November 17, 2021; ***Filed under seal as containing protected health information pursuant to RSA 91-A:5, IV.*** **WITHDRAWN**
6. Recording of Interview with Julie Normand, dated November 18, 2021; ***Filed under seal as containing protected health information pursuant to RSA 91-A:5, IV.*** **WITHDRAWN**
7. Recording of Interview with Mary Bowen, dated December 1, 2021; ***Filed under seal as containing protected health information pursuant to RSA 91-A:5, IV.*** **WITHDRAWN**

b. Exhibits were filed by Licensee, labeled as follows:

A. None.

b. Sworn testimony was received from:

1. Jessica Reeves, OPLC Investigator (called by Hearing Counsel)
2. Eryn Daly, Licensee (called by Licensee)

At the outset of the hearing, Hearing Counsel withdrew Exhibits 5 through 7 after learning the Licensee had not had an opportunity to review them.[1] The Licensee stated no objection to the withdrawal of the exhibits, even after Hearing Counsel had provided alternative ways of proceeding which would have allowed her to review them before the hearing. The Licensee had no objection to

[1] Hearing Counsel explained the efforts he had taken to make the withdrawn exhibits accessible to the Licensee in advance of the hearing.

Exhibits 1 through 4, which the Presiding Officer admitted into evidence as full exhibits after determining they were material and relevant. The Licensee also had no objection to the redactions contained in Exhibits 1, 2 and 4 and the sealing of Exhibit 3. After considering the relevant law, the Presiding Officer approved redacted Exhibits 1, 2, and 4 and sealing Exhibit 3.[2]

IV. CONDUCT OF THE HEARING AND EVIDENCE PRESENTED

Hearing Counsel bears the burden of proof by a preponderance of the evidence with respect to the Issues Presented contained in the Notice of Hearing at section II.c, which are:

1) [w]hether Licensee engaged in professional misconduct, as defined at RSA 326-B:37, II(e); RSA 326-B:37, II(k); RSA 326-B:37, II(m) and/or RSA 326-B:37, II(q)(2) (*see* Rule Nur 402.04 (6) by allegedly attempting to cut the nails of the resident despite the resident's objections.

2) Whether and to what extent the Licensee should be subject to discipline pursuant to RSA 326-B:37, III and Rule 402.04.

NOH at II.c.

Based upon the credible evidence presented at the hearing, the Board finds the following facts.

HEARING COUNSEL'S CASE-IN-CHIEF:

Jessica Reeves

Jessica Reeves began her testimony by explaining that she has been a New Hampshire Nurse Practitioner for six years, a registered nurse for ten years, and has acted as a nurse investigator for the Board for approximately one year. After explaining that she had investigated this matter,[3] Nurse Reeves then turned her attention to Exhibit 1, which is the complaint filed against the Licensee upon which the Board initiated this disciplinary proceeding. The complaint generally alleges that on 01/15/21 the

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[2] *See* RSA 541-A:33, RSA 91-A:5, IV, and *Riddle Spring Realty Co. v. State*, 107 N.H. 271, 273 (1966) ("The common law rule that confidential communications between a client and an attorney are privileged and protected from inquiry is recognized and enforced in this jurisdiction") (internal citations and quotations omitted). Although withdrawn from consideration as full Exhibits, the Presiding Officer also hereby seals Exhibits 5-7 pursuant to RSA 91-A:5, IV based upon the offer of proof offered by Hearing Counsel at the time of adjudication.

[3] *See* Exh. 4.

Licensee "forced nail cutting against resident's wishes. Accused held hand firmly of Resident to cut nails not letting go when asked. Used unprofessional tone and comments to Resident during act. Threatened she would hold her down later to cut nails." Exh. 1 at HC006.

Nurse Reeves testified that the complaint was accompanied by witness statements from Mary Bowen, Tracey Guerrier, Tatem Florence, and Julie M. Normand, who work at the residential nursing facility where the incident took place. She additionally stated that the statements corroborated the complaint, and that Mary Bowen had witnessed the incident alleged in the complaint. Nurse Reeve's testimony and Exhibit 1 reveal that on the date and time of the incident, Mary Bowen heard the resident yelling for help, went to assist, and found her "extremely distraught". *See* Exh. 1 at HC008. Additionally, Ms. Bowen's statement explains that she saw the Licensee holding the resident's left hand firmly, trying to clip her nails, and that the resident told her "[n]o, Mary I told them I don't want my nails cut! But they will not listen to me! I told them I do my own nails! I didn't mean to scratch them Mary, I apologized to them." *Id*. Ms. Bowen also indicates in the statement that during the incident the Licensee said "[s]he [the resident] has to have her nails clipped! Multiple people have been scratched", *Id.*, and "[i]t needs to get done. I will cut them later even if I have to hold her down I'm going to cut them." *Id.*

After refreshing her recollection with Exhibit 2, Nurse Reeves explained that the Licensee provided a response to the complaint in which she acknowledged that the resident had scratched her earlier in the day, had rebuffed her suggestion to cut her nails, and that the Licensee had misled the resident into thinking she was going to clean her nails and then tried to cut them against her wishes. The Resident was distraught enough from the incident that a social worker monitored her for some time thereafter. *See also* Exh. 3.

<u>LICENSEE'S CASE-IN-CHIEF:</u>

The Licensee testified on her own behalf that her written statement (Exh. 2) summarizes her recollection of what happened. She apologized for having caused the patient distress and explained she knew she was being deceitful to the resident in leading her to believe she would only clean the nails. The Licensee also acknowledged having not acted professionally and having grown from the experience. Upon questioning by Hearing Counsel and the Board, the Licensee explained that she has not taken any continuing education coursework related to her conduct but had, following the incident, read approximately ten hours of online material related to how to cope with stress. She also provided an explanation of how she would better handle a similar incident in the future.

V. DISCUSSION AND FINDINGS OF FACTS / CONCLUSIONS OF LAW:

After reviewing the evidence, drawing all reasonable inferences therefrom, and accounting for the demeanor and credibility of the witnesses, the Board finds, by a preponderance of the evidence, that the Licensee committed professional misconduct. Based upon the evidence presented, the Board makes the following findings of fact in support:

1. On 01/15/21, the Licensee was licensed as an LNA in the State of New Hampshire and working at a residential nursing facility where the resident lived. *See* testimony of Jessica Reeves, Exh. 1 at HC005, Exh. 2 at HC0024, and Exh. 4 HC 0061-62;

2. On 01/15/21, the resident accidentally scratched the Licensee with her fingernails and informed the Licensee that she did not want her fingernails clipped after the Licensee had suggested they should be. *See* Exh. 2 at HC024 and Testimony of Licensee;

3. On 01/15/21, following the aforementioned interaction, the Licensee told the resident that she intended to clean the resident's fingernails, even though Licensee intended to cut them. *See* Exh. 2 at HC024 and Testimony of Licensee;

4. On 01/15/21, the Licensee attempted to cut the resident's fingernails after telling the resident she only intended to clean them. *See* Testimony of Jessica Reeves, Exh. 1 and Exh. 2 at HC 0024;

5. Despite protests from the resident, the Licensee continued to attempt cutting the resident's nails until Mary Bowen arrived on scene. *See* testimony of Jessica Reeves, testimony of Licensee, Exh. 1 and Exh. 2 at HC 0024;

6. On 01/15/21 and sometime thereafter, the resident was emotionally distraught from this interaction with the Licensee. *See* testimony of Jessica Reeves, Exh. 3.

Based upon those findings of facts and the evidence presented, the Board makes the following conclusions of law:

1) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(e).

2) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(k).

3) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(q)(2) by violating Rule 402.04(b)(6).

4) The Board concludes that the Licensee's conduct demonstrates she is deficient in the nurse practice areas of resident rights, dealing with difficult resident, and ethics.

Further, after consideration of the factors contained in Rule 402.04(g), and pursuant to RSA 326-B:37, III and Rule 402.04(i), (h), the Board takes the following disciplinary action intended to be the minimum sanctions, both in type and extent, that the Board believes will, based upon the unique facts and circumstances of each act of misconduct, protect the public and deter both the licensee charged and any other licensee from engaging in such misconduct in the future:

1. Pursuant to RSA 326-B:37, III(a) and Rule 402.04(i)(1), the Licensee's license is **REPRIMANDED**.

2. Pursuant to RSA 326-B:37, III(c) and Rule 402.04(i)(8), the Board directs the Licensee to participate in five (5) hours of program(s) of **CONTINUING NURSING EDUCATION** in the areas of resident rights, dealing with difficult residents, and ethics within ninety (90) days of the signed date of this order. To document successful completion of the course(s), the Licensee shall provide the Board with written documentary proof issued/authored by the program(s) offering the course(s). **Whether any program(s) meets the requirements of this section shall be determined by the Board. Therefore, the Licensee is strongly encouraged to seek the Board's pre-approval of program(s) before taking them.** The Licensee can submit information about proposed programs to the Board's Administrator, who shall present same to the Board for determination. The five (5) hours of continuing education ordered hereunder shall be in addition to any normal continuing education required for licensure under Board statue and rules.

VI. <u>CONCLUSION AND DECISION:</u>

Pursuant to RSA 326-B:37, and Rule 402, the Board hereby makes findings of professional misconduct and disciplined as specified herein.

DATED: 6/1/2023

___/s/ Nikolas K. Frye, Esq.________________
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