STATE OF NEW HAMPSHIRE
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

BOARD OF NURSING

In Re: Lisa Greenspon,
RN Lic. #079256-21

Docket No.: 2023-NUR-0024

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
Michael Porter, OPLC Investigator and as Witness
Lisa Greenspon, Licensee

II. CASE SUMMARY/PROCEDURAL HISTORY

On 04/27/23, the Board of Nursing ("Board") reviewed a Discipline Case Summary Report and accompanying documentation stating the Vermont Board of Nursing had indefinitely suspended Lisa Greenspon, RN ("Licensee") at a default hearing based upon charges that she had practiced incompetently by performing unsafe and unacceptable patient care and failing to conform to the essential standards of

acceptable and prevailing practice. After an expedited investigation and follow-up on the matter, the Board voted on 05/16/23 to emergently suspend the Licensee's license and initiate a reciprocal disciplinary hearing, pursuant RSA 541-A:30(III), RSA 310-A:1-m, RSA 326-B:37(IV), N.H. Code Admin. R., Title Nur 402.03(a) ("Rules"), and N.H. Code Admin. R., Title Plc 206.07 ("Plc"). 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. Verified Petition for Emergency Temporary Suspension of Licensure Pursuant to RSA 326-B:37, IV and RSA 310-A:1-m, IV and N.H. Code Admin. R.Title Plc 206.07, Pending a Show Cause Hearing Pursuant to N.H. Code Admin.R. Title Nur. 402.04(d).

2. Discipline Case Summary Report, 03/14/23 Vermont Board of Nursing Default Order, *In re: Lisa Greenspon*, Docket # 2022-226, 10/26/22 State of Vermont Specification of Charges, *In re: Lisa Greenspon*, Docket # 2022-226.

3. OPLC Enforcement, Unsigned Draft Voluntary Agreement Not to Practice, *In re: Lisa Greenspon* and 05/11/23 Email Correspondence between OPLC Investigator Michael Porter and Licensee.

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

A. None.

b. Sworn testimony was received from:

1. Lisa Greenspon, Licensee (called by Licensee)
2. Michael Porter, OPLC Chief Bureau Investigator (called by Hearing Counsel via offer of proof)

During the hearing, the Licensee indicated that she had no objection to the full admission of Exhibits 1 through 3. The Presiding Officer fully admitted Exhibits 1 through 3 after determining that they were material and relevant.

IV. PRELIMINARY MATTERS

Hearing Counsel had filed a Motion to Bifurcate the Proceedings, stating concern that the Licensee had not received 15 days' notice pursuant to RSA 326-B:38, V. He argued the Board could only proceed with hearing issue II.c.3 for the hearing. The Licensee indicated she desired to proceed forward with all issues presented and waived any right to 15 days' notice she might have on the record. Hearing Counsel indicated he found this arrangement acceptable. The Presiding Officer therefore denies the Motion to Bifurcate as MOOT.[1]

V. CONDUCT OF THE HEARING AND EVIDENCE PRESENTED

The Licensee bears the burden of persuasion/proof by a preponderance of the evidence with respect to the Issues Presented contained in the Notice of Hearing at section II.c.1[2], which is:

1) Whether the Licensee can demonstrate why reciprocal discipline should not be imposed in New Hampshire, where the Licensee was disciplined in the State of Vermont. *See* RSA 326-B:37, II(f) and/or (r). *See also* Rules 402.04(d) and (e).

   NOH at II.c.1.

Hearing Counsel bears the burden of persuasion/proof by a preponderance of the evidence with respect to the Issues Presented contained in the Notice of Hearing at section II.c.3 and 3, which are:

2) Whether the Licensee should be subject to discipline pursuant to RSA 326-B:37, III that exceeds what has been imposed by the State of Vermont.

3) If no finding of misconduct is made, whether or not the Licensee's license should be suspended pending a full adjudicatory hearing in this matter on non-reciprocal discipline-related grounds, where she allegedly has improperly administered medication to patients in Vermont and was indefinitely suspended in that jurisdiction as a result.

NOH at II.c.2 and 3.

[1] But *see* 06/16/22 "Order on Motion for Final Ajudicative Hearing" [sic], In Re: Amy Matthews, RN DNP, 2022-NUR-016; *see also* RSA 326-B:38, IX ("at least 15 days' written notice of the date, time and place of a hearing **except as otherwise provided in this chapter**")(emphasis added); *see also* RSA 326-B:37, IV; and *see also* the procedural posture and dicta set forth in *Appeal of Boulard*, 165 N.H. 300 (2013).

[2] *See* Rules 207.10, 402.04(d), and Plc Rule 206.

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

LICENSEE'S CASE-IN-CHIEF:

Lisa Greenspon

The Licensee testified that she worked at the nursing home in Vermont for three to four weeks. She explained that she has worked as a registered nurse for approximately 34 years, values those she works with as if they were her family, and loves nursing. She requested the Board impose no reciprocal disciplinary sanctions against her New Hampshire license. Upon questioning from Hearing Counsel she stated she had not practiced nursing since October of 2022, is licensed in the state of Arizona (as well as New Hampshire and Vermont), had not practiced in Arizona since 2016, and had taken no continuing education courses related to the conduct upon which the Vermont disciplinary order is based.

Upon Board questioning the Licensee testified that she knew of her right to appeal the default disciplinary order in Vermont but had never followed through with the required formal process, had missed the hearing in Vermont because her son was in a car accident, and had failed to contact the Board to let it know she would be missing the hearing. She explained her failure to follow through with defending herself in the Vermont matter as caused by stress and anxiety. She also addressed the findings of fact made by the Vermont Board in its default order by generally stating that she was accused of things that never happened; had poor training at the nursing home; and was following the nursing home's standard medication practices when administering patient medications. The Licensee justified why she indiscriminately provided patient medications earlier than was ordered. She explained home's policy was because the dementia patients were combative, and it was difficult to near impossible to provide the medication after they had fallen asleep. Upon further Board questioning on the matter, she agreed that the practice was not safe, but she would rather give the medication early rather than not at all. She stated that

she would not do it again and acknowledged that some of the medication she was providing patients could adversely affect a person's cardiac health if administered earlier than scheduled.

The Licensee's testimony on examination by the Board also focused on inconsistencies in her statements and actions. For example, Exhibit 3 shows that the Licensee had appeared open to reviewing and signing a preliminary agreement not to practice but had never done so and then requested a hearing. The Licensee's testimony revealed that she considered signing it but wanted to argue her case. Finally, she relayed the extreme difficulty in providing adequate care to patients post-COVID was the context in which her conduct took place. She explained that these difficulties was why she had left the nursing profession.

HEARING COUNSEL'S CASE-IN-CHIEF:

Hearing Counsel declined to argue that the Board should consider greater sanctions than those imposed in Vermont. He provided an offer of proof that was supported by sworn testimony from Michael Porter, OPLC Investigations Bureau Chief and Exhibits 1 through 3. The offer of proof generally summarized what had taken place in Vermont, what actions OPLC and the Board had taken to avoid having a hearing, and why the Board had decided to emergently suspend the Licensee's license. He advocated for applying the same discipline as Vermont had but did not believe that the evidence presented at the hearing warranted a continuation of the emergency suspension of her license.

VI. 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 failed to demonstrate, by a preponderance of the evidence, that her conduct in the jurisdiction of Vermont, as has been adjudicated, does not constitute grounds to impose no or lesser sanctions in New

Hampshire. *See* Rule 402.04(d) and Plc Rule 213.04(b). Based upon the evidence presented, the Board makes the following findings of fact in support:

1. The Licensee is actively licensed in New Hampshire as a registered nurse with a multi-state license and a residence listed in NURSYS as Somersworth, New Hampshire. *See* Testimony of Michael Porter and Exhs. 1 and 2.

2. On 10/26/22, the state of Vermont filed a Specification of Charges against the Licensee, alleging that while working at a retirement home in Vermont she had, on multiple occasions, dispensed or failed to dispense medications to a variety of the home's patients. *See* testimony of Michael Porter and Exhs. 1 and 2.

3. After the Licensee failed to answer the charges, the State of Vermont moved to default the Licensee. *See* Exh. 2.

4. Subsequently, on 03/09/23, the Vermont Board of Nursing issued a default order finding the factual allegations contained in the Specific of Charges constituted misconduct under Vermont law. *See* Exh. 2.

5. Specifically, the Vermont Board found that the Licensee, when not administering and incorrectly administering medication to home's patients, had failed to practice competently by performing unsafe and unacceptable patient care and failing to conform to the essential standards of acceptable and prevailing practice. *See* Exh. 2.

6. The Vermont Board sanctioned her by indefinitely suspending her license. S*ee* Testimony of Michael Porter and Exhs. 1 and 2.

7. Regardless of whether the nursing home approved of these practices, as argued by the Licensee, the Board finds, based upon its training and experience, that the medication administration practices of the Licensee, as described in Exhibit 2 and in the Licensee's testimony were unsafe, unacceptable, and failed to conform to the standards of acceptable and prevailing practice.

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

1) Pursuant Plc Rule 213.04, the Board concludes that the Licensee's conduct in the State of Vermont constitutes grounds to impose sanctions in New Hampshire. *See, i.e.,* RSA 326-B:37, II(f) and (r).

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

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

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), Rule 402.04(i)(10), and Rule 402.04(d) and (e), the Licensee's license is **INDEFINTELY SUSPENDED**. At such time as the Respondent applies for reinstatement, the Board may impose preconditions to reinstate as well as conditions on her reinstated license as it deems appropriate at the time.

Finally, the Board's findings of fact and conclusions of law made herein render a determination on issues II.c.2 and 3 of the notice of hearing moot.

VII. CONCLUSION AND DECISION:

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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