STATE OF NEW HAMPSHIRE
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

BOARD OF NURSING

In Re: Lynn Huggins **LPN Lic. # 016642-22** Docket No.: 2023-NUR-050	**ORDER OF EMERGENCY SUSPENSION – 11/21/2023**

I. CASE SUMMARY/PROCEDURAL HISTORY:

On or about 11/20/2023, the Office of Professional Licensure and Certification, Division of Enforcement ("OPLC Enforcement") filed a "Verified Petition for Emergency Temporary Suspension of Licensure Pursuant to RSA 310:12, IV and N.H. Code Admin. R. Title Plc 206.07" pertaining to Lynn Huggins, Licensed Practical Nurse ("Licensee"). On 11/21/2023, the Board held an emergency meeting during which it voted to immediately suspend Licensee's license on an emergency basis pursuant to RSA 310:12, IV and N.H. Code Admin. R., Title Plc 206.07 ("Plc") ("Rules"). This Order of Emergency Suspension follows.

II. LEGAL STANDARD:

"In cases involving imminent danger to public health, safety, or welfare, a board may order immediate suspension of a license or certification pending an adjudicative proceeding before the board to determine if the suspension should remain in place pending final adjudication of the matter." RSA 310:12, IV. The Office of Professional Licensure and Certification has further interpreted that to mean that the Board "… shall issue an order that immediately suspends the respondent's license based on: (1) [a] determination that there is a reasonable basis to believe that public health, safety, or welfare requires emergency action…" Rule 206.07(a)(1).

III. EVIDENCE PRESENTED AND FINDINGS OF FACT:

A. Evidence Presented

The Board was presented with and/or considered the following evidence: the 11/20/2023 Verified Petition for Emergency Temporary Suspension of Licensure Pursuant to RSA 310:12, IV and N.H. Code Admin. R. Title Plc 206.07 pertaining to the Licensee ("Verified Petition"), which was filed by Michael Porter, OPLC Investigations Bureau Chief, OPLC Enforcement. A review of the evidence presented, and the reasonable inferences taken there from, allows the Board to find the following facts.

B. Findings of Fact

The Board hereby makes the following findings of fact which were extracted from the Verified Petition for Emergency Suspension filed by Michael Porter, OPLC Investigations Bureau Chief, OPLC Enforcement.

1. The Board of Nursing first granted the Respondent a license to practice as an LPN on 8/6/2014.
2. On 11/9/2023, Hanover Hill Health Care Center ("Facility") began an investigation into the Respondent when Nurse Manager Cameron Canney detected what appeared to be suspicious controlled substance pain medication administration by the Respondent.
3. Canney noted multiple pulls for a controlled substance, Oxy IR, for resident A.I. during the month of November 2023.
4. As part of the investigation into the Respondent, the Facility conducted an audit and noted the Respondent was consistently pulling Oxy IR for three specific residents, A.I., H.F. and J.J.
5. Of the three residents, two (A.I., and H.F.) are cognitively impaired but the third resident, identified as J.J. is not cognitively impaired and was able to speak with Facility staff to determine J.J. had not received the doses of PRN Oxycodone as recorded by the Respondent for November 6th, 7th, 8th, and 9th of 2023.

6. A urine drug screen was requested of the respondent. However, the respondent did not provide the urine sample and left the facility.
7. According to the Facility, one resident, J.J., is not cognitively impaired and was able to inform investigating staff that her pain has not been bothering her and rarely requires anything beyond the scheduled Tylenol she receives from the Respondent.
8. According to documentation provided by the Facility, Resident J.J. was provided 18 doses of Oxy IR 5mg in the month of October 2023.
9. A review of records indicates the order for Oxy IR, 5mg, PRN, began on or about 10/18/2023.
10. According to records provided by the Facility, the Respondent did not work between 11/1/2023 and 11/5/2023.
11. According to records provided by the Facility, the Respondent signed off on administering the PRN Oxy IR, 5 mg, to resident J.J., four times between 11/6/2023 and 11/9/2023.
12. As part of the Facility investigation, resident J.J. was asked to provide a urine sample to determine whether the Respondent actually administered J.J. the PRN oxy as the Respondent noted in the resident chart.
13. When the Division of Enforcement spoke with NHA McIntyre, she was informed by the Facility physician if J.J. actually received the PRN Oxy, it would be detected on a urine screen. McIntyre was informed the urine screen could detect Oxycodone in the resident's urine for up to 5 days.
14. Considering the Respondent noted in the chart that she administered PRN Oxy to J.J. for November 6th, 7th, 8th, and 9th, a urine test on November 10th should detect the presence of the Oxycodone in J.J.'s urine.
15. On 11/10/2023, resident J.J. agreed to provide a urine sample for a drug screen.
16. On 1/10/2023, at approximately 2:20 PM, a specimen was collected.

17. The specimen was received at Health Solutions at the Elliot at approximately 3:52 PM.
18. Results were provided by Health Solutions at the Elliot at approximately 4:33 PM.
19. According to the results provided by Health Solution at the Elliot, Oxycodone (Opiates) was not detected in resident J.J.'s urine.
20. On 11/14/2023, resident J.J. was interviewed by Facility staff and reported she had received PRN Oxy over a week before she was tested but had not requested or received any PRN Oxy the week leading up to 11/10/2023.
21. While the Facility was conducting its investigation into the Respondent on 11/9/2023, the Facility learned that while the Respondent was waiting to provide a urine sample for the Facility, the Respondent text messaged another LPN, Amanda Colvin, requesting Amanda to provide a urine sample for the Respondent.
22. The Facility obtained a copy of the text messages between the Respondent and Colvin.
23. LPN Amanda Colvin also provided the Facility with a written statement about her interaction with the Respondent on 11/9/2023.
24. In her written statement, Colvin verifies that when she read the text messages from the Respondent on 11/9/2023, Colvin immediately notified her unit manager, and she ultimately provided the text messages as part of the Facility investigation.

CONCLUSIONS OF LAW:

The Board concludes there is a reasonable basis to suspend the Licensee's New Hampshire license on an emergency basis pursuant to RSA 310:12, IV Rule 206.07. The central facts are straightforward — The Board's Findings of Fact reflect that the Licensee diverted a controlled substance under the guise that it was for one of her patients and repurposed the controlled substance for her own use. The Board's Findings of Fact further evidence the Licensee texted a co-worker in attempt to procure urine when confronted by

the investigators at the Facility to submit a urine sample. The Licensee's conduct on its face therefore warrants immediate emergency suspension of her registration pursuant to RSA 310:12, IV and Rule 206.07, pending a follow-up emergency suspension hearing/disciplinary hearing.

ORDER:

Pursuant to RSA 310:12, IV and Rule 206.07 (a) the Board hereby orders the immediate emergency suspension of Lynn Huggin's license as a LPN, pending a follow up emergency hearing in this matter. A Notice of Emergency Hearing with an appropriate date/time shall follow forthwith.

DATED: 11/21/2023

__/s/ Shane D. Goulet, Presiding Officer_____
Shane D. Goulet, Hearings Examiner
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