STATE OF NEW HAMPSHIRE
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

BOARD OF NURSING

In Re: Lee Ann Griggs, RN
License No.: # 044076-21

Docket No.: 22-NUR-028

NOTICE OF DECISION DATED 11/17/2023

Enclosed please find a copy of the Board's Order dated 11/17/2023 relative to:

FINAL DISCIPLINARY ADJUDICATIVE HEARING

MOTIONS/PETITIONS FOR RECONSIDERATION OR REHEARING:

Pursuant to N.H. Code Admin. R. Plc 206.29(a) ("Rules") and RSA 310:14, II, motions/petitions for reconsideration or rehearing shall be filed within 30 calendar days after service of a final adjudicative order. Pursuant to Rule 206.29(b), the Motion/Petition shall: 1) clearly identify points of law or fact that the movant asserts the Board and/or Presiding Officer has overlooked or misapprehended; 2) contain such argument in support of the motion as the movant desires to present; and 3) be served by the movant on all other participants in accordance with Rule 206.11. Pursuant to Rule 206.29, no answer to a motion/petition for reconsideration or rehearing shall be required, but any answer or objection filed shall be delivered to the Presiding Officer's Office within 5 working days following receipt of service of the motion/petition for reconsideration. Pursuant to RSA 541:5, upon the filing of such motion/petition for rehearing or reconsideration, the Board or Presiding Officer shall within ten days either grant or deny the same, or suspend the order or decision complained of pending further consideration, and any order of suspension may be upon such terms and conditions as the Board or Presiding Officer may prescribe.

RIGHT TO APPEAL:

Pursuant to RSA 310:14, III, appeals from a decision on a rehearing and/or motion for reconsideration shall be by appeal to the New Hampshire Supreme Court pursuant to RSA 541. Pursuant to RSA 541:6, within 30 days after the application for a rehearing is denied, or, if the application is granted, then within thirty days after the decision on such rehearing, the applicant may appeal by petition to the New Hampshire Supreme Court. Pursuant to RSA 310:14, III, no sanction shall be stayed by the Board during an appeal.

STATE OF NEW HAMPSHIRE
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BOARD OF NURSING

In Re: Lee Ann Griggs, RN
RN Lic. # 044076-21

Docket No.: 22-NUR-028

FINAL DECISION AND ORDER – 11/16/23

I. PARTICIPANTS:

Board Members and Support Staff and Counsel:

Samantha O'Neill, Board Chair and Member
Joni Menard, Board Vice Chair and Member
Dwayne Thibeault, Board Member
Wendy Stanley Jones, Board Member (remote)
Melissa M. Tuttle, Board Member
Maureen Murtagh, Board Member
Melissa A. Underhill, Board Member
Matthew Kitsis, Board Member
Jennifer Thibeault, Board Member
Michele Melanson-Schmitt, Board Member

Michael Gianunzio, OPLC Board Administrator
Terese Barton, OPLC Board Administrator
Rahkiya Medley, OPLC Board Counsel
Elizabeth Eaton, OPLC Board Counsel

Presiding Officer:

Attorney Nikolas Frye, OPLC Hearings Examiner

Parties:

John Garrigan, Esq., OPLC Chief Administrative Prosecutor and Hearing Counsel
Lee Ann Griggs, Licensee (failed to appear)

II. CASE SUMMARY/PROCEDURAL HISTORY:

On 08/16/22, the Office of Professional Licensure and Certification, Division of Enforcement ("OPLC Enforcement") received, on behalf of the Board of Nursing ("Board"), a complaint alleging Lee Ann Griggs ("Licensee") was intoxicated while working as a registered nurse ("RN") at Merrill Gardens, LLC and failed to provide residents medication. After reviewing a Verified Petition of Emergency Suspension of Licensure Pursuant to RSA 326-b:37, IV and hearing from Michael Porter, Investigations Bureau Chief at OPLC Enforcement, the Board voted at an emergency meeting held on 08/19/22 to suspend the Licensee's license on an emergency basis pursuant RSA 541-A:30(III), RSA 326-B:37(IV), and N.H. Code Admin. R., Title Nur 402.03(a) ("Rules"). On 08/25/22, the Board held an adjudicatory hearing at which it determined to uphold the emergency suspension, pending a final disciplinary adjudicatory hearing in this matter. A final hearing in this matter was held on 11/16/23. This final decision and order follows.

III. SUMMARY OF THE PROPOSED EVIDENCE AND EVIDENTIARY RULINGS:

The Board received the following evidence pursuant to RSA 541-A:33 and Plc Rules 206.22 and 206.18(d):

A. Exhibits were submitted by Hearing Counsel, numbered as follows:

1. Emailed complaint and follow up email with additional information from Robert Fowler, dated August 16, 2022 and August 22, 2022 (Bates #HC001, HC023-024);
2. Michael Porter *Verified Petition for Emergency Suspension*, dated August 19, 2022 (Bates #HC002-007);
3. Newmarket Police Department reports, dated August 13, 2022 (Bates #HC008-009);
4. Licensee's April 16, 1999 *Settlement Agreement* (Bates #HC010-011);
5. Board's December 20, 2000 *letter of notification and conditions of reinstatement* (Bates #HC013-015);
6. Licensee's September 27, 2006 Voluntary Surrender (Bates #HC016-019);
7. Board's September 25, 2007 *Letter of notification and conditions of reinstatement* (Bates #HC020-021);

8. Board's July 20, 2018 Order on Motion to Lift Disciplinary Sanctions (Bates #HC022);

9. Witness statement from Emily Perron, dated August 13, 2022 (Bates #HC031-032);

10. Partial Witness statement from *FNU LNU*, dated August 13, 2022 (Bates #HC033); **Note: Hearing Counsel is attempting to obtain the full statement. This exhibit may be updated in the*

11. Withdrawn.

12. Witness statement from Melissa Babula, dated August 13, 2022 (Bates #HC052-053);

13. Witness statement from Jennifer Roy, dated August 15, 2022 (Bates #HC038-040);

14. Newmarket Police Department Custodial Release form, dated August 13, 2022 (Bates #HC037);

15. Photographs of Vitamin Water bottle contents, discarded and un-administered medication packs, and damaged Honda Pilot (Bates HC043-051) ***** Note: Certain areas of the pictures of medication packs have been redacted pursuant to RSA 91-A:5, IV to remove visible patient identifiers *****

B. Exhibits were submitted by the Licensee and labeled as follows:

None.

C. Sworn testimony was received from:

1. Emily Perron
2. Jennifer Roy
3. Michael Porter, OPLC Investigations Bureau Chief

The Presiding Officer fully admitted Exhibits 1-15 after reviewing them and determining they were material and relevant to the proceeding. He then instructed the Board that it could only consider Exhibits 4-8 with respect to issue presented #2 in the notice of hearing. Hearing Counsel explained the redactions in the Exhibits and the Presiding Officer approved them pursuant to RSA 91-A:5, IV. Hearing Counsel withdrew Exhibits 10 and 11 submitted on 09/27/23. Exhibit 10 was replaced with a new Exhibit 10. Exhibit 11 was not replaced. For simplicity, the Presiding Officer did not re-number the exhibits from 11 onward.

IV. CONDUCT OF THE HEARING AND EVIDENCE PRESENTED:

The Licensee failed to appear for the final hearing in this matter. The record showed that on 06/13/23 at 8:09 AM EST the Licensee emailed Hearing Counsel and the former Board Administrator (Czechowicz, A.) the following: "I have not received any notice as I have not lived at Haverhill MA address in 4+ years. Please forward to … [this address]. I'm requesting a hearing date as well. Thank you, Lee Ann Griggs." The Licensee's email was written in response to a 08/22/22 at 4:34 PM EST email sent by Hearing Counsel to the former Board Administrator and the Licensee under which he filed his notice of appearance, witness list, and exhibits for the emergency suspension hearing held on 08/25/22.[1] That 2022 email from Hearing Counsel further explains that Hearing Counsel would be mailing all the documents to the Licensee's Haverhill, MA address that was on file with the Board.

The Presiding Officer reviewed the Licensee's 06/13/23 email and issued an order on 06/15/23 stating as follows:

> The Presiding Officer interprets this email as a Motion for Reconsideration and/or Rehearing of the Board's Final Decision and Order dated 09/01/22. *See* Rule 209. Hearing Counsel shall have the requisite time to respond, pursuant to the terms of the Notice of Hearing. On or before 06/23/23, the parties shall provide mutual dates of availability for an upcoming prehearing conference held pursuant to PlC Rule 206.07(j).
>
> Int. ORD 06/15/23.

On 06/16/23 at 12:29 PM EST, Hearing Counsel sent an email to the Licensee and the Hearings Clerk with an attached objection to the Licensee's motion for reconsideration/06/13/23 email. On 06/16/23 at 1:47 PM EST, the Licensee replied to Hearing Counsel's 06/6/23 email via email, stating:

> I have been hospitalized & transferred to sober living. Only recently have I had the ability to respond. I committed myself to treatment 8/15/2022. All I've asked of the board is to allow me to be accountable. You've denied me w/o having any idea other than " the facts". Having no idea what I've done to make amends & seek treatment. I'm not seeking anything except accountability.
>
> Licensee's Email of 06/16/23 at 1:47 PM EST.

[1] The former Board Administrator served the function of the Hearings Clerk for the purposes of the emergency license suspension hearing held on 08/25/22.

That same day the Presiding Officer issued another Interim Order that stated:

> The Presiding Officer interprets this email [the Licensee's 06/16/23] as an Answer to Hearing Counsel's Objection to her Motion for Reconsideration/Rehearing. It will be presented to the Board for consideration, along with her original email, and Hearing Counsel's Objection and accompanying Exhibits. Once the Board reviews these items, it will make a determination of how to handle the Licensee's request and issue a further written order.
>
> 06/16/23 INT ORD.

On 06/16/23, the Presiding Officer's Office mailed and emailed all pleadings and orders contained in this docket to the Licensee at the mailing address she had provided in her 06/13/23 and to the email address she had been using for the aforementioned correspondence with the Board Administrator, Hearings Clerk.

Thereafter, the Presiding Officer's Office continued to send all correspondence in this matter to the email address used by the Licensee in the June 2023 correspondence but inadvertently began sending mailed copies to the Licensee's former Haverhill, MA address. This correspondence included the notice of hearing for the prehearing conference, the prehearing conference order, and the notice of hearing for the final disciplinary adjudicative hearing. The record shows that none of the emails sent to the Licensee by the Presiding Officer's Office returned as undeliverable, including the one that had the Notice of Final Disciplinary Adjudicative Hearing attached to it. The record also indicates that Hearing Counsel continued to send correspondence to the Licensee at the email address she had used in the June 2023 correspondence and sent at least some mailings to the Licensee's new address, including his 09/27/23 Witness List and Exhibits for the hearing. Additionally, the record shows that the "Notice of Final Disciplinary Adjudicative Hearing- 11/16/23 @ 10:00 AM" stated the hearing was on 11/16/23 at 10:00 AM, was located at OPLC, 7 Eagle Square, Concord, NH 03301, and contained the information required by RSA 541-A:31 and Plc Rule 206.06(b). The record contains no correspondence from the Licensee in which she indicates an inability to make the hearing or requests a continuance.

After considering the aforementioned record and hearing from Hearing Counsel, the sole issue of concern for the Presiding Officer was whether the failure to send the notice of disciplinary adjudicative hearing to the Licensee's correct mailing address meant the Licensee had received insufficient notice under RSA 310:10, II. RSA 310:10, II explains that "[b]oards shall conduct disciplinary and non-disciplinary remedial proceedings in accordance with procedural rules adopted by the executive director." The executive director has adopted the Plc 200s for disciplinary proceedings. *See* OPLC Executive Director's Standing Order 2023-1. These rules instruct that:

> Notices, orders, decisions, or other documents issued by the regulatory authority or presiding officer in connection with an adjudicative proceeding shall be served by the issuer upon all participants in the matter by:
>
> (1) Depositing a copy of the document, first class postage prepaid, in the United States mail, addressed to the address of record in the proceeding for the participant being served;
>
> (2) Delivering a copy of the document in hand to the participant being served; or
>
> (3) Sending a copy of the document to the participant being served as an attachment to an email addressed to the email address of record, provided that the participant who provided the email address has indicated that service would be accepted in this manner.
>
> Plc Rule 206.11(b).

Although the Presiding Officer's Office mailed the 10/03/23 "Notice of Final Disciplinary Adjudicative Hearing- 11/16/23 @ 10:00 AM" to the Licensee's former address instead of her present one, the Presiding Officer found and concluded that OPLC still sent "… a copy of the document to the participant being served as an attachment to an email addressed to the email address of record". Plc Rule 206.11(b)(3). Moreover, the Presiding Officer found and concluded that the Licensee— by first requesting a hearing by email and then responding to Hearing Counsel's Objection to her request for a hearing via email— "indicated that service would be accepted in this manner [by email]." Plc Rule 206.11. Where the Presiding Officer's Office did not receive any delivery failure notifications when sending emails to the Licensee, the Presiding Officer also found and concluded that the Licensee received sufficient notice

pursuant to Plc Rule 206.02(e) and thus RSA 310:10, II. The Presiding Officer additionally found and concluded that OPLC had provided "notice reasonably calculated, under all the circumstances, to apprise … [the Licensee] … of the pendency of the action and afford … [her] … an opportunity to present … [her] … objections." *See, i.e., Jones v. Flowers*, 547 U.S. 220, 225-26 (2006); *See also City of Claremont v. Truell*, 126 N.H. 30, 35 (1985). Hence, the Presiding Officer found and concluded that notice was sufficient under both the Federal and State Constitutions.

The hearing was then held pursuant to RSA 310:10 with the burden of proof, by a preponderance of the evidence, placed upon Hearing Counsel. *See* Rule 206.07(e). The issues before the Board were:

(1) Whether the Licensee committed professional misconduct as defined at RSA 326-B:37, II(o) and/or RSA 326-B:37(q)(2) by allegedly violating the terms of the Board's 10/07/19 Findings of Fact, Rulings of Law and Sanctions Order in *In re Marie Fletcher*, Docket No. 19-061 2-0594-NA and the related NHPHP monitoring agreement.

(2) If a finding of misconduct is made pursuant to RSA 326-B:37, II, what if any disciplinary action the Board should take in accordance with RSA 326-B:37, III and/or RSA 310:12.

NOH at II.(c).

The Board then heard evidence related to these inquiries as summarized below.

HEARING COUNSEL'S CASE-IN-CHIEF:

Emily Perron:

Ms. Perron testified she has been employed at the Pines of New Market ("Pines") for a total of seven years—the last two as a caregiver. She stated the Licensee was a fellow staff member with her at the Pines for approximately two years. According to her testimony, she worked a 6:00 AM EST to 2:00 PM EST shift with the Licensee on 08/13/22. She described the Licensee as being "confused, disoriented, and sloppy", as well as "fumbling" her words and "stumbling" during that shift. Ms. Perron clarified that the Licensee's behavior during that shift was not typical of her normal behavior. She explained that the Licensee was normally "put together" and a "really good nurse." The Licensee's testimony also revealed

that during the shift the Licensee had provided morning medications for some residents late and failed to provide morning medication for other residents altogether. Ms. Perron explained that she and a coworker had discovered the undispensed resident medications in a trash can at the Pines, and which are shown in Exhibit 15. Ms. Perron also noted that the Licensee had been drinking out of a water bottle during the shift in question. According to her testimony, Ms. Perron opened the Licensee's bottle and smelled it, and, because it smelled like alcohol, she gave it to supervisors on staff.

Ms. Perron also described an incident involving the Licensee's car that occurred during the work shift in question. According to her testimony, the Licensee's car looked normal around 10:00 AM. She explained; however, that the Licensee took a break around 11:00 AM. She stated that when the Licensee returned from her break, the front left side of her car was smashed. Additionally, she noted that the car was parked partially in a parking spot and partially on a curb. Ms. Perron testified that in response to this event, she and another staff member of the Pines called the Newmarket Police, which came and questioned them about the Licensee. Ms. Perron said that by the time the police arrived the Licensee was "more confused and sloppy" then when she had come in for her shift the morning.

Jennifer Roy:

Ms. Roy testified that she is a supervisor for Merrill Gardens, which owns the Pines. She stated that on 08/13/22 at approximately 1:00 PM EST she received a call from a staff member at the Pines, informing her that the Licensee was acting unusual. According to her testimony, the staff member had also described much of the circumstances noted in Ms. Perron's testimony, including that staff had found medication the Licensee should have administered to patients in the trash can and the Licensee had crashed her car. Ms. Roy explained that she went to the Pines and observed both the Licensee's damaged car and the Licensee stumbling, unable to finish sentences, and acting confused. She described this behavior as abnormal for the Licensee. Ms. Roy also noted that she smelled and observed the water bottle described by Ms. Perron in her testimony. She testified the contents looked and smelled like white wine. Ms. Roy

also provided clarification that the Licensee had thrown out approximately 30 residents' morning medications and the facility had 36 to 38 total patients at that time.

Ms. Roy also described the process of bringing the Licensee back to her home from the Pines. She stated that the Licensee was stumbling from her car[2] and could barely get out when they arrived at her residence. Ms. Roy testified that she later received a telephone call from the Newmarket police asking that she bring the Licensee to the police station for booking on an outstanding bench warrant. Ms. Roy's testimony revealed that she returned to the Licensee's house and brought her to the police station. She described the Licensee as "confused" and "slouched" during the ride. Lastly, the Licensee described an instance where she brought the Licensee to Convenient MD for a drug test, which was required by work policy in response to the incidents involving the Licensee. Ms. Roy stated that the Licensee told her she was refusing to take the test because she had taken tramadol. She explained that the Licensee was terminated from employment.

Michael Porter:

The Board took administrative notice of Michael Porter, OPLC Division of Enforcement Bureau Chief Investigator's training, experience, and qualifications. Mr. Porter testified that OPLC had received a complaint involving the Licensee on 08/16/22. According to his testimony, OPLC Enforcement sought, and the Board granted, a request for an emergency suspension of the Licensee's license, given the Licensee's alleged conduct on 08/13/22 and further information obtained during an initial investigation. Mr. Porter explained that the Newmarket police records show that the police had to release the Licensee into the custody of someone else due to her level of intoxication. He also said that he had spoken to member(s) of the police department, who confirmed this information. Lastly, Mr. Porter reviewed the

[2] Ms. Roy drove her home.

Licensee's disciplinary history, which involves multiple instances of previous Board discipline for diversion.

LICENSEE'S CASE-IN-CHIEF:

None.

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

Based upon the evidence that was presented to the Board at the hearing, and considering the presentation and demeanor of all the witness, the Board makes the following findings of facts:

1. On August 13, 2022, the Licensee was engaged in practice as a Registered Nurse while working between 6:00 A.M. and 2:00 P.M. at the Pines of Newmarket.

2. The Licensee was consuming alcohol and intoxicated while engaged in practice as demonstrated by her erratic behavior, by staff observing her drinking from a Vitamin Water bottle that staff members, including Emily Perron, later smelled and found to contain alcohol, by her leaving the facility during her shift and returning with a damaged car that was improperly parked, and by the Newmarket Police requiring her release later that day to the custody of Jennifer Roy due to the Licensee's level of impairment.

3. The Licensee failed to dispense medications to residents during her shift as demonstrated by a medication audit that found multiple errors and by staff observing undispensed medication having been placed in a trash can.

4. The Licensee's disciplinary history is as follows:

    a. In 1999, the Licensee executed a Settlement Agreement related to diversion of Dilaudid for personal use. Her license was suspended for one year.

    b. In 2000, the Board reinstated her license with significant supervision conditions.

    c. In 2006, the Licensee voluntarily surrendered her license to resolve allegations that she falsified health care records pertaining to controlled drugs and diverted controlled drugs, among other violations.

    d. In 2007, the Board reinstated her license and placed the Licensee on probation for two years with significant supervision conditions to begin once the Licensee became employed as a nurse.

    e. In 2016, the Licensee gained employment as a nurse.

    f. In 2018, the Licensee moved the Board to lift her probationary restrictions. The Board granted that motion on July 20, 2018.

g. On August 19, 2022, the Board emergently suspended the Licensee's license to practice following the events at question in this proceeding.

h. On August 25, 2022, following a hearing where the Licensee failed to appear, the Board voted to sustain the emergency suspension of the Licensee's license pending the outcome of this proceeding.

11/13/23 Hearing Counsel's Proposed Findings of Fact and Conclusions of Law, and Recommended Sanctions, paragraphs 1-4.

Based upon the findings of fact made by the Board, the Presiding Officer makes and adopts the following conclusions of law and renders the following legal opinions:

1. The Licensee has committed professional misconduct by violating RSA 326-B:37, II(e) by demonstrating a willful or careless disregard for the health or safety of a client by consuming alcohol and being intoxicated while working as a licensee, and by failing to dispense medication to residents.

2. The Licensee has committed professional misconduct by violating RSA 326-B:37, II(g) by demonstrating a failure or inability to perform nursing or nursing assistant practice as defined in this chapter, with reasonable skill and safety by consuming alcohol and being intoxicated while working as a licensee, and by failing to dispense medication to residents.

3. The Licensee has committed professional misconduct by violating RSA 326-B:37, II(k) by engaging in nursing practice that may create unnecessary danger to a client's life, health, or safety by consuming alcohol and being intoxicated while working as a licensee, and by failing to dispense medication to residents.

4. The Licensee has committed professional misconduct by violating RSA 326-B:37, II(h) by departing from or failing to conform to nursing standards by consuming alcohol and being intoxicated while working as a licensee, and by failing to dispense medication to residents.

5. The Licensee has committed professional misconduct by violating RSA 326-B:37, II(l) by demonstrating an inability to practice safely, including demonstration of actual or potential inability to practice nursing with reasonable skill and safety to clients by reason of illness or as a result of any mental or physical condition by consuming alcohol and being intoxicated while working as a licensee, and by failing to dispense medication to residents.

6. The Licensee has committed professional misconduct by violating RSA 326-B:37, II(p)(1) by using alcoholic beverages to an extent or in a manner dangerous or injurious to herself, any other person, or the public, or to the extent that such use may impaired her ability to conduct with safety to the public the practice of nursing by consuming alcohol and being intoxicated while working as a licensee, and by failing to dispense medication to residents.

7. The Licensee has committed professional misconduct by violating RSA 326-B:37, II(q)(2) and Nur 402.04(17) by engaging in a pattern of behavior consisting of more than one incident of professional misconduct that is incompatible with the standards of practice by consuming alcohol and being intoxicated while working as a licensee, and by failing to dispense medication to residents.

8. The Licensee has committed professional misconduct by violating RSA 326-B:37, II(q)(2) and Nur 501.03(a) by failing to hold the health and safety of clients to be of first consideration and render to each client the full measure of her ability as an essential health care provider by consuming alcohol and being intoxicated while working as a licensee, and by failing to dispense medication to residents.

9. Pursuant to Plc Rule 206.24, Hearing Counsel has proven all elements of the misconduct found above by clear and convincing evidence.

Upon a finding of misconduct made pursuant to RSA 326-B:37, II, by clear and convincing evidence, the Board imposes the following disciplinary action against the Licensee pursuant to RSA 310:12(c):

1. The Licensee's license is **REVOKED**.

VI. CONCLUSION AND DECISION:

Pursuant to RSA 310:10, RSA 310:12, and RSA 326-B:37, the Presiding Officer and Board hereby makes the herein findings of professional misconduct and **REVOKES** the Licensee's New Hampshire Registered Nurse license **# 044076-21**.

DATED: 11/17/2023

___/s/ Nikolas K. Frye, Presiding Officer_____
Presiding Officer
New Hampshire Office of
Professional Licensure & Certification
7 Eagle Square
Concord, NH 03301