STATE OF NEW HAMPSHIRE
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

_____

BOARD OF VETERINARY MEDICINE

In Re: Kellyann Haydon, DVM

Vet. License # 1490

Docket No.: 23-VET-004

FINAL DECISION AND ORDER – 07/19/23

I. PARTICIPANTS:

Board Members:

Winifred G. Krogman, Board President and Member
Jill Patronagio, Board Vice President and Member
Robyn Eldridge, Board Member
Stephen K. Crawford, Board Member (Left early and did not participate in deliberation)
Elaine Forst, Board Member

Board Support Staff and Board Counsel:

Traci Weber, OPLC Board Administrator
Attorney Rahkiya Medley, OPLC Board Counsel

Presiding Officer:

Attorney Nikolas Frye, OPLC Hearings Examiner

Parties:

Attorney Collin Phillips, Hearing Counsel
Laura Thompson, OPLC Enforcement Intern, 3L, and Hearing Counsel
Attorney Laura Devine, Counsel for Licensee
Kellyann Haydon, Licensee

II. CASE SUMMARY/PROCEDURAL HISTORY:

On or about 01/25/19 the New Hampshire Board of Veterinary Medicine ("Board") received a complaint alleging that Kellyann Haydon, DVM ("Licensee") had not offered blood pressure evaluations and failed to recognize hypertension, which led to retinal detachment, blindness, and suffering in one cat and a similar condition and suffering in another cat. Further investigation by the Board and OPLC-Enforcement found potential violations of N.H. Admin. R. Ann., Title Vet, Part 701.01 relating to alleged failures in the documentation of an exam, assessment, and plan. On 04/19/23 the Board voted to initiate an adjudicative proceeding in this matter. This Final Order and Decision follows.

III. SUMMARY OF THE PROPOSED EVIDENCE AND EVIDENTIARY RULINGS:

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

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

Exhibit 1	Report of Investigation	Pg. 001 – 005
Exhibit 2	Complaint	Pg. 006 - 015
Exhibit 3	Response	Pg. 016 - 022
Exhibit 4	Banfield Pet Hospital Records	Pg. 023 - 152
Exhibit 5	Banfield Wellness Plans, 2018: Tiffy & Meagan	Pg. 153 - 164
Exhibit 6	Banfield Invoices, 2018 [Reserved for Rebuttal]	Pg. 165 - 223

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

A. Kellyann M. Haydon, DVM, Resume
B. Banfield Hospital Wellness plan contracts for Tiffy and Megan in effect in 2018;
C. Banfield Hospital website information regarding Wellness plans, including wellness plan video (Cat Plans https://www.banfield.com/en/products/optimum-wellness-plan/Cat-plans);
D. Cat Wellness plans;
E. Banfield Hospital medical veterinary records (Exhibits A and B to Respondent's Answer to Complaint); and
F. Emergency veterinary records for Tiffy.

C. Sworn testimony was received from:

1. Sonnya Dennis, DVM (called by Hearing Counsel)
2. Kellyann M. Haydon, DVM (called by Licensee)

3. Emily Rajaniemi, DVM (called by Licensee)

By agreement or previous orders, all proposed exhibits submitted by the parties were already fully admitted by the Presiding Officer. Exhibits 4, 5, 6, A, B, D, E, and F contain redactions agreed upon by the parties that remove personal identification information of individuals named in the documents. *See* RSA 91-A:5, IV. The parties were given leave to file post-hearing motions requesting other redactions in the admitted Exhibits pursuant to former RSA 310-A:1-m and/or RSA 310:12, eff. 07/01/23.

IV. BRIEF SUMMARY OF THE HEARING:

Board Member Claire Timbas, DVM recused herself before the hearing commenced. She sat separately from the Board and did not participate in ruling on the dispositive motions, questioning witnesses, or deliberation. At the outset of the hearing, the Board announced a non-recused quorum had voted to deny the Licensee's Motion to Dismiss but grant her Motion to Strike Issue Presented #3. Insofar as RSA 310:10, IV and VI, eff. 07/01/23 may apply to these Board decisions, the Presiding Officer concludes that the correct legal standard was applied.

HEARING COUNSEL'S CASE-IN-CHIEF:

Sonnya Dennis, DVM

Dr. Dennis began her testimony by describing her training and experience in veterinary medicine. She then focused her attention on her investigation into the matter, which included, among other things: 1) reviewing the 01/25/19 complaint filed with the Board about the Licensee's care of cats Tiffy and Megan (*See* Exh. 2); 2) obtaining and reviewing relevant medical records from Banfield Pet Hospital for Tiffy and Megan (*See* Exh. 4); 3) and obtaining and reviewing a response to the complaint from the Licensee (*See* Exh. 3), who treated Tiffy and Megan. Dr. Dennis' direct testimony also generally covered the contents of her investigative report and conclusions that 1) the Licensee failed to document an exam, assessment, and plan for Tiffy and 2) failed to recommend blood pressure measurements for Tiffy and Megan on multiple occasions, despite that being the appropriate standard of care. *See also* Exh. 1.

On cross examination, Dr. Dennis acknowledged that she had not spoken with the complainant or Licensee and had not obtained the wellness plans related to Tiffy and Megan. *See* Exh. 5. Nonetheless, she explained those investigative steps were not necessary for her to draw her investigative conclusions. Dr. Dennis also conceded that unlike the Licensee she had not worked in a corporate setting as a veterinarian. Nonetheless, she noted her extensive training and experience in both recordkeeping and the recordkeeping software used by veterinarians in the corporate setting.

Exhibits

In addition to the testimony of Sonnya Dennis and the previously referenced Exhibits 1-5, Hearing Counsel also offered Exhibit 6, which contains the invoices from 2018 for Megan and Tiffy's treatment.

LICENSEE'S CASE-IN-CHIEF:

Kellyann Hadyon, DVM, Licensee

The Licensee started her testimony by reviewing her credentials and background, which are summarized in Exh. A. She described Banfield Pet Hospital, where she treated Tiffy and Megan, as a very busy corporate setting that used petware software for medical records. Her testimony revealed that she left Banfield on good terms, not because of the 01/25/19 complaint involving Tiffy and Megan.

The Licensee's testimony also focused on the struggles she and others had with helping treat the complainant's pets, including Tiffy and Megan. She described the complainant as difficult in terms that indicated the complainant was sometimes belligerent in communication with Banfield staff, including the Licensee. The Licensee noted that the complainant had purchased wellness plans[1] for Tiffy and Megan through Banfield that were not suited for the geriatric needs of the animals, and constantly complained and declined recommended services (including blood pressure readings) due to additional costs involved. She testified the complainant had been advised that the wellness plans she purchased for Tiffy and Megan

[1] *See also* Exhs. B and C.

were insufficient for their needs. The Licensee's testimony also acknowledged: 1) the Licensee did not recommend a blood pressure assessment when Tiffy presented with two detached retinas; and 2) she did not properly document some medical records for Megan and Tiffy and "that is what got me here today".

Emily Rajaniemi, DVM

Dr. Rajaniemi briefly described her training and experience and that she had worked with the Licensee at Banfield Pet Hospital during the time of the 01/25/19 complaint. She confirmed the Licensee's testimony regarding the complainant's demeanor toward Banfield staff and the medical treatment the Licensee provided to Tiffy and Megan. She also explained how the petware recordkeeping software at Banfield worked.

Exhibits

In addition to the previously referenced Exhibits A – C, the Licensee also relied upon Exhibits D, E, and F. Exhibit D are the wellness plans offered by Banfield Pet Hospital. Exhibit E are Tiffy's and Megan's medical records for 2018. Exhibit F are the emergency medical records for Tiffy from the Veterinary Emergency Center Manchester.

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

After reviewing all the evidence and considering the presentation and demeanor of all the witnesses, the Board makes the following findings of facts:

1. The Board adopts Hearing Counsel's Proposed Findings of Fact contained in paragraphs 1-6, 8, 11, and 13-25:

    - At all times relevant, Kellyann Haydon ("Licensee") was a licensee of the Board having Veterinarian license #1490. *See* Board Licensing Records.

    - At all times relevant, Licensee worked as a veterinarian at Banfield Pet Hospital ("Banfield") located at 4 Cellu Dr., Nashua, NH 03063. *See* Exhibit 3 and Exhibit 4.

    - On 01/09/2018, Licensee conducted a certified physical examination of patient, Tiffy, a cat having a date of birth on 09/01/2000 with a medical history including hyperthyroidism and chronic renal failure. Licensee documented bodily evaluations as "Normal" with the

exception of two areas: "Body condition score – underweight" and "Oral/Nasal: tartar on Teeth – Found." *See* Exhibit 4, p. 25-29 and Exhibit 3, p. 17.

- In connection with the 01/09/2018 certified physical examination, Licensee did not document anything under the "Plan[Notes]" section under prognosis, client education, recheck, or follow-up. *See* Exhibit 4, p 28.

- The standard of care for a geriatric cat with renal disease, heart disease, and thyroid disease would reasonably require a blood pressure assessment to diagnose the common comorbidity of hypertension. *See* Exhibit 1, p. 4.

- During the 01/09/2018 physical examination, Licensee did not recommend a blood pressure assessment. *See* Exhibit 4, 25-29.

- On 02/18/2018, Licensee recorded discussing euthanasia with Client due to "renal disease, heart disease, and thyroid disease." *See* Exhibit 4, p. 39.

- Tiffy's medical records of [sic] do not contain any record of a follow-up discussion by Dr. Haydon concerning the Client request on 04/23/2018. *See* Exhibit 4.

- Tiffy's medical records do not contain any record of a follow-up review of thyroid values as requested by Client on 09/20/2018. *See* Exhibit 4.

- On 12/20/2018, Licensee conducted a certified physical examination of patient, Tiffy, where client expressed concern about cataracts and weight loss. Licensee diagnosed retinal detachment of both eyes. In addition, a heart murmur grade of 3/6 and cardiovascular issues were noted in "Abnormal findings." Licensee recommended Client euthanasia Tiffy. Client declined. Licensee did not recommend a blood pressure assessment. Licensee documented that the prognosis was "poor" and client education involved: "Exam findings. Owner refuses to euthanize Tiffy. Tiffy's quality of life is deteriorating." *See* Exhibit 4, p. 77-81.

- On 12/21/2019, Client asked Banfield to ask if a blood pressure assessment was performed on 12/20/2018. Dr. Rajaniemi responded, "[p]er Dr Em, no BP was done yesterday. If it was she would have been charged for it. Also, if [Licensee] had thought it was necessary she would have recommended it." *See* Exhibit 4, p. 83.

- The standard of care for a geriatric cat diagnosed with retinal detachment would reasonably require a recommendation of a blood pressure assessment to diagnose the common comorbidity of hypertension. *See* Exhibit 1, p. 4.

- Licensee never recommended a blood pressure assessment to Client for Tiffy. *See* Exhibit 4.

- On 12/25/2018, Client took Tiffy to Veterinariy Emergency Center of Manchester in Manchester, NH. Dr. Sara Junkin performed a physical examination. Dr. Junkin recorded the following:

a. "Per o RDVM has never checked BP." *See* Exhibit 4, p 151.
b. " 'A': DDX: Blindness R/O retinal detachment (secondary to hypertension)." *See* Exhibit 4, p 152.
c. " 'P' Disc'd w/o poss cause of blindness and recc begin w. baseline bloodwork to evaluate renal values and T4 level as well as obtain BP." *See* Exhibit 4, p 152.
d. "LAB: BP 248/167 MAP 206 226/169 MAP 195." *See* Exhibit 4, p 152.
e. "Disc'd results w/ o: adv of presence of hypertension (likely secondary to underlying renal dz) adv will start meds and ow will need to recheck BP w/ RDVM in 1-2 wks." *See* Exhibit 4, p 152.
f. "She should have her blood pressure rechecked in 1-2 weeks . . . Some (although not a large percentage) of cats can have a return of their vision with correction of hypertension." *See* Exhibit 4, p 152.

- Tiffy passed away in January 2019. *See* Exhibit 2, p. 12 and Exhibit 3, p. 17.

- On 02/08/2018, 03/11/2018, 07/09/2018, and 12/20/2018, Licensee conducted physical examinations of patient, Meagan, a cat having the date of birth on 12/11/2001 with a medical history including hyperthyroidism, chronic renal failure, and being overweight. Licensee did not recommend a blood pressure assessment during any of these physical examinations. *See* Exhibit 4, p. 86 – 149.

- In her formal response, Licensee states:

  a. "[Licensee] expressly denies any wrongdoing and states clearly and directly that any treatment performed or not performed with the Complainant's cats Tiffy … and Meagan … was within the standard of care." *See* Exhibit 3, p. 16-17.
  b. "The wellness plans are designed to help pets get regular checkups. Blood pressure monitoring is not part of the covered services under the wellness plan. There are indications in the vet records that the complainant had unreasonable expectations for her pet care given that it was a primary care facility." *See* Exhibit 3, p. 17.
  c. "The second and last time Dr. Haydon saw Tiffy was in December 2018 where she again did a full exam and blood work. There was nothing in this exam that indicated a need for a blood pressure test." Exhibit 3 at 18.
  d. "To the extent that Dr. Haydon did not take Tiffy's blood pressure it was because she did not feel that it would be beneficial to take the Complainant's money when Tiffy's other chronic problems were so advanced and monitoring her blood pressure would have minimal impact on her health." *See* Exhibit 3 at 18-19.

- Licensee established a Veterinarian Client Patient Relationship with Tiffy and Meagan.

- Licensee's medical judgment was influenced by the financial interests of the Client and the contract for the Wellness Plan.

- Licensee was negligent in failing to recommend blood pressure assessment in a [sic] geriatric cats, Tiffy and Meagan, with renal disease, heart disease, and thyroid disease.

- Licensee was negligent in failing to provide a plan of care for Tiffy related to treating diagnosed retinal detachment by failing to recommend a blood pressure assessment and/or recommending a plan of care for treatment.

Hearing Counsel's Proposed Findings of Fact 1-6, 8, 11, and 13-25.

2. The Board adopts Licensee's Proposed Findings of Fact contained in Paragraphs 1[2], 2-6, and 9-11:[3]

   - Kellyann M. Haydon, DVM, is a licensed veterinarian, licensed in the State of New Hampshire, State of New York, and Commonwealth of Massachusetts.

   - On January 20, 2019, Ms. Lynn Page made a Complaint to the Board concerning Dr. Haydon's care of her cats, while Dr. Haydon was working as Chief of Staff at Banfield Pet Hospital, Nashua, New Hampshire.

   - Dr. Haydon, through counsel, submitted a written response on April 29, 2019.[4]

   - On August 10, 2019, Dr. Sonnya Dennis completed a report of investigation ("ROI"), a copy of this ROI was not supplied to Dr. Hayden until June 5, 2023, through counsel.

   - At Banfield Pet Hospital, Veterinarians use a medical management software called Petware.

   - The Exhibits containing 2018 medical records for Megan and Tiffy are printouts of this Petware software.

   - On or about May 19, 2023, Dr. Haydon received the Notice of Adjudicatory Hearing, which outlined four issues presented, at the July 19, 2023, Adjudicatory Hearing.

   Licensee's Proposed Findings of Fact Paragraphs 1, 2-6, and 9-11.

3. The Board found the Licensee's testimony credible and weighted heavily her statements acknowledging that she did not recommend blood pressure assessment when Tiffy presented with two detached retinas.

---

[2] Insofar as this proposed finding of fact agrees with Hearing Counsel's Proposed Findings of Fact contained in Paragraph 1.

[3] Pursuant to RSA 310:12, the findings of facts contained in paragraphs 5 and 6 of Licensee's Proposed Findings of Fact are not included in this order verbatim. Those findings of fact also have no weight in determining whether the Licensee engaged in professional misconduct as contemplated in issues presented 1 and 2 of the notice of hearing. The Board also considered the proposed facts contained in paragraphs 12 and 13 in determining what if any sanctions were appropriate.

[4] The portion of the proposed finding of fact shown was adopted.

4. The Board found the Licensee's testimony credible and weighted heavily her statements acknowledging that she did not properly document medical records for both cats pursuant to Vet Rule 701.01.

5. The Licensee stated [sic] regarding her then practice of record keeping was "what got me here today." The Board considers this an admission of culpability as it relates to Issue #2.

6. Hearing Counsel's witness testified credibly that Licensee knowingly failed to provide all treatment plans of care to the client in order for the client to make an informed decision regarding her pets.

Based upon the findings of fact made by the Board, the Presiding Officer makes the following conclusions of law:

1. The Licensee engaged in professional misconduct as defined at RSA 332-B:14, II(c) and RSA 332-B:14, II(d) by negligently failing to provide the appropriate standard of care to one or more patients.

2. The Licensee engaged in professional misconduct as defined at RSA 332-B:14, II(p) by violating Vet Rule 701.01 when failing to document an exam, assessment, and plan for a patient.

3. Hearing Counsel and Licensee's proposed conclusions of law are adopted insofar as they are consistent with the Presiding Officer's conclusions of law. All others are denied.

Upon a conclusion of professional misconduct made pursuant to RSA 332-B:14, II and RSA 310:10, IV and VI, the Board imposes the following disciplinary action against the Licensee:

A. Pursuant to RSA 332-B:14, III(a), the Licensee is **REPRIMANDED**.

B. Pursuant to RSA 332-B:14, III(d), the Licensee shall participate in 18 hours of **CONTINUING EDUCATION** from an approved provider of continuing education or an approved program of continuing education as defined at Vet Rules 102.01(c) and (d) in the following areas: 6 hours in medical record keeping, 6 hours in client communication, and 6 hours in feline internal medicine. These hours shall be completed within 12 months of the signed date of this order. Such continuing education shall be in addition to the continuing education requirements for licensure. The Board, in its sole discretion, shall determine compliance with this provision by reviewing what the Licensee files with the Board Administrator to demonstrate completion of the required coursework.

C. Pursuant to RSA 332-G:11, the Board recommends affirmatively assessing the Licensee the **REASONABLE COST OF INVESTIGATION** and prosecution of this disciplinary proceeding in the amount of $1,000.00. The fine shall be paid within 60 days of the signed date of this order.

In imposing these sanctions, the Board applied the following mitigating factors pursuant to Vet Rules. 402.01, which were the existing rules at the time the misconduct occurred:[5]

i. Licensee's history of misconduct;

ii. Licensee's state of mind at the time of the offense;

iii. Licensee's acknowledgement of wrongdoing;

iv. Licensee's willingness to cooperate with the Board's investigation;

v. Potential of harm to public health and safety; and

vi. Nature and extent of the enforcement activities required of the board as a result of the offense.

VI. CONCLUSION AND DECISION:

Pursuant to RSA 310:10 and RSA 332-B:16, the Presiding Officer hereby makes the conclusions of professional misconducted noted herein and the Board administers the disciplinary sanctions outlined above.

DATED: 8/11/2023

___/s/ Nikolas K. Frye, Presiding Officer_____
Nikolas K. Frye, Presiding Officer - Authorized Representative of the Board of Veterinary Medicine-
New Hampshire Office of
Professional Licensure & Certification
7 Eagle Square
Concord, NH 03301
Office: 603-271-3825

[5] The parties agreed to apply the substantive laws and rules in place at the time of the alleged conduct when determining whether professional misconduct occurred and what if any sanctions to impose. *See* Prehearing Conference Order of 07/14/23. Based upon that agreement, the Presiding Officer, sua sponte, reconsiders his 07/28/23 Order on Hearing Counsel's Motion to Correct the Record and Licensee's Limited Objection to Hearing Counsel's Motion to Correct the Record. Prayer B of Hearing Counsel's Motion to Correct the record is DENIED because the rule he cited during the hearing was the rule in effect at the time of the alleged misconduct. Therefore, it was a correct rule to cite when determining admissibility of evidence in this proceeding. The relief sought in Licensee's Limited Objection to Hearing Counsel's Motion to Correct the Record is therefore GRANTED, but not for the reasons stated therein.