STATE OF NEW HAMPSHIRE
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

BOARD OF NURSING

In Re: Lynn Huggins, LPN
LPN Lic. # 016642-22

Docket No.: 23-NUR-050

NOTICE OF DECISION DATED 3/25/2024

Enclosed please find a copy of the Board's Order dated 3/25/2024 relative to:

DISCIPLINARY HEARING FINAL DECISION AND ORDER

PETITIONS FOR REHEARING:

Pursuant to N.H. Code Admin. Rs. Plc 206.31(b), 206.33 ("Rules") and RSA 310:14, II, petitions for rehearing shall be filed within 30 calendar days after service of a final adjudicative order. Pursuant to Rule 206.31(c) and (d), the Petition shall: 1) clearly identify the respondent, by name and license number, and the docket number of the matter for which the petition is being filed, for rehearing in a disciplinary or non-disciplinary remedial proceeding; 2) clearly state whether the petitioner is seeking to have the decision reversed or modified and, if modified, the specific modification(s) sought; 3) clearly identify the specific findings of fact or conclusions of law, or both, that the petitioner asserts are erroneous; 4) contain such argument in support of the petition as the petitioner desires to present, including an explanation of how substantial justice would be done by granting the relief requested; and 5) be served by the petitioner on all other participants in accordance with Plc 206.11. Pursuant to Rule 206.31(e), the petitioner or petitioner's representative shall sign the petition. Pursuant to Rule 206.31(f), such signature shall constitute attestation that: 1) the signer has read the petition for rehearing; 2) the signer is authorized to file the petition for rehearing; 3) to the best of the signer's knowledge, information, and belief, there are good grounds to support the petition for rehearing; and 4) the petition for rehearing has not been filed solely or primarily for purposes of delay or harassment in any pending or contemplated administrative, civil, or criminal proceeding. Pursuant to Rule 206.31(g), no answer to a petition for 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 petition for rehearing. Pursuant to RSA 541:5, upon the filing of such petition for rehearing, 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. The Presiding Officer and/or Board shall rule upon a Motion for Rehearing in accordance with Rule 206.32. Pursuant to Rule 206.32(e), a decision on reconsideration shall be issued after fully considering the petition and any responses thereto, which reconsideration shall include a hearing on the factual issues identified in the motion if the board determines a hearing to be necessary to a full consideration of the facts.

RIGHT TO APPEAL:

Pursuant to RSA 310:14, III, appeals from a decision on a petition for rehearing 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. *See also* Rule 206.33.

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FINAL DECISION AND ORDER – 02/22/24

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
Michele Melanson-Schmitt, Board Member
Huyen L. Fowler, Board Member

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

Presiding Officer:

Attorney Shane D. Goulet, OPLC Hearings Examiner and Presiding Officer

Parties:

Marissa Schuetz, Esq., OPLC Prosecutor and Hearing Counsel
John Vanacore, Esq., Counsel for the Licensee
Lynn Huggins, Respondent/ Licensee

II. 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"). A final hearing in this matter was held on 02/22/24. 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. Michael Porter Verified Petition for Emergency Suspension (Bates #HC001-014);
2. Heather Foster Complaint, dated November 9, 2023 (Bates #HC015-016);
3. Hanover Hill investigation report, statements, and resident records for JJ, dated November 9, 2023 (Bates #HC017-046); Note: Patient identifying information has been redacted as private medical information pursuant to RSA 91-A:5, IV.
4. Michelle Sousa and Michael Porter Report of Interview with Respondent, dated November 14, 2023 (Bates #HC047-049);
5. Michelle Sousa Report of Investigation, dated November 15, 2023 (Bates #HC050-054).

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

A. Medical News Today Article (Oxycodone)
B. OPLC Discovery (M.A.R. documentation)
C. MLADC Evaluation (SEALED) [1]

C. Sworn testimony was received from:

[1] The Licensee offered Exhibit C during the trial. Hearing Counsel highlighted the fact that the evaluation was not on a formal letterhead and questioned the veracity of the document. The Presiding Officer found the document to be relevant and material and the parties agreed to its admission.

1. Michael Porter, OPLC Investigations Bureau Chief
2. Heather Foster, DNS at Hanover Hill
3. Lynn Huggins, Respondent/ Licensee

The Presiding Officer fully admitted Exhibits 1-5 and A-C after reviewing them and determining they were material and relevant to the proceeding.

IV. CONDUCT OF THE HEARING AND EVIDENCE PRESENTED:

The Licensee appeared with Counsel for the final hearing in this matter. The hearing was 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 Board then heard evidence related to these inquiries as summarized below.

HEARING COUNSEL'S CASE-IN-CHIEF:

Heather Foster:

Ms. Foster was sworn in under oath and testified that she is the Director of Nursing Services for Hanover Hill (the "Facility"). Prior to that she served as the staff development coordinator for the Facility and has known the Respondent for approximately two years. Ms. Foster stated that the Respondent is no longer employed at the Facility. Respondent was discharged from the Facilities after their internal investigation concluded. Ms. Foster acknowledged that prior to the "incident" which gave rise to the Respondents termination, she had no concerns regarding the Respondent or her performance at the Facility.

Ms. Foster testified that on November 9, 2023, the nurse manager for Respondent's unit, Cameron Canney, presented her with what appeared to be a pattern of concerning narcotic administration documentation involving the Respondent and three of her patients. The pattern allegedly evidenced that the Respondent had been prescribing narcotics to three separate residents when other providers were not.

Upon further review, Ms. Foster identified one specific resident was being given Oxycodone IR exclusively by the Respondent during her shifts and not by other providers. Ms. Foster testified that the Facility did a comprehensive review of the medical records for all the residents Respondent had cared for. The records were inconsistent. However, the medication counts were never off. Ms. Foster testified that she brought the Respondent to her office and discussed the concerns regarding the alleged inconsistencies. The Respondent was asked to submit to a urine drug screen and consented but was never able to provide a sample. Ms. Foster testified that the Respondent wanted to leave the Facility but was not permitted to do so. The Respondent was permitted to sit in the lobby supervised. While the Respondent was sitting in the lobby, she texted another Facility nurse (A.C.) seeking assistance in providing a urine sample on her behalf. *See Exhibit 2 pg. 27*. The Respondent ultimately left the Facility without providing a urine sample. Ms. Foster testified that A.C. immediately approached her after the Respondent left the Facility and provided her a copy of the text messages she received from the Respondent. *See Exhibit 2 pg. 27*.

Ms. Foster testified that she spoke to three of the residents who were receiving pain medication from the Respondent as part of the Facilities investigation. She represented two of the three residents had cognitive impairments which made conversation difficult. However, Resident J.J. revealed that she had not been provided Oxycodone IR in "quite some time." J.J. represented to Ms. Foster that she was provided Tylenol. J.J. consented to a drug test and the results showed that J.J.'s urine was negative for all drugs. Ms. Foster testified that a pain assessment was conducted every shift for every resident. She represented that staff documented before every administration of the pain medication and that the medications were not wasted. Resident J.J. gets out of bed approximately once a week and is completely dependent on staff for all repositioning and transferring. Ms. Foster opined that Resident J.J. had no ability to stockpile medication in her condition.

Upon cross examination Ms. Foster acknowledged that she has never had any concerns for Respondent's performance as a nurse. She represented that J.J.'s drug screen was taken at the Facility and completed at completed at Elliot Hospital. She acknowledged that the drug screen was never sent out for confirmation testing. Ms. Foster never discussed the text messages between A.C. with the Respondent.

Upon Board questioning, Ms. Foster represented that after receiving J.J.'s urine sample she followed the appropriate "chain of custody" and the sample was maintained in a locked room prior to the transfer to Elliot Hospital.

Michael Porter:

The Board took administrative notice of Michael Porter, OPLC Division of Enforcement Bureau Chief Investigator's background, training, experience, and qualifications as an investigator. Investigator Porter testified that OPLC had received a complaint involving the Licensee on 11/09/23. The OPLC Division of Enforcement sought, and the Board granted, a request for an emergency suspension of the Licensee's license, given the Licensee's alleged conduct on 11/09/23 and further information obtained during an initial investigation regarding alleged diversion of narcotic medication by the Respondent. Inspector Porter testified that his primary role in the investigation was to assist Investigator Michelle Sousa because it was one of her first cases.

Investigator Porter testified that Ms. Huggins was interviewed by the Division of Enforcement. He represented that after the interview concluded the Division received additional information from the Facility which he contends contradicted some of Ms. Huggins answers. Specifically, the text messages between A.C. and Respondent reflect that the Respondent initiated the text communication. Investigator Porter opined that the Respondent was less than forthcoming during her interview as it related to her interactions with A.C. while she was waiting in the lobby.

Investigator Porter stated that the Respondent provided the Division with a pre-employment drug screen taken on 11/10/2023. *See Exhibit 3 pg. 46*. Investigator Porter acknowledged that the test produced a negative result but highlighted that the drug screen taken by the Respondent did not test for benzodiazepines. Investigator Porter concluded by praising the Facility's investigation of the Respondent as both thorough and complete.

LICENSEE'S CASE-IN-CHIEF:

Lynne Huggins:

The Respondent was sworn in under oath and testified that she has been providing care for others since she was 16 years old. The Respondent testified that she began working as a "float" when she became employed by the Facility approximately 2 years ago. She was ultimately assigned to the unit where resident J.J. was lodged. She provided for J.J.'s personal care, medications, dressing changes, and anything else that she needed for approximately the last 6 or 7 months. The Respondent testified that she provided resident J.J. with her daily medications, including PRN Oxycodone. The Oxycodone medication was provided to resident J.J. in a cup along with the rest of her daily medications. The Respondent testified that J.J. regularly required Oxycodone PRN prior to receiving a dressing change. The Oxycodone PRN was administered to J.J. prior to her dressing change in attempt to alleviate J.J's obvious pain and discomfort during the procedure. J.J. suffered from a persistent wound on her right buttocks which necessitated a dressing change daily. Respondent testified that her unit manager, Cameron Canney, was aware that she was premedicating J.J. with Oxycodone. prior to the dressing change regularly.

The Respondent testified that she first became aware of the allegations against her on 11/9/2023. The unit manager, Ms. Cameron explained to the Respondent her suspicions regarding the pattern involved in administering Oxycodone PRN to 3 separate residents. The Respondent explained to Ms.

Canney the reasons why she administered the Oxycodone to the 3 residents. The Respondent consented to a urine drug screen which she was unable to complete.

The Respondent acknowledged sending the text messages to A.C, which she opined was "stupid and worthy of punishment." She testified that never took any Oxycodone and she opined that the drug test she took on 11/10/2024 reflects that. The Respondent acknowledged that she was both talking and texting A.C. while she was sitting in the lobby. Respondent admitted that she uses THC edibles a couple times a week to help her sleep. She referenced that the Ativan referenced in her text messages to A.C. was an in error and was a result of the auto-correct feature on her phones texting application. The Respondent testified that she meant to text "a THC" rather than Ativan. Respondent testified that she never took Ativan but was concerned that the drug test would evidence her use of THC edibles.

The Respondent testified that after leaving the Facility on 11/9/2024 she reached out to Dr. Molly Rossignol at New Hampshire Professional Health Program. She recalled speaking to Dr. Rossignol and someone names Pete. The Respondent requested to submit to a drug screen which only evidenced alcohol use. The Respondent was referred to a MLADC and followed through on her appointments.

Upon cross-examination the Respondent testified that she consistently discussed pain levels with residents prior to providing them with PRN medications. The Respondent acknowledged that she does not always view the Resident swallow the medication.

Upon Board questioning the Respondent admitted that she uses THC edibles but does not hold a medical marijuana card. The Respondent clarified that she was merely assessing J.J.'s pain level when determining whether to provide the Oxycodone PRN which was authorized by a physician's order, "as needed for pain", which permitted multiple administrations per day. The Respondent never gave multiple administrations. The Respondent testified that J.J. is a double amputee with an above the knee amputation who is consistently in pain. The Oxycodone PRN greatly reduced J.J.'s discomfort.

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. 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. The Respondent documented administering oxycodone to three patients in a manner inconsistent with other nurses who were caring for those same patients.

4. On 11/9/2023, the Facility filed a complaint with the Division of Enforcement alleging possible diversion of controlled substance, Oxycodone, by the Respondent.

5. The Respondent initially agreed to a drug screen at the Facility but ultimately walked out prior to providing a urine sample for the drug test.

6. The Respondent requested by text another nurse provide a urine sample for the Respondent at the Facility.

7. On or about 11/9/2023, Cameron Canney a Nurse Manager at the Facility, detected what appeared to be suspicious controlled substance pain medication administration by the Respondent, initially, to one resident, A.I. The Facility initiated an internal investigation on 11/9/2023. 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.

8. The three identified residents were consistently being cared for by the Respondent.

9. 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.

10. On 11/9/2023 at approximately 12:15 PM, as the investigation began to unfold, the Respondent was approached by investigating staff and requested to provide a urine sample. The Respondent initially agreed to provide a sample and signed a consent form to do so. The Respondent informed investigating staff that she is unable to go to the bathroom as

she just went to the bathroom during lunch. The Facility staff offered the Respondent water and she accepted.

11. The Respondent then requested to leave the Facility and go to her car or go to the unit to finish her water. The Respondent was informed she was not able to go to the unit nor was she allowed to go to her car at this time. The Respondent requested to go to the lobby to finish her water and she was allowed to do so while under supervision. The Respondent was informed she was not allowed to leave the lobby and go onto the unit unless accompanied by the DNS.

12. The Respondent left the building at 1:00 PM without ever providing the required urine sample.

13. The Facility investigation notes two of the three identified residents suffer from cognitive impairment and were not reliable reporters. 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.

14. According to documentation provided by the Facility, Resident J.J. was provided 18 doses of Oxy IR 5mg in the month of October 2023.

15. A review of records indicates the order for Oxy IR, 5mg, PRN, began on or about 10/18/2023. According to records provided by the Facility, the Respondent did not work between 11/1/2023 and 11/5/2023. 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.

16. 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.

17. When the Division 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.

18. 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.

19. On 11/10/2023, resident J.J. agreed to provide a urine sample for a drug screen. On 1/10/2023, at approximately 2:20 PM, a specimen was collected. The Facility followed the standard chain of custody for urine collection and testing. 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. 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.

23. On 11/14/23 the Respondent attended an interview with Investigators of the Division of Enforcement.

24. During the interview and during the testimony provided at the hearing, the Respondent provided inconsistent statements between her interview and the statements and evidence provided by the investigation.

25. For example, the Respondent stated in the interview that A.C. reached out to her to check how she was doing, but the text messages supplied by A.C. reflect that the Respondent initiated the text conversation and asked A.C. to provide a urine sample.

26. Additionally, in the text message string the Division received between the Respondent and LPN Colvin; the Respondent admits to using Ativan that the Respondent does not have a prescription for. Yet, the Respondent testified that "Ativan" was an error by autocorrect. She had intended to type "a THC" but it was autocorrected to "Ativan." This is further problematic because no prescription for THC exists; it is a medical marijuana card that permits therapeutic consumption of marijuana. The Respondent does not have a medical marijuana card.

27. Further, when questioned about why she left the facility without giving a urine sample, she indicated she did not want to test positive for THC and lose her job as a result. The facility policy, which the Respondent received and signed that she understood, showed that the drug screen she would be submitting to would not test for THC. She knew or should have known that she was not in danger of being terminated for using THC.

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 not committed professional misconduct by violating RSA 326-B:37, II(e), (h)(1), (k), (n), and/or (p)(2). The Board's findings do not reflect that the Licensee diverted a controlled substance under the guise that it was for one or more of her patients and repurposed the controlled substance for some other use.

2. The Licensee has committed professional misconduct by violating RSA 326-B:37, II (h)(1), (k), and/or (p)(2) where, while she was working as an LPN at Hanover Hill Health Care Center, she

allegedly documented administration of a controlled substance to one or more of her patients and failed to administer said medication.

3. Pursuant to Plc Rule 206.24, Hearing Counsel has proven all elements of the misconduct found above by a preponderance of the evidence.

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

1. The Respondent's license is hereby subject to a (3) year probationary period. The Respondent shall submit to a formal consult and treatment plan with N.H. PHP within (45) days from the date of this final order. The treatment plan shall be submitted to the Board. The Licensee shall follow the treatment plan which shall be subject to Board review. The Respondent shall appear before the Board for a hearing prior to the expiration of her probationary period.
2. The Licensee shall engage in (6) hours of continuing education as follows: (2) hours in ethics, (2) hours in medication administration, and (2) hours in pain assessment. This continuing education shall be in addition to her regular biennial requirements required for renewal.

VI. CONCLUSION AND DECISION:

Pursuant to RSA 310:10, RSA 310:12, and RSA 326-B:37, the Presiding Officer and Board hereby make the finding of professional misconduct and further **REINSTATE** the Respondent's License as a N.H. LPN subject to the sanctions listed above.

DATED: 3/25/2024

___/s/ Shane D. Goulet, Presiding Officer_____
Administrative Law Judge
New Hampshire Office of
Professional Licensure & Certification
7 Eagle Square
Concord, NH 03301