STATE OF NEW HAMPSHIRE
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

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BOARD OF NURSING

In Re: Jeanne Uwamungu, LPN
LPN Lic. #013776-22

Docket No.: 2022-NUR-018

ORDER ON EMERGENCY LICENSE SUSPENSION HEARING- 07/12/22

I. ATTENDEES:

Samantha O'Neill, Board Chair
Joni Menard, Vice Chair
Melissa Underhill, Board Member
Matthew Kitsis, Board Member
Maureen Murtaugh, Board Member
Gene Harkless, Board Member
Wendy Stanley Jones, Board Member
Michele Melanson-Schmitt, Board Member
Melissa Tuttle, Board Member
Attorney Michael Haley, DOJ Board Counsel
Ashley Czechowicz, OPLC Board Administrator
Jeanne Uwamungu, Licensee (unrepresented)
Attorney Nikolas K. Frye, OPLC Hearings Examiner and Presiding Officer
Attorney John Garrigan, OPLC Chief Prosecutor and Hearing Counsel
Karen Belair, OPLC Investigator
Eric Goulet, OPLC Investigative Paralegal
Michael Porter, OPLC Chief Administrative Investigator

II. CASE SUMMARY/PROCEDURAL HISTORY:

On or about 06/29/22, the Office of Professional Licensure and Certification, Division of Enforcement ("OPLC Enforcement"), acting on behalf of the Board of Nursing ("Board"), received a complaint alleging Jeanne Uwamungu ("Licensee") had been diverting controlled substances from Premier Rehab and Healthcare in Nashua, New Hampshire between 10/31/21 and 06/19/22. On 07/01/22,

after learning of the complaint and details of OPLC Enforcement's investigation into the matter, the Board held an emergency meeting at which it voted to suspend Licensee's license on an emergency basis pursuant to RSA 541-A:30(III), RSA 326-B:37(IV), and N.H. Code Admin. R., Title Nur 402.03(a) ("Rules"). The Board held the hearing on the emergency license suspension on 07/12/22. This 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 submitted by Hearing Counsel, labeled as follows:

1. Michael Porter Verified Petition for Emergency Temporary Suspension, dated 07/01/22
2. Complaint, dated 06/29/22
3. Michael Porter Email to Respondent, dated 06/30/22
4. Karen Belair Confidential Memorandum, dated 07/01/22
5. Respondent's Work Times and Locations from 07/30/21 through 06/25/22
6. Intelycare Internal Investigation Notes
7. Premier Summary of Respondents Recorded Drug Loss from 10/30/21 through 06/19/22
8. Premier Patient Records Supporting Exhibit 7 Summary (Redacted)

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

The Licensee submitted no exhibits.

C. Sworn testimony was received from the following witnesses:

1. Karen Belair (called by Hearing Counsel)
2. Eric Goulet (called by Hearing Counsel)
3. Michael Porter (called by Hearing Counsel)
4. Jeanne Uwamungu, Licensee (called by Licensee)

VI. PRELIMINARY MATTERS:

The Presiding Officer reviewed Exhibits 1 through 8 with the Licensee. She had no objection to their relevance and materiality and did not claim they were unduly repetitious or privileged. The Presiding Officer determined Exhibits 1 through 8 were fully admissible and also explained how the adjudicatory hearing would proceed.

IV. CONDUCT OF HEARING AND EVIDENCE PRESENTED:

The Board's inquiry at this hearing is narrow. Pursuant to Rule 207.10, Hearing Counsel has the burden of proving, by a preponderance of the evidence, that the Licensee being licensed pending full adjudication of this matter poses an imminent danger to public health, safety, or welfare. RSA 326-B:37, IV. The credible evidence presented at the hearing allows the Board to find the following facts.

HEARING COUNSEL'S CASE-IN-CHIEF

Karen Belair

Karen Belair was the first witness for Hearing Counsel. She began by testifying that she is an investigative paralegal with OPLC, who has been assisting in the investigation into the 06/29/22 complaint involving Licensee. She explained the complaint, Exh. 2., came from Premier Nursing Home ("Nursing Home") in Nashua, New Hampshire where the Licensee was working before she was emergently suspended. Investigator Belair's testimony and Exhibit 2 show that the Nursing Home had recently completed an audit of its narcotic documentation and discovered a pattern of discrepancies pertaining to the Licensee's practice. According to Exhibit 2, between 10/31/21 and 06/19/22 the Licensee documented 110 pills as "dropped" or "wasted" in the Nursing Home's controlled substance log. Additionally, the complaint alleges the Nursing Home's documentation showed that 1) the times that the Licensee removed medication from the controlled substance log ("CSL") did not always match the times in the Medication Administration Record; 2) many of the Licensee's CSL entries for removal of controlled substances were missing dates and times; 3) several of the Licensee's entries for removal of narcotics were overwritten; and 4) some of the Licensee's entries showed that she had removed more than the prescribed dose of a narcotic on three occasions.

Investigator Belair's testimony then shifted to how she responded to the complaint. She stated that she contacted the Nursing Home by telephone and spoke with the Nursing Home administrator, the

director of nursing, and an individual from social services. *See also* Exh. 4. Investigator Belair testified that during this telephone interview, she learned the narcotics involved were Oxycodone, Oxycontin, Hydrocodone, Percocet, Klonopin, Tramadol, Morphine, and Ativan. According to Investigator Belair's testimony, these individuals also shared with her some of the Nursing Home's controlled substance policies and procedures, including that it is uses a manual CSL. Investigator Belair explained that after the interview, the Nursing Home provided her with a copy of the patient records upon which it had based the 06/29/22 complaint it filed against the Licensee, *see* Exh. 8, as well as a summary of the issues noted in the records that it had compiled. *See* Exh. 7.

Investigator Belair next described the patient records and summary she had received from the Nursing Home. She explained that Exhibit 8 was voluminous, and she had not reviewed it in its entirety. Nonetheless, she stated she had begun comparing its contents to the summary provided by the Nursing Home. She testified that her review of Exhibit 8 thus far corroborates the summary provided by the Nursing Home in Exhibit 7. According to her testimony, her review of the documentation thus far shows some noticeable trends. She testified that the most common explanations for discrepancies provided by the Licensee was "popped in error" and "wasted". She stated Exhibit 7 showed there were 83 instances of discrepancies involving the Licensee's documentation.

Cross and Board Examination of the witness revealed additional information. Investigator Belair testified that she did not know how many medications the Licensee was administering at the Nursing Home on any given day. She explained that she did not know if there were other discrepancies at the Nursing Home that involved other staff and was unaware of what if any training the Licensee had received in relation to the Nursing Home's controlled substance policies and procedures. She clarified that OPLC was still investigating the matter.

Eric Goulet

Hearing Counsel's next witness was Eric Goulet, who started his testimony by explaining he is an investigative paralegal at OPLC assisting in the 06/29/22 complaint involving the Licensee. He testified that as part of his investigation, he had contacted IntelyCare, which is the nursing agency that had employed the Licensee and referred her to the various facilities at which she has been working in New Hampshire, including the Nursing Home. *See* Exh. 2. According to Investigator Goulet, IntelyCare provided him with a spreadsheet showing the various locations at which the Licensee has worked through the agency. *See* Exh. 5. Investigator Goulet explained the spreadsheet reveals the Licensee has worked at 8 or 9 different facilities in New Hampshire between 07/30/21 and 06/05/22 but has spent the majority of her employment at the Nursing Home. Mr. Goulet also referenced a note he had obtained from IntelyCare, relating to its internal investigation into the alleged conduct of the Licensee. He explained that the note indicates the Licensee responded to the discrepancy concern at the Nursing Home by stating she had previously forgotten to document a PRN but had spoken with the director of nursing and cleared everything up. The note shows the Licensee was reeducated on drug administration and understanding the events that had transpired. *See* Exh. 6. It also indicates that IntelyCare has placed her on hold pending the outcome of the investigation. Investigator Goulet clarified that the hold only applied to work the Licensee could obtain through IntelyCare.

On cross examination, Investigator Goulet agreed that Premier is the only facility where the Licensee has worked that has raised a concern about her medication administration. On Board questioning, Investigator Goulet agreed that the spreadsheet suggested the Licensee has worked at multiple facilities on the same day but noted he has been unable to confirm the accuracy of that information. He affirmed that the note, Exh. 6, came from IntelyCare, as opposed to the Nursing Home, but he could only speculate from which department it originated.

Michael Porter

Hearing Counsel's last witness was Michael Porter. He began his testimony by explaining he is the chief administrative investigator for OPLC and has worked on the investigation into the 06/29/22 complaint involving the Licensee. Investigator Porter's testimony was mostly limited to his efforts to communicate with the Licensee and her other employers. He explained that the paperwork supplied by IntelyCare indicated the Licensee worked for multiple other facilities, the Nursing Home had stated she was working for Corvel in Manchester, and the Board's MLO entry showed the Licensee working at Mount Carmel. His testimony revealed that Corvel had reported to OPLC that the Licensee last worked at its facility on 06/27/22 during a double-shift. Investigator Porter expressed he was about the allegations because the Licensee appeared to be working at multiple facilities and not returning his calls and emails. He testified that he had been unable to communicate with the Licensee until the hearing, despite his efforts to do so. He explained that one of the purposes of his communicating with her was to see whether she would be willing to participate in NHPHP.

Licensee

Licensee testified on her own behalf. She explained that she worked a lot during the COVID-19 pandemic and sometimes forgot to write down or record what she had done. She stated that she never used or took the medication noted in Nursing Home's records and discrepancies summary. She described herself as having been naïve— working at too many different facilities and taking on too many hours. Her testimony indicated that she undertook the additional shifts to help patients and the facilities and for additional income. The Licensee testified that she has been a nurse for 16 years and never had any issue before the pandemic. She explained that she sometimes was working 12 hours shifts back-to-back during the pandemic. She stated that she "thought I was helping them [patients and facilities]. I forgot my duty. I should not have done it."

On cross examination, she confirmed that the list provided by IntelyCare are the only locations where she works. Board examination of the witness revealed that she was "popping medications by mistake [from blister packs]" because she was doing too many things at one time. She noted she was sometimes confused about which medications were for whom because patients shared the same last name.[1] She described herself as clearly struggling but noted no one at the Nursing Home told her she was making mistakes.

The Licensee also mentioned her training in administering medications at the Nursing Home and the process used by the facility. She explained that she had not done a medication class while there and did not go through an orientation before starting the position. She said that the Nursing Home had given her paperwork to sign that related to policies and procedures for controlled substances. She was certain there was documentation at the Nursing Home that would show she wasted the medication and was cosigned. She was adamant that this showed she had not diverted medication. Lastly, the Licensee admitted that since the pandemic there are times when she goes home from a shift and is concerned with what she is doing. She mentioned that she had concerns for her mental health that she had tried to address by going to a doctor.

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

After reviewing all the evidence, and accounting for the presentation and demeanor of all the witnesses, the Board finds, by a preponderance of the evidence, that Hearing Counsel has met its burden of proof. Pursuant to Rule 402.03, Hearing Counsel has shown that Licensee's license should remain suspended on an emergency basis, pending disciplinary adjudication. Because the focus of this hearing is not on whether the Licensee committed misconduct and the investigation is ongoing, the Board's findings and conclusions of law are narrow. The Board finds and concludes the evidence presented shows that the

[1] The blister packs that she popped the pills out of have patients' last names on them.

Licensee poses an imminent danger to public health, safety, or welfare. RSA 326-B:37. Based upon the testimony of Investigator Porter and the Licensee, it does not appear as though the underlying cause of the Licensee's concerning behavior is being adequately addressed. The Board notes that the purpose of the NHPHP program, which Investigator Porter had previously offered to the Licensee, is to assist individuals who may have medical health issues that affect cognitive ability, mental health issues, and substance use disorders.

VI. CONCLUSION AND DECISION:

Pursuant to RSA 326-B:27(IV), Rule 402.03, the Board hereby upholds its emergency suspension of Jeanne Uwamungu's license as an LPN, pending a full adjudicatory disciplinary hearing in this matter. A Notice of Adjudicative Hearing with an appropriate date/time shall follow. The parties shall provide the Board Administrator with dates and times of availability for a prehearing conference to occur within 30 days of the signed date of this order.

DATED: 7/21/2022

___/s/ Nikolas K. Frye, Esq._____
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