

**STATE OF NEW HAMPSHIRE  
OFFICE OF PROFESSIONAL  
LICENSURE AND CERTIFICATION**

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**BOARD OF NURSING**

**In Re: Ruth Guin,  
RN Lic. # 068597-21**

**FINAL DECISION AND  
ORDER – 11/10/22**

Docket No.: 2022-NUR-041

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**I. ATTENDEES**

Samantha O'Neill, Board Chair  
Joni Menard, Vice Chair  
Melissa Tuttle, Board Member  
Melissa Underhill, Board Member  
Maureen Murtaugh, Board Member  
Dwayne Thibeault, Board Member  
Wendy Stanley Jones, Board Member  
Lauren Warner, Board Counsel  
Ashley Czechowicz, OPLC Board Administrator  
Attorney Collin Phillips, OPLC Hearing Counsel  
Attorney Nikolas K. Frye, OPLC Hearings Examiner and Presiding Officer  
Ruth Guin, Licensee

**II. CASE SUMMARY/PROCEDURAL HISTORY**

The Office of Professional Licensure and Certification, Division of Enforcement (“OPLC Enforcement”), acting on behalf of the Board of Nursing (“Board”), has received multiple allegations that between approximately August of 2022 through October of 2022 that nursing staff at Pleasant View Nursing Home in Concord, New Hampshire, while under the supervision of Ruth Guin (“Licensee”) have neglected some of its resident patients. Upon receipt of the allegations, OPLC Enforcement conducted an expedited investigation. On 10/27/22, the Board voted to suspend the Licensee’s license on an emergency basis pursuant RSA 541-A:30(III), RSA 310-A:1-m, RSA 326-B:37(IV), N.H. Code Admin. R., Title Nur

402.03(a) ("Rules"), and/or N.H. Code Admin. R., Title Plc 206.07 ("Plc"). The Board held an adjudicatory hearing in this matter on 11/10/22. This Final Decision and 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 filed by Hearing Counsel, numbered as follows:

1. 10/26/22 Complaint
2. 10/28/22 Confidential Memorandum of
3. 08/22/22 Concord Fire Dept. Report S.P.
4. 08/26/22 NH Adult Protective Services Report Form, S.P.
5. 08/30/22 Concord Fire Dept. Report T.C.
6. 08/30/22 NH Adult Protective Services Report Form T.C.
7. 10/12/22 NH Adult Protective Services Report Form T.C.
8. 10/10/22 Concord Fire Dept. Report E.S.
9. 10/11/22 NH Adult Protective Services Report Form E.C.
10. 10/06/22 Concord Fire Dept. Report Patient T.C.
11. 11/02/22 Interview with Adam Morris, S.P. **NOT PROVIDED TO BOARD**
12. 11/02/22 Interview with Adam Morris, T.C. **NOT PROVIDED TO BOARD**
13. 11/03/22 Interview with Ian Gill **NOT PROVIDED TO BOARD**
14. 11/03/22 Interview with Samuel Atkins **NOT PROVIDED TO BOARD**
15. 11/02/22 Interview with Ryan Baron, E.S. **NOT PROVIDED TO BOARD**
16. 11/06/22 Interview with Kim and Ken Pierce **NOT PROVIDED TO BOARD**
17. 10/22/22 Photograph of S.P.'s foot
18. 11/04/22 Interview with Ann Currier **NOT PROVIDED TO BOARD**
19. 11/04/22 Interview with E.S. **NOT PROVIDED TO BOARD**<sup>1</sup>
20. 02/24/22 DHHS CMS Statement of Deficiencies and Plan of Correction
21. 07/29/22 DHHS CMS Statement of Deficiencies and Plan of Correction
22. 09/14/22 DHHS CMS Statement of Deficiencies and Plan of Correction

b. Exhibits were filed by Licensee, numbered as follows:

- A. Resume of Ruth Guin, RN
- B. CV of Gary A. Sobelson, M.D.
- C. Resume of Misty C. Hackett, RN, LNHA
- D. 09/20/22 and 10/07/22 Letters of Compliance from the NH DHHS
- E. Pleasant View Center Medical Records for S.P. **REDACTED**<sup>2</sup>

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<sup>1</sup> The parties orally requested the Board lift the emergency suspension order. Since the Presiding Officer never resolved the dispute over these exhibits, they were not presented to or considered by the Board in deciding the oral motion. The Licensee's Motions to exclude are therefore denied as MOOT.

<sup>2</sup> The Presiding Officer finds the redacted portions of Exhibits E-G are appropriate because they protect personal identification information of patients of the Nursing Home.

- F. Pleasant View Center Medical Records for T.C. **REDACTED**
- G. Pleasant View Center Medical Records for Patient E.S. **REDACTED**
- H. NH DHHS Survey Grid

c. Sworn testimony was received from:

1. Michael Porter, Investigative Bureau Chief at OPLC (Through offer of proof and questioning)
2. Licensee (Through offer of proof and questioning)

All exhibits except 11-16 and 18-19 were considered by the Board.

#### **IV. CONDUCT OF THE HEARING AND EVIDENCE PRESENTED**

At the outset of the scheduled adjudicatory hearing, the parties jointly moved the Board to lift the emergency suspension of the Licensee’s license. Hearing Counsel and the Licensee presented brief offers of proof as to why the Board should lift the suspension—namely that Hearing Counsel learned on the day of the hearing that the Licensee was not serving as director of nursing at Pleasant View Nursing Home in Concord, New Hampshire (“Nursing Home”) for two out of three of the alleged incidents that had resulted in the emergency suspension of her license. Hearing Counsel explained that OPLC Investigator Michael Porter had relied on a representation in the Licensee’s LinkedIn profile that she had been working at the Nursing Home since “September of 2022” when requesting the Board consider an emergency suspension of her license on 10/27/22.<sup>3</sup>

After hearing from the parties, the Board determined it desired additional information before ruling on the oral motion. Investigator Porter responded to Board questioning first by providing greater clarity as to when the incidents at the Nursing Home occurred and how and when they were reported to OPLC. He testified the first incident occurred on 08/22/22 and was first reported on 08/26/22, the second incident occurred on 08/30/22 and was reported on 09/06/22 (and again on 10/06/22), and the third incident occurred on 10/10/22 and was reported on 10/11/22. He explained OPLC received all the incident reports

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<sup>3</sup> The Board was under the assumption from the information provided to it on 10/27/22 that the Licensee served in a supervisory role with respect to all the incidents noted in its 10/27/22 Order of Emergency Suspension.

through an email alert system that includes OPLC, the Bureau of Elderly and Adult Services (“BEAS”), and Adult Protective Services.

The Board then shifted its questioning to the Licensee to learn when she started working at the Nursing Home. Through offer of proof and testimony, the Licensee explained that she began orientation at the Nursing Home on 09/19/22, but did not begin her duties as director of nursing until 10/07/22. She described her orientation period as consisting of training, paperwork, and learning the systems. She explained that she was not informed of the incidents pre-dating her employment at the Nursing Home and there were no New Hampshire Department of Health and Human Services BEAS tag related to them. According to her testimony there was also no formal “handoff” of duties between she and the former director of nursing before or after she assumed supervisory duties.

The Licensee also discussed several initiatives the Nursing Home recently instituted to improve patient safety. There are now three clinical floors and each one is treated as its own “pseudo” facility. Each floor has an assistant director of nursing, two floor registered nurses, and the requisite number of licensed nursing assistants. Additionally, the Nursing Home has hired a full-time wound care nurse who started on 10/11/22. The Licensee explained she has also made more recommendations to improve patient safety since she became director of nursing. She stated she desires to hire an admission registered nurse to handle phone calls, paperwork, etc. She also noted that she has recommended hiring a full-time nurse educator to assist staff, evaluated the Nursing Home’s LNA staffing issues in the immediate and long-term, and placed all nurses on a consistent 14-day schedule.

The Licensee finished her testimony by explaining she knew nothing about the patient care issues noted in the Board’s 10/27/22 Order of Emergency Suspension until 10/31/22. She explained that although she assumed the duties of director of nursing on 10/07/22, she was not informed about the 10/10/22 incident until after it had occurred. The Licensee reaffirmed this position, even when presented

with a note from the Nursing Home's records that states an individual on staff notified the director of nursing about the incident. She claimed the "DON" mentioned in this note was not her.

Following the presentation of evidence, both Hearing Counsel and the Licensee requested the Board lift the emergency suspension and expunge it from her licensure record. Additionally, the Licensee requested that the Board dismiss the investigation and not initiate a further disciplinary proceeding.

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

After reviewing all the evidence, accounting for the presentation and demeanor of all the witnesses, and considering the legal arguments of the parties, the Board partially GRANTS the oral motion to dismiss, insofar as it LIFTS the emergency suspension of the Licensee's license. The Board finds the evidence shows the Licensee is not an imminent danger to public health, safety, or welfare. Nonetheless, it defers ruling on the request for expungement of the emergency suspension from the Licensee's licensure record. The Board is troubled by the events at the Nursing Home and wants a clearer picture of what occurred there and how, if at all, the Licensee was involved before taking any further action. The Board recognizes that the investigation is ongoing and reserves further judgment based upon all the evidence that investigation yields. When appropriate, the Board will timely issue a notice of hearing or otherwise dispose of this matter.

**VI. CONCLUSION AND DECISION:**

Pursuant to RSA 326-B:27(IV), Rule 402.03, the Board hereby LIFTS its emergency suspension of Ruth Guin's licenses as an RN.

DATED: 11/15/2022

\_\_\_\_\_/s/ Nikolas K. Frye, Esq.\_\_\_\_\_  
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