STATE OF NEW HAMPSHIRE
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

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BOARD OF NURSING

In Re: Sarah Heed, **RN License #RN 059433-21 (multi-state)** **Expired**	Docket No.: NUR 22-0002 **FINAL DECISION AND ORDER – 03/24/22**

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
Ashley Czechowicz, OPLC Board Administrator
Attorney Marissa Schuetz, OPLC Hearing Counsel
Attorney Michael Haley, Board Counsel
Attorney Nikolas K. Frye, OPLC Hearings Examiner and Presiding Officer
Attorney John Garrigan, OPLC Chief Prosecutor (Observing)

II. CASE SUMMARY/PROCEDURAL HISTORY

On or about 08/05/19, the Board received a complaint from a staff member at Elmwood Center Genesis alleging Sarah Heed ("Licensee") was allegedly intoxicated while working and had diverted/attempted to divert medication. After investigation, the Board voted on or about 11/22/21 to commence an adjudicative/disciplinary proceeding in this matter. A Notice of Adjudicative Hearing followed. The Board then held the adjudicatory hearing at and on the date, time and place stated in the Notice of Adjudicative Hearing.

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, numbered as follows:

1. Complaint
2. Report of Investigation (redacted)
3. Written Response of Sarah Heed
4. Drug Test Results dated 08/06/19
5. Medication Administration Record
6. Final Report to Long Term Care Ombudsman
7. Elmwood Employment Records of Sarah Heed
8. Memorandum of Interview with Sybil McClay

b. Testimony/Offer of Proof[1] was received from:

1. Marissa Schuetz, Esq., Hearing Counsel

c. Proposed Findings of Fact and Conclusions of Law presented by Hearing Counsel, as orally amended.

All exhibits were admitted into evidence as full exhibits after the Presiding Officer determined they were material and relevant. The Board accepted Hearing Counsel's Proposed Findings of Fact and Conclusions of Law for its consideration, as orally amended.

IV. CONDUCT OF THE HEARING AND EVIDENCE PRESENTED

The Licensee failed to appear for the hearing, which was available via in-person attendance and Zoom. The Board took notice of its file in this matter. The Board's file shows the Licensee was served with a Notice of Hearing via certified mail, return receipt requested. The Notice of Hearing contains the date, time, and location of the adjudicatory hearing, as well as the items required by RSA 541-A:31, III. A Return Receipt came back signed "COVID-19", indicating someone had accepted it at the address the Licensee had provided to the Board. The Board finds that the service complies with RSA 326-B:38, IX. The Board's file also shows the Administrator emailed a copy of the Notice of Hearing to the Licensee at

[1] The offer was akin to an opening and closing statement, explaining the exhibits, and making a case for why there was a preponderance of the evidence and recommendations for handling the matter if the Board makes a finding.

the email address she had provided to the Board. It unfortunately was not delivered because it was a work email address and she was terminated from her employment. The Board sought further information from Hearing Counsel as to any efforts she had made to inform the Licensee of this matter. Hearing Counsel stated that she had attempted to contact the licensee as follows: via telephone, email, first-class mail, and certified mail. Hearing Counsel was unable to reach Licensee at the telephone number or email she had provided to the Board. She had also sent a return receipt item to the Licensee *after* the Notice of Hearing was sent that came back "unclaimed". The Witness and Exhibit List and Exhibits were sent to the Licensee via first-class mail and certified mail, return receipt requested on 03/17/22. To Hearing Counsel's knowledge at the time of the hearing, neither the return receipt nor the first-class mail had come back to OPLC. Based on the aforementioned, the Board finds that it has 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). Additionally, although not necessarily required in this situation, the Board finds the Board's record and Hearing Counsel's offer of proof demonstrate that the Board took "additional reasonable steps" to provide notice to the Licensee. *See Id.* For these reasons, the Presiding Officer recommended to the Board that it move forward with the hearing *in absentia* (without the Licensee present), pursuant to Rule 208.02(f). The Board voted unanimously in favor of this recommendation. This order serves as the Presiding Officer's written memorialization of that recommendation to the Board. **Parties and intervenors have 10 days from the date of this Order to file any written objections with the Board regarding that decision**. Rule 208.02(f).

The Board next proceeded to adjudicate the matter. Although the Licensee failed to appear, Hearing Counsel still held the burden of proof by a preponderance of the evidence. Rule 207.10. To make her case, Hearing Counsel provided Exhibits 1-8, which were accepted as full exhibits by the Board, and

provided an explanation of those documents.[2] Based upon the evidence presented at the hearing, the Board finds the following facts:

New Hampshire first issued a multi-state Registered Nurse ("RN") license bearing #059433-21 to the Licensee on 06/25/08.[3] While still licensed, Licensee worked as an RN at Elmwood Senior Living ("Elmwood") in Claremont, New Hampshire between approximately 05/01/18 and 08/05/19. On or about 08/05/19, the Board received a written complaint from Cyndi Tubman-Woodman, RN, CNE, at Elmwood, alleging that on 08/01/19 the Licensee had diverted drugs from Elmwood and displayed symptoms of impairment. According to the complaint, on the night in question the Licensee was involved in a verbal altercation with Doloris Perkins, MNA during a narcotic shift cart count at Elmwood. Initially no discrepancy was noted in the narcotic log but an investigation conducted the next day revealed a discrepancy. Consequently, Licensee was suspended on 08/01/19 and terminated on 08/05/19.

Submitted with the complaint were the following supporting documents: 1) A Facility Report from Elmwood to the State of New Hampshire Long Term Care Ombudsman Program, dated 08/02/19; 2) an 08/02/19 written statement from Doloris Perkins, MNA; 3) an Individual Performance Improvement Plan for Licensee dated 08/05/19; 4) a Management Observation Form for Suspected Impairment by Drugs/Alcohol relating to Licensee and the 08/01/19 incident. These documents reveal that Elmwood conducted an expedited investigation into the allegations of Licensee being intoxicated and diverting drugs between 08/01/19 and 08/05/19. As part of its investigation, Elmwood re-checked the narcotic count conducted by Doloris Perkins and Licensee on 08/01/19 and noticed a discrepancy of one oxycodone pill missing.

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[2] New Hampshire attorneys have a professional obligation of candor to the tribunal. *See* New Hampshire Rules of Professional Conduct 3.3. The Board fits the definition of "tribunal" under the Rules of Professional Conduct. *See* R. Prof. Cond. 1.0(m).

[3]On or about 02/03/20 the Licensee's license expired. The Licensee also held a Vermont license as a RN, which expired in 2019.

Doloris Perkins 08/02/19 statement indicates that during the 08/01/19 narcotic count, Licensee appeared disheveled, her breath smelled of alcohol, her speech was erratic, and she was sweating a lot. Ms. Perkins further alleges that during that shift count, Licensee took five cards of narcotics out of the medical cart and began fanning herself, then proceeded to take the cards with her into a locked medical room, and finally returned with the cards without making eye contact. Following this, Ms. Perkins noted that the count was off by one oxycodone pill and the Licensee allegedly began accusing Ms. Perkins of drug diversion. Ms. Perkins' statement indicates that she was scared and intimidated because the Licensee was acting unstably. Thus, she signed the book as if she had provided that oxycodone pill to a patient. Her statement also acknowledges her wrongdoing, says she has never diverted drugs, and offers to take a urinalysis same day to prove her sobriety. The Facility Report from Elmwood indicates Ms. Perkins took an 08/02/19 observed drug screen that was negative for all substances. In contrast, Licensee refused to take a urine test on 08/01/19 after being confronted by management about the allegations involving intoxication, as documented in the Individual Performance Improvement Plan and Management Observation Form for Suspected Impairment by Drugs/Alcohol.

The Report of Investigation ("ROI") dated 02/19/21 indicates that the former Administrative Prosecution Unit[4] at the New Hampshire Department of Justice investigated the complaint further by interviewing Cynthia Tubman-Woodman, reviewing Licensee's response to the complaint, reviewing Licensee's employment records, reviewing the Medication Administration Record for Patient J.S.; reviewing the CRL Global Services On-Site Custody and Control/Result Form for Dolores Perkins, dated 08/03/19; reviewing Claremont Police Department records for this incident, as well as one occurring in 2017; and interviewing Dolores Perkins, Kelly Pelletier and Sybil McClay.

[4] Responsibility for investigating and prosecuting allegations of professional misconduct has since been moved from this unit to OPLC Enforcement. The Administrative Prosecution Unit was dissolved when this transition occurred.

In relevant part, the 08/09/19 interview of Ms. Tubman-Woodman revealed that even before the incident involving Licensee, Ms. Tubman-Woodman had been closely monitoring the narcotics count due to suspected diversion by nurse employees at Elmwood. Ms. Tubman-Woodman stated that Licensee was "nervous, shaking, sweating, and trembling" when they met. Ms. Tubman-Woodman thought these were signs of withdrawal. She noted having previously seen track marks on Licensee's arms and that Licensee wore long sleeve shirts in very hot weather. The interview also revealed that she had concerns for Licensee's practice of giving the maximum dose for a narcotic from a doctor's order, even if the patient did not need that much. Ms. Tubman-Woodman was concerned enough by this practice that she had scheduled herself to work with the Licensee.

With respect to the investigation of the incident involving Licensee on 08/01/19, Ms. Tubman-Woodman corroborated that Licensee had refused to take a drug test on 08/01/19[5] and that Ms. Marsh (a supervisor at Elmwood) and Ms. Kelly Pelletier (executive director of Elmwood at the time of the incident) had observed Licensee was shaking, sweating, excessively energetic, irritable, argumentative, smelled of alcohol, and had tired eyelids and red eyes.[6] Ms. Tubman-Woodman also indicated that she had interviewed Ms. Perkins regarding the incident and pill discrepancy. Her explanation of what Ms. Perkins told her happened corroborates Ms. Perkins written statement as submitted with the complaint.[7]

[5] Licensee did take a urine drug screen on 08/06/19 that was negative for all tested substances but there is no indication whether it was observed. *See* Exhibit 4. The Board gives this result little weight given the lapse in time between when the test was taken on 08/06/19 and 08/01/19 and because there is no indication that it was observed.

[6] This description of the Licensee jibes with Ms. Perkins', Ms. McClay's, and Ms. Pelletier's firsthand descriptions of the Licensee to the Board investigator.

[7] Ms. Tubman-Woodman's representations to the Board investigator as to what occurred between Ms. Perkins and Licensee on 08/01/19 are also consistent with those she made to the Claremont Police Department about the incident in question. Further, Ms. Perkins' representations to the Board investigator about her interaction with the Licensee are consistent with her statement provided with the complaint and as retold by Ms. Tubman-Woodman to both the Board investigator and Claremont Police Department. Further bolstering Ms. Perkins account of events is the interview of Sybil McClay, who was the supervisor that was called over to assist Ms. Perkins and Ms. Heed with the 08/01/19 narcotics count. For these reasons, the Board finds Ms. Perkins' representations as to what happened with the Licensee on 08/01/19 credible.

The Licensee's response to the complaint denies responsibility for the pill count discrepancy. She states she noticed the issue and told a new Med Tech that they could not sign off on the count but that the nurse who complained to management came over and approved it. Licensee's complaint fails to provide names for either the Med Tech or the nurse and attributes her appearance and demeanor on the night in question to suffering from being pre-menopausal and having familial benign hand tremor. She acknowledges not taking the urine test on 08/01/19 but states it was her right not to do so. She claims that there is significant drug diversion at Elmwood. She associated the report of misconduct against her with her having made a complaint on a patient's behalf two weeks prior.[8]

The documentary evidence and Attorney Schuetz's offer also shed light on the Licensee's past history with the Board, Claremont Police Department and Elmwood. The Licensee's past history with Elmwood consists mainly of forgetting to punch her timecard altogether or in an untimely manner. In 2017, the Licensee was arrested by the Claremont Police Department for driving under the influence when she was found parked in a car with her minor child. In 2012 the Board received a complaint alleging the Licensee appeared impaired at work and had tested positive for marijuana. The Licensee received a confidential letter of concern because of that incident. With respect to the case at hand, the Licensee has been uninvolved ever since signing a Preliminary Agreement Not to Practice in 2019. Since that point, she has been unresponsive to OPLC Enforcement and this Board and has generally not participated in these proceedings.

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

After reviewing all the evidence and drawing all reasonable inferences therefrom, the Board finds, by a preponderance of the evidence, that the Licensee committed professional misconduct. In addition to

[8] Given the significant discrepancies between the Licensee's account of events and everyone else's involved, the Board assigns the Licensee's statements little to no weight. *See supra* footnote 5.

the findings of facts and rulings of law already made herein, the Board specifically finds the following facts and makes the following rulings of law based upon the evidence presented:

1) The Board finds, by a preponderance of the evidence, that on 08/01/19, without permission or right to do so, the Licensee, while working as a RN at Elmwood, took one pill of oxycodone from the medical cart during a narcotic count. *See* Exhibits 1, 2, 5, 6, 8.
2) The Board finds, by a preponderance of the evidence, that the Licensee, while working as a RN at Elmwood on 08/01/19, was intoxicated and/or under the influence. *See* Exhibits 1, 2, 6, 8.
3) The Board finds, by a preponderance of the evidence, that the Licensee, while licensed in New Hampshire as an RN, was investigated by the Board in 2012 over allegations of being intoxicated in the workplace and arrested in 2017 for driving under the influence. Exhibit 2.
4) The Board concludes the Licensee committed professional misconduct as defined at RSA 326-B:37, II(e) by engaging in conduct likely to deceive, defraud, or harm the public or demonstrating a willful or careless disregard for the health or safety of a client when, while working at Elmwood as a RN on 08/01/19, she was intoxicated and/or under the influence and, without permission or right to do so, took one pill of oxycodone from the medical cart.
5) The Board concludes the Licensee committed professional misconduct as defined at RSA 326-B:37, II(h)(1) by departing from or failing to conform to nursing standards when, while working at Elmwood as a RN on 08/01/19, she was intoxicated and/or under the influence and, without permission or right to do so, took one pill of oxycodone from the medical cart.
6) The Board concludes the Licensee committed professional misconduct as defined at RSA 326-B:37, II(k) by engaging in a nursing practice that may create unnecessary danger to a client's life, health, or safety when, while working at Elmwood as a RN on 08/01/19, she was intoxicated and/or

under the influence and, without permission or right to do so, took one pill of oxycodone from the medical cart.

7) The Board concludes the Licensee committed professional misconduct by engaging in "diversion", as that term is used in RSA 326-B:37, II(n), when on 08/01/19, without permission or right to do so, she took a controlled medication from the medical cart intended for patients while working at Elmwood as a RN; and

8) The Board concludes the Licensee committed professional misconduct as defined at RSA 326-B:37, II(p)(1) by using a controlled substance or any drug or device or alcoholic beverages to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public, or to the extent that such use may impair his or her ability to conduct with safety to the public the practice of nursing when, while working at Elmwood as a RN on 08/01/19, Licensee was intoxicated and/or under the influence and, without permission or right to do so, took one pill of oxycodone from the medical cart.

9) The Board concludes the Licensee committed professional misconduct as defined at RSA 326-B:37, II(q)(2) by violating Rule 402.04(b)(17) when she engaged in a pattern of behavior consisting of more than one incident of professional misconduct involving her being intoxicated and/or under the influence between 2012 and 08/01/19, which threatened the safety of the public.

The Board next considers the appropriate discipline to administer, if any, pursuant to RSA 326-B:37(III)(b). In doing so it looks at the factors enumerated in RSA 326-B:37(III) and Rule 402.04(g). Factors 1, 2, 5, 6, 7 and 8 of Rule 402.04(g), when applied to the facts of this case, weigh heavily in favor of imposing significant discipline against the Licensee, whose misconduct can be concisely described as

egregious and a threat to the public safety, health, and welfare.[9] Taking those factors into consideration, the Board INDEFINITELY SUSPENDS Licensee's license. *See* RSA 326-B:37, III(a).

VI. CONCLUSION AND DECISION:

Pursuant to RSA 326-B:37, and Rule 402, the Board hereby makes the herein findings of professional misconduct and indefinitely suspends the Licensee's license.

DATED: 3/25/2022

___/s/ Nikolas K. Frye, Esq._____
Nikolas K. Frye, Esq., Hearings Examiner
Authorized Representative of the Board of Nursing-
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[9] The Board took into consideration the fact that the Licensee signed a preliminary agreement not to practice but weighed that against her otherwise utter lack of disregard for participating in this disciplinary proceeding.