STATE OF NEW HAMPSHIRE
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

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BOARD OF NURSING

In Re: Karen Janoski,
LPN License # 012344-22

Docket No.: 2022-NUR-0039

FINAL DECISION AND ORDER – 12/09/22

I. ATTENDEES

Samantha O'Neill, Board Chair
Melissa Tuttle, Board Member
Melissa Underhill, Board Member
Matthew Kitsis, Board Member
Maureen Murtaugh, Board Member
Wendy Stanley-Jones, Board Member
Michele Melanson-Schmitt, Board Member
Attorney Lauren Warner, OPLC Board Counsel
Ashley Czechowicz, OPLC Board Administrator
Jeanne Webber, OPLC Board Administrator
Attorney John Garrigan, OPLC Hearing Counsel
Attorney Nikolas K. Frye, OPLC Hearings Examiner and Presiding Officer
Michael Porter, OPLC Bureau Chief Investigator and as Witness

II. CASE SUMMARY/PROCEDURAL HISTORY

On 03/10/21, the Board of Nursing ("Board") received a complaint alleging that Karen Janoski ("Licensee") had diverted controlled substances while working as an LPN at Maple Leaf Health Care Center in Manchester, New Hampshire. The OPLC Division of Enforcement investigated the complaint on behalf of the Board; however, the Licensee did not respond to inquiries and allegedly had provided inaccurate information about the complaint relating to Maple Leaf Health Care Center on her license reinstatement application submitted to the Board on or about 10/29/21. After investigation, the Board

voted on 09/22/22 to commence an adjudicative/disciplinary proceeding in this matter. A Notice of Adjudicative Hearing followed, and the Board then held the adjudicatory hearing on 12/09/22 at 1:00 PM EST. 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 submitted by Hearing Counsel, numbered as follows:

1. 06/07/21 Complaint
2. 01/14/21 Maple Leafe Health Care Narcotic Investigation
3. Pictures of Patient Pill Cards
4. Pictures of Licensee's Urine Test Panel
5. 06/08/21 Letter from OPLC Enforcement to Licensee with associated certified mail receipts
6. Licensing Database Entry RE: Licensee contact with OPLC on 11/02/21
7. 11/01/21 Licensee's Reinstatement Application

b. Exhibits were submitted by Licensee, labeled as follows:

A. None.

b. Sworn testimony was received from:

1. Michael Porter, OPLC Investigations Bureau Chief (called by Hearing Counsel, through offer of proof)

All exhibits were admitted into evidence as full exhibits after the Presiding Officer determined they were material and relevant. The witness swore to the offer of proof under oath.

IV. PRELIMINARY MATTERS

The Licensee failed to appear for the hearing, which was available via in-person and Zoom. The Board took administrative notice of its file in this matter. The Board's file shows the Board Administrator mailed the Licensee a Notice of Hearing via certified mail, return receipt requested on 10/14/22 at the last known address she provided to the Board. Both receipts were returned undeliverable as addressed. 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. It also informs the recipients that the Board's action was initiated based

upon a complaint and provides the complainant with the ability to intervene. The Notice of Hearing was also sent to the Licensee's addresses on file with the Board by first class mail and to the email she has on file with the Board. The regular mailing was not returned. Hearing Counsel represented that he had received no correspondence from the Licensee, despite multiple attempts at contacting her through various modes of communication.

Based upon the foregoing, the Board finds that it has complied with the service requirements under RSA 326-B:38, IX. The Board additionally 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). Although not necessarily required in this situation, the Board also find its 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).**

V. CONDUCT OF THE HEARING AND EVIDENCE PRESENTED

Hearing Counsel bears the burden of proof by a preponderance of the evidence with respect to Issues Presented II.c.1, 2, 3, 5, and 5. Rule 207.10. To present his case, Hearing Counsel provided an offer of proof supported by the sworn testimony of Michael Porter, OPLC Bureau Investigations Chief,

who was assigned to this case and Exhibits 1 through 7. Based upon the evidence presented at the hearing, the Board finds the following facts.

The Board adopts Hearing Counsel's Proposed Findings of Fact paragraphs 1 through 37, which are attached to this order as Exhibit A and incorporated by reference herein. The Board also grants Hearing Counsel's requests that it take administrative notice as contemplated in paragraphs 2, 6, 9, 10, 11, 13, 15, and 17 of Hearing Counsel's Proposed Findings of Fact. Investigator Porter testified that he had reviewed all the documentation provided by Hearing Counsel and had no correction to make to the offer of proof.

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

After reviewing all the evidence and drawing all reasonable inferences therefrom, as well as accounting for the demeanor and credibility of the witness, the Board finds, by a preponderance of the evidence, that the Licensee committed professional misconduct. Based upon the evidence presented and the findings of fact made herein, the Board additionally finds and concludes as follows:

1) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(e). In drawing this conclusion, the Board specifically finds, by a preponderance of the evidence, that the Licensee, while working as an LPN at Maple Leaf Health Care Center in Manchester, New Hampshire in 2021, diverted controlled substances from the facility by manipulating controlled substance records and replacing controlled substance pills in patient blister packs with other medications.
2) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(h). In drawing this conclusion, the Board specifically finds, by a preponderance of the evidence, that the Licensee, while working as an LPN at Maple Leaf Health Care Center in Manchester, New Hampshire in 2021, diverted controlled substances from the

facility by manipulating controlled substance records and replacing controlled substance pills in patient blister packs with other medications.

3) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(k). In drawing this conclusion, the Board specifically finds, by a preponderance of the evidence, that the Licensee, while working as an LPN at Maple Leaf Health Care Center in Manchester, New Hampshire in 2021, diverted controlled substances from the facility by manipulating controlled substance records and replacing controlled substance pills in patient blister packs with other medications.

4) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(m). In drawing this conclusion, the Board specifically finds, by a preponderance of the evidence, that the Licensee, while working as an LPN at Maple Leaf Health Care Center in Manchester, New Hampshire in 2021, diverted controlled substances from the facility by manipulating controlled substance records and replacing controlled substance pills in patient blister packs with other medications.

5) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(n). In drawing this conclusion, the Board specifically finds, by a preponderance of the evidence, that the Licensee, while working as an LPN at Maple Leaf Health Care Center in Manchester, New Hampshire in 2021, diverted controlled substances from the facility by manipulating controlled substance records and replacing controlled substance pills in patient blister packs with other medications.

6) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(p)(2). In drawing this conclusion, the Board specifically finds, by a preponderance of the evidence, that the Licensee, while working as an LPN at Maple Leaf Health

Care Center in Manchester, New Hampshire in 2021, diverted controlled substances from the facility by manipulating controlled substance records and replacing controlled substance pills in patient blister packs with other medications.

7) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(q)(2) *See* Rule 402.04(b)(5), (6), (10), (11), and(17)). In drawing this conclusion, the Board specifically finds, by a preponderance of the evidence, that the Licensee, while working as an LPN at Maple Leaf Health Care Center in Manchester, New Hampshire in 2021, diverted controlled substances from the facility by manipulating controlled substance records and replacing controlled substance pills in patient blister packs with other medications.

8) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(h). In drawing this conclusion, the Board specifically finds, by a preponderance of the evidence, that the Licensee, while working as an LPN at Maple Leaf Health Care Center in Manchester, New Hampshire in 2021, was requested by her employer during her shift to take a drug screen as part of a diversion investigation, actively attempted to avoid providing a urine sample, and eventually provided a urine sample that tested positive for THC and Oxycodine.

9) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(m). In drawing this conclusion, the Board specifically finds, by a preponderance of the evidence, that the Licensee, while working as an LPN at Maple Leaf Health Care Center in Manchester, New Hampshire in 2021, was requested by her employer during her shift to take a drug screen as part of a diversion investigation, actively attempted to avoid providing a urine sample, and eventually provided a urine sample that tested positive for THC and Oxycodine.

10) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(p)(1). In drawing this conclusion, the Board specifically finds, by a

preponderance of the evidence, that the Licensee, while working as an LPN at Maple Leaf Health Care Center in Manchester, New Hampshire in 2021, was requested by her employer during her shift to take a drug screen as part of a diversion investigation, actively attempted to avoid providing a urine sample, and eventually provided a urine sample that tested positive for THC and Oxycodine.

11) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(p)(3). In drawing this conclusion, the Board specifically finds, by a preponderance of the evidence, that the Licensee, while working as an LPN at Maple Leaf Health Care Center in Manchester, New Hampshire in 2021, was requested by her employer during her shift to take a drug screen as part of a diversion investigation, actively attempted to avoid providing a urine sample, and eventually provided a urine sample that tested positive for THC and Oxycodine.

12) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(h). In drawing this conclusion, the Board specifically finds, by a preponderance of the evidence, that the Licensee failed to meaningfully respond to the Board's inquiries regarding the 03/10/21 complaint.

13) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(m). In drawing this conclusion, the Board specifically finds, by a preponderance of the evidence, that the Licensee failed to meaningfully respond to the Board's inquiries regarding the 03/10/21 complaint.

14) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(q)(2) (*See* Rule 402.04(b)(15)). In drawing this conclusion, the Board specifically finds, by a preponderance of the evidence, that the Licensee failed to meaningfully respond to the Board's inquiries regarding the 03/10/21 complaint.

15) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(d). In drawing this conclusion, the Board specifically finds, by a preponderance of the evidence, that the Licensee knowingly provided the Board with inaccurate information on her 10/29/21 application for reinstatement with respect to Question 7.

16) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(h). In drawing this conclusion, the Board specifically finds, by a preponderance of the evidence, that the Licensee knowingly provided the Board with inaccurate information on her 10/29/21 application for reinstatement with respect to Question 7.

17) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(q)(2)(*See* Rule 402.04(b)(15)). In drawing this conclusion, the Board specifically finds, by a preponderance of the evidence, that the Licensee knowingly provided the Board with inaccurate information on her 10/29/21 application for reinstatement with respect to Question 7.

18) Pursuant to RSA 326-b:37(III)(a), and upon a finding of misconduct under RSA 326-B:37, II, the Board **REVOKES** the Licensee's license to practice in New Hampshire as an LPN.

19) In administering this discipline, the Board considered and weighed the factors enumerated in RSA 326-B:37(III) and Rule 402.04(g).

VI. CONCLUSION AND DECISION:

Pursuant to RSA 326-B:37, and Rule 402, the Board hereby makes the herein findings of professional misconduct. The Licensee' license to practice in New Hampshire as an LPN is **REVOKED**.

DATED: 12/19/2022

___/s/ Nikolas K. Frye, Esq._____
Nikolas K. Frye, Esq., Hearings Examiner
Authorized Representative of the Board of Nursing-
New Hampshire Office of

Professional Licensure & Certification
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STATE OF NEW HAMPSHIRE
BOARD OF NURSING
CONCORD, NH

In the matter of: DOCKET #22-NUR-039
Karen Janoski
Lic. #12344-22 - LPN

HEARING COUNSEL'S PROPOSED FINDINGS OF FACT

NOW COMES John W. Garrigan, Hearing Counsel, who provides the following proposed findings of fact for the Board of Nursing ("Board") to adopt during the adjudicative hearing in this matter:

1. On January 14, 2021, a nurse at Maple Leaf Health Care reported a suspicious card package of Oxycontin 20mg tablets. *Exh 2, pg HC010*.
2. Hearing Counsel requests the Board to take notice, pursuant to Nur 207.09(d), that Oxycontin is an opioid pain medication. See https://www.drugs.com/oxycontin.html (accessed November 29, 2022).
3. The nurse had attempted to "pop" the Oxycontin from the card but noted that there was no resistance from the back of the card and the cardboard backing appeared broke. *Exh 2, pg HC010.*
4. On further inspection, the nurse noted that the pill did not look like the pill she administered to this particular patient nightly. *Exh 2, pg HC010*.
5. The nurse looked up the pill on a pill identifier and found it to be amlodipine. *Exh 2, pg HC010*.
6. Hearing Counsel requests the Board to take notice, pursuant to Nur 207.09(d), that amlodipine is used to treat high-blood pressure and hypertension. See https://www.drugs.com/amlodipine.html (accessed November 29, 2022).

7. On January 15, 2021, the Director of Nursing ("DON") at Maple Leaf Health, Kristin Provencher, checked every narcotic card in the building for irregularities. She discovered five instances of irregularities. *Exh 2, pg HC010.*
8. The first patient's (the same one with the tampered Oxycontin discovered on 1/14) card of oxycodone 5mg tablets had 4 pills along the bottom with loose edges. The pills located within the card at those locations were not oxycodone, but rather three pills of clonidine 0.1mg and one pill of Seroquel 50mg. *Exh 2, pg HC010; Exh 3, pg HC013.*
9. Hearing Counsel requests the Board to take notice, pursuant to Nur 207.09(d), that oxycodone is an opioid pain medication. See https://www.drugs.com/oxycodone.html (accessed November 29, 2022).
10. Hearing Counsel requests the Board to take notice, pursuant to Nur 207.09(d), that clonidine is used to treat high-blood pressure https://www.drugs.com/clonidine.html (accessed November 29, 2022).
11. Hearing Counsel requests the Board to take notice, pursuant to Nur 207.09(d), that Seroquel is an anti-psychotic medication. See https://www.drugs.com/seroquel.html (accessed November 29, 2022).
12. A second patient's card of oxycodone 5mg had one bill with loose cardboard backing. That pill was identified as prednisone. *Exh 2, pg HC010; Exh 3, pg HC013.*
13. Hearing Counsel requests the Board to take notice, pursuant to Nur 207.09(d), that prednisone is a corticosteroid used to decrease inflammation. See https://www.drugs.com/prednisone.html (accessed November 29, 2022).
14. A third patient's card of oxycodone 5mg tablets had 2 pills with breeched cardboard backings, which were identified as atenolol 50mg tablets. *Exh 2, pg HC010.*

15. Hearing Counsel requests the Board to take notice, pursuant to Nur 207.09(d), that atenolol is a beta-blocker that is used to treat angina and hypertension. See https://www.drugs.com/atenolol.html (accessed November 29, 2022).
16. A fourth patient's card of oxycodone 5mg had one pill with breeched cardboard backing, which was identified as buspirone 5mg. *Exh 2, pg HC010.*
17. Hearing Counsel requests the Board to take notice, pursuant to Nur 207.09(d), that buspirone is an anti-anxiety medication. See https://www.drugs.com/buspirone.html (accessed November 29, 2022).
18. A fifth patient's card of Ativan had 4 pills with cardboard backing that appeared loose. The tablets appeared to be Ativan (though the DON acknowledged that the pills are too small to identify without removing them from the card.) *Exh 2, pg HC010.*
19. On January 18, 19, and 20, all narcotic cards were checked. No irregularities were discovered. *Exh 2, pg HC010.*
20. On January 21, the DON noted that a sixth patient's records showed that she appeared to get 2 pro re nata ("PRN") oxycodones on the night shift every day. The patient stated that she does not need a pill every night and did not recall getting one the night before. However, 2 tablets had been signed out by the Respondent. *Exh 2, pg HC011.*
21. The DON reviewed the narcotic books again on February 3. She noted that the Respondent was administering the majority of oxycodone as PRN. The DON also spoke to the sixth patient again. She reported that she was not positive about receiving oxycodone nightly for breakthrough pain. *Exh 2, pg HC011.*

22. The DON noted that it was apparent that the sixth patient was not receiving PRN oxycodone nightly on the nights that the Respondent was not scheduled to work. *Exh 2, pg HC011.*
23. The DON reported that Maple Leaf Health's Consultant Pharmacist Laurence Sweeney examined the irregular medication cards and confirmed the identification of the replaced medications. *Exh 2, pg HC011.*
24. The DON compared the narcotic book records against the MAR records and found that the Respondent was noting signing out oxycodone in the narcotic book but not in the MAR. The DON reviewed records from a year prior and found that the Respondent had perfect documentation at that time. *Exh 2, pg HC011.*
25. There were no visible signs of tampering with the narcotic cards in the subsequent two weeks. *Exh 2, pg HC011.*
26. On the morning of February 21, Nurse Manager Margie Feliciano did narcotic count and noted that a liquid oxycodone bottle for a seventh, and expired, patient contained 85ml. *Exh 2, pg HC012.*
27. That evening, at the beginning of the 11-7 shift, a nurse performed the narcotic count with the Respondent and noted that the same bottle of oxycodone contained the same volume of liquid as before. *Exh 2, pg HC012.*
28. The following morning, at the close of the 11-7 shift, the oncoming nurse counted the same bottle of oxycodone with the Respondent and noted that the contents were only 65ml, being short by 20ml. *Exh 2, pg HC012.*
29. The oncoming nurse asked to be drug tested. Her test panel was negative for all drugs. *Exh 2, pg HC012.*

30. The next morning, February 23, the DON confronted the Respondent at the end of her shift about the incorrect narcotic count and asked the Respondent to provide a urine sample. *Exh 2, pg HC012.*
31. After several attempts at voiding the specimen, the Respondent claimed that she was unable to produce urine. The Respondent remained in the lobby, supervised, for approximately 1 ½ hours and drank approximately 10 cups of water. The Respondent was escorted back to the bathroom and emerged with a cup with approximately 10cc of urine. The DON inspected the bathroom and it appeared that the Respondent had voided into the toilet, but was unable to flush it due to the water being turned off as part of the testing. *Exh 2, pg HC012.*
32. The Respondent refused to be tested again. She was warned that leaving would be construed as an admission of guilt. The Respondent left, stating "I am leaving, and I guess I won't be back." *Exh 2, pg HC012.*
33. The DON performed a dipstick test on the small urine sample provided by the Respondent. It tested positive for oxycodone and THC. *Exh 2, pg HC012; Exh 4.*
34. DON Provencher reported this incident to the Board on June 7, 2021. *Exh 1.*
35. On June 8, 2021, the Division of Enforcement mailed a copy of the complaint to the Respondent at her address of record in Florida and requested a response within 30 days. No response was received. *Exh 5.*
36. On October 29, 2021, the Respondent filed an application for license reinstatement with this Board where she indicated that her primary state of residency was Florida. Under question #7, which asks "[h]ave you previously or currently been impaired by or diverted

any chemical substances that impaired your ability to practice that has not been annulled," the Respondent answered "no." *Exh 7, pg HC024-025.*

37. On November 2, 2021, OPLC licensure staff noted a call with the Respondent where she stated that she would be moving back to NH. Licensure staff provided guidance to the Respondent on filing for a compact license. *Exh 6.*

Respectfully Submitted,

HEARING COUNSEL

Date: November 30, 2022

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I certify on November 30, 2022, that a copy of these Proposed Findings of Fact were sent to the Respondent via email and first class mail to [redacted].

John W. Garrigan
John W. Garrigan, Esq.