STATE OF NEW HAMPSHIRE
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

BOARD OF NURSING

In Re: Briana Mayhew, **LNA License # 058171-24 (Inactive)**	Docket No.: 2022-NUR-0035 **FINAL DECISION AND ORDER – 12/15/22**

I. ATTENDEES

Samantha O'Neill, Board Chair
Joni Menard, Board Vice-Chair
Melissa Tuttle, Board Member
Melissa Underhill, Board Member
Matthew Kitsis, Board Member
Maureen Murtaugh, Board Member
Dwayne Thibeault, Board Member
Michele Melanson-Schmitt, Board Member
Wendy Stanley Jones, Board Member
Attorney Lauren Warner, OPLC Board Counsel
Ashley Czechowicz, OPLC Board Administrator
Jeanne Webber, OPLC Board Administrator
Attorney Collin Phillips, OPLC Hearing Counsel
Attorney Nikolas K. Frye, OPLC Hearings Examiner and Presiding Officer
Karen Belair, OPLC Investigator and as Witness

II. CASE SUMMARY/PROCEDURAL HISTORY

On 03/05/21, the Board of Nursing ("Board") received a complaint alleging that Briana Mayhew ("Licensee") had recorded vital signs for multiple patients without ever having taken them and documented multiple newborn screenings as "passed" that were incomplete. The OPLC Division of Enforcement reached out to the Licensee on multiple occasions for a response but never heard back. After investigation and discussion, the Board voted on 08/25/22 to commence an adjudicative/disciplinary

proceeding in this matter. A Notice of Adjudicative Hearing followed, and the Board then held the adjudicatory hearing on 12/15/22 at 9:00 AM 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. 03/04/21 Complaint filed by Erin Collins
2. 03/5/21 Board Request for Response
3. 03/09/21 Additional Information and Request for Response
4. 04/21/21 Request for Response
5. 05/25/21 2nd Attempt for Response
6. 06/08/21 Confidential Memo – Lynne Theuner
7. Board Investigator Complaint Review – Tracey Collins, DNP, RN
8. Concord Hospital Email
9. 02/24/21 I/O Patient Records: Rm 401, 403, 405, 408
10. 02/24/21 Patient Vital Signs. Rm 401, Rm 403, Rm 405, Rm 408
11. 02/24/2021 3:43 PM EST Text Message from License to Nurse Devine
12. Hearing Screening Audit Patients A-M
13. Hearing Screening Machine Report for the period 01/06/20 – 02/24/21
14. Interview Report – Karen Belair

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

A. None.

b. Testimony was received from:

1. Melissa Devine, RN (called by Hearing Counsel, through offer of proof)
2. Susan Hall, RN (called by Hearing Counsel, through offer of proof)
3. Karen Belair, OPLC Investigator (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 witnesses 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. 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 10/02/22 at the last known

address she provided to the Board, as well as another on file. The receipt was returned as undeliverable with an indication that the Licensee had moved and left no address, so the post office was unable to forward it. 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 first class mail was not returned and the Licensee never responded to the email. Hearing Counsel represented that he had received an email from the Licensee on 12/01/22 via the same email address that the Board had used to send the Notice of Hearing but had received no further correspondence from her, despite further efforts of communication.[1]

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**

[1] The contents of the email was reviewed by the Presiding Officer but not the Board Members, given the potential that its contents might affect any decision the Board rendered in this matter. The Presiding Officer confirms that the email was not exculpatory in nature and in fact was moot given the inactive status of the Licensee's license on the date it was written. The contents of the email was also disclosed to Board Counsel by the Presiding Officer, before the Board made any decision in this matter.

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 the Issues Presented contained in the Notice of Hearing at section II.c, which are:

1) [w]hether Licensee engaged in professional misconduct when in 2021, while working for Concord Hospital, she recorded vital signs for one or more patients without having ever taken the vital signs in violation of RSA 326-B:37, II(e), RSA 326-B:37, II(g), RSA 326-B:37, II(h), RSA 326-B:37(h)(1), RSA 326-B:37, II(k), RSA 326-B:37, II(m), and/or RSA 326-B:37, II(q)(2) (*See* Rule 402.04(b)(11)).

2) Whether the Licensee engaged in professional misconduct when, between 2020 and 2021, while working at Concord Hospital, she documented one or more newborn screenings as passed that were incomplete in violation of RSA 326-B:37, II(e), RSA 326-B:37, II(g), RSA 326-B:37, II(h), RSA 326-B:37, II(h)(1), RSA 326-B:37, II(k), RSA 326-B:37, II(m), and/or RSA 326-B:37, II(q)(2) (*See* Rule 402.04(b)(11).

3) Whether the Licensee engaged in professional misconduct by failing to respond to inquiries for a response to a Board investigation into the 03/05/21 complaint in violation of RSA 326-B:37, II(h), RSA 326-B:37, II(m), and/or RSA 326-B:37, II(q)(2) (*See* RSA 326-B:38, VII, and/or Rule 206.02(e)).

4) If any of the above allegations are proven, whether and to what extent Licensee should be subjected to one or more of the disciplinary sanctions authorized by RSA 326-B:37, III.

NOH at II.c.

To present his case, Hearing Counsel provided an offer of proof supported by the sworn testimony of Melissa Devine, RN, Susan Hall, RN, Karen Belair (the OPLC Investigator assigned to this case), and Exhibits 1 through 14. Based upon the credible evidence presented at the hearing, the Board finds the following facts.

The Board's file reflects that the Licensee was actively licensed as a Licensed Nursing Assistant ("LNA") in New Hampshire, with license number 058171-24 during the time of the conduct alleged in

the complaint, which is Exhibit 1.[2] Based upon the offer of proof, the Board adopts Hearing Counsel's Proposed Findings of Facts 2 through 14, which are restated below:

2. Respondent has no prior disciplinary history.
3. On 02/24/2021, Respondent worked as an LNA at The Family Place, Concord Hospital in Concord, NH. [*See* Exhibit 3].
4. The Respondent's assigned duties for the patients included taking and recording vital signs and intake/output ("I/O"). [*See* Exhibit 1 and Exhibit 3].
5. On 02/24/2021, the Respondent carried a patient assignment for patients in rooms 401, 403, 405, and 408. [*See* Exhibit 3].
6. On 02/24/2021, Respondent recorded taking vital signs and I/O for patients in 401, 403, 405, and 408. [See Exhibit 1, Exhibit 3, Exhibit 9, Exhibit 10].
7. On 02/24/2021, Susan Hall, RN was informed by the patient in Rm 405 that the Respondent had not entered her room, yet vital signs were recorded by Respondent. [*See* Exhibit 3].
8. RN Hall promptly informed Manager Melissa Devine, RN that RN Hall was concerned that the Respondent was not performing tasks that the Respondent had documented. [*See* Exhibit 3].
9. RN Devine reviewed [*sic*] spoke to patients and reviewed records for patients in Rms 401, 403, 405, and 408, and all four patients confirmed that Respondent had not been in their room and did not take their vital signs. [*See* Exhibit 3].
10. RN Devine spoke to Respondent about her conduct. [*See* Exhibit 1].
11. On 02/24/2021 at or about 3:43 [PM EST], Respondent abandoned her patient assignment without providing report. [*See* Exhibit 1 and Exhibit 11].
12. RN Devine reviewed additional hearing screening records performed by the Respondent. [*See* Exhibit 1].
13. The records show thirteen (13) instances where a hearing screening test had been aborted on the device, yet the corresponding documentation indicated the hearing screen as a "pass." [*See* Exhibit 1, Exhibit 12, and Exhibit 13].
14. Respondent failed to respond to inquires [*sic*] for a response to the Board investigation. [*See* Exhibit 2, Exhibit 7].

12/14/22 Proposed Findings of Fact and Conclusions of Law at pages 1-2.[3]

The witnesses testified that the offer of proof submitted by hearing counsel was true and accurate to the best of their knowledge and belief.

V. <u>DISCUSSION AND FINDINGS OF FACTS / CONCLUSIONS OF LAW:</u>

---

[2] Her license is currently listed as inactive.

[3] Respondent refers to the Licensee. For clarification, the Board has added bracketed *sics* in paragraphs 9 and 14, as well as the bracketed "PM EST] in paragraph 11.

After reviewing all the evidence and drawing all reasonable inferences therefrom, as well as accounting for the demeanor and credibility of the witnesses, the Board finds, by a preponderance of the evidence, that the Licensee committed professional misconduct. The Board further finds that Hearing Counsel's proposed findings of fact as restated herein are supported by the Exhibits he cites, as well as the oral offer proof he presented, which was confirmed as accurate by the sworn testimony of the three witnesses. Based upon the evidence presented, the findings of fact made herein, and the combined training and experience of the Board in the practice of nursing, the Board makes the following conclusions of law:

1) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(e) when in 2021, while working for Concord Hospital, she recorded vital signs for multiple patients without having ever taken the vital signs.

2) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(g) (*see* RSA 326-B:14, III(e)), while working for Concord Hospital, she recorded vital signs for multiple patients without having ever taken the vital signs.

3) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(h)(1) when in 2021, while working for Concord Hospital, she recorded vital signs for multiple patients without having ever taken the vital signs.

4) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(k) when in 2021, while working for Concord Hospital, she recorded vital signs for multiple patients without having ever taken the vital signs.

5) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(m) when in 2021, while working for Concord Hospital, she recorded vital signs for multiple patients without having ever taken the vital signs.

6) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(q)(2) when in 2021, while working for Concord Hospital, she recorded vital signs for multiple patients without having ever taken the vital signs.

7) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(e), when, between 2020 and 2021, while working at Concord Hospital, she documented multiple newborn screenings as passed that were incomplete.

8) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(g) (*see* RSA 326-B:14, III(e)), when, between 2020 and 2021, while working at Concord Hospital, she documented multiple newborn screenings as passed that were incomplete.

9) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(h)(1), when, between 2020 and 2021, while working at Concord Hospital, she documented multiple newborn screenings as passed that were incomplete.

10) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(k), when, between 2020 and 2021, while working at Concord Hospital, she documented multiple newborn screenings as passed that were incomplete.

11) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(m), when, between 2020 and 2021, while working at Concord Hospital, she documented multiple newborn screenings as passed that were incomplete.

12) 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)(11), when, between 2020 and 2021, while working at Concord Hospital, she documented multiple newborn screenings as passed that were incomplete.

13) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(h) when failing to respond to inquiries for a response to a Board investigation into the 03/05/21 complaint made on 03/05/21, 04/21/21, and 05/21/21. in violation of RSA 326-B:37, II(h), RSA 326-B:37, II(m), and/or RSA 326-B:37, II(q)(2) (*See* RSA 326-B:38, VII, and/or Rule 206.02(e)).

14) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(m) when failing to respond to inquiries for a response to a Board investigation into the 03/05/21 complaint made on 03/05/21, 04/21/21, and 05/21/21.

15) The Board concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(q)(2) (*See* RSA 326-B:38, VII, and Rule 206.02(e)) when failing to respond to inquiries for a response to a Board investigation into the 03/05/21 complaint made on 03/05/21, 04/21/21, and 05/21/21.

16) Pursuant to RSA 326-B:37, III(a), in the event the Licensee reapplies for licensure and the Board determines that she qualifies for licensure pursuant to RSA 326-b and applicable Board Rules, the Board hereby **SUSPENDS** her license indefinitely, commencing from the date the Board approves her application for licensure. The Licensee may request a hearing, or the Board may schedule a hearing, on this matter at any time. At that hearing, the burden of proof shall be upon the Licensee to prove, by a preponderance of the evidence, that her current circumstances are such that the Board should end the indefinite suspension and/or modify or restrict her license in another manner that allows her to practice.

17) 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's ability to practice as an LNA in New Hampshire is disciplined as stated in Section V.16 of this Order.

DATED: 12/22/2022

___/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
7 Eagle Square
Concord, NH 03301