STATE OF NEW HAMPSHIRE
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

BOARD OF NURSING

In Re: Dawn Nicholls,
RN License # 060959-21

Docket No.: 2021-NUR-0019

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
Michele Melanson-Schmitt, Board Member
Wendy Stanley Jones, Board Member
Attorney Lauren Warner, OPLC Board Counsel
Jeanne Webber, OPLC Board Administrator
Ashley Czechowicz, OPLC Board Administrator
Attorney Nikolas K. Frye, OPLC Hearings Examiner and Presiding Officer
Attorney Collin Phillips, OPLC Hearing Counsel
Attorney Alyssa Cassotis, Counsel for Licensee
Dawn Nicholls, Licensee

II. CASE SUMMARY/PROCEDURAL HISTORY

On 02/05/21, the Board of Nursing ("Board") received a complaint alleging that Dawn Nicholls ("Licensee") had falsified documentation, not followed physicians' orders, solicited controlled drugs from a patient, and threatened/harassed a patient. On or about 02/05/21, Licensee voluntarily resigned rather than be terminated by her employer. OPLC Enforcement investigative staff conducted an expedited investigation. Pursuant to RSA 326-B:37(IV), the Board found Licensee's alleged actions as stated above demonstrated an imminent threat the public health, safety, and welfare, so as to warrant emergency

suspension on 03/12/21. On 03/25/21, following a 10-day hearing, the Board sustained its emergency suspension order. After investigation, the Board voted on 02/24/22 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 8:30 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. Complaint
2. Report of Investigation
3. Text Messages between BL and Licensee
4. Text Messages between KB and Licensee
5. Call Logger Notes
6. Patient KB Physician Orders
7. Patient KB Nurse Notes
8. Patient BL Physician Order **EXCLUDED BY AGREEMENT**
9. Patient BL Nurse Notes **EXCLUDED BY AGREEMENT**
10. Licensee's Response
11. Order on Emergency Suspension
12. NH Dos 2020 Non-Profit Report – Michael Stephen Boyd Memorial Foundation
13. Facebook Post "Dawn's Birthday Fundraiser **SEALED BY AGREEMENT**
14. Facebook Post Dawn's GivingTuesday Fundraiser **SEALED AGREEMENT**
15. Plan of Care AV
16. Plan of Care BS
17. Plan of Care SS
18. Plan of Care TD

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

A. Letter by Lisa Warner
B. Letter by David Butler
C. Letter by Whitney Ozkan
D. BrightStar Care Facebook post: Star of the Week
E. Facebook Posts from the Michael Stephen Boyd Memorial Foundation **EXCLUDED**
F. WMUR Article **EXCLUDED**
G. Doucette-Nicholls Email **EXCLUDED**

c. Sworn testimony was received from:

1. Brittney Briggs, RN (called by Hearing Counsel)
2. Ashley Daniels, RN (called by Hearing Counsel)
3. Michael Doucette (called by Hearing Counsel)
4. Whitney Ozkan (called by Licensee)
5. Samantha Jean (called by Licensee)
6. Lisa Warner, RN (called by Licensee)
7. Licensee (called by Licensee)

IV. PRELIMINARY MATTERS

The admissibility of exhibits and witness testimony were determined at previous prehearing conferences and by orders on written pleadings. The Presiding Officer also instructed the Board that the Licensee was testifying but would be invoking her right against self-incrimination as needed. The Board was further instructed that it may draw an adverse inference from the Licensee's decision to invoke the right against self-incrimination with respect to any question.

V. CONDUCT OF THE HEARING AND EVIDENCE PRESENTED

The issues enumerated in the notice of hearing were as follows:

1) Whether Licensee engaged in professional misconduct while working at BrightStar Care of Bedford/Manchester in Bedford, New Hampshire when she allegedly engaged in non-professional relationships with patients at her place of work and with her friend/patient "Tony" and solicited and/or obtained controlled substances from said patients at work to treat "Tony" in violation of RSA 326-B:37, II(e), RSA 326-B:37, II(g) [*See* RSA 326-B:12, I(f) and/or II], RSA 326-B:37, II(h)(1), RSA 326-B:37, II(m), RSA 326-B:37, II(n), RSA 326-B:37, II(p)(1), Rule 402.04(b)(3), Rule 402.04(b)(5), and/or Rule 402.04(b)(6).

2) Whether Licensee engaged in professional misconduct while working at BrightStar Care of Bedford/Manchester in Bedford, New Hampshire when she allegedly failed to take vital signs on four patients, completed infusions for patients faster than prescribed, failed to complete hydration for patients in violation, and/or falsified and/or failed to properly document patient care records in violation of RSA 326-B:37, II(e), RSA 326-B:37, II(g) [*See* RSA 326-B:12, I(f) and II], RSA 326-B:37, II(h)(1), RSA 326-B:37, II(m), Rule 402.04(b)(6), Rule 402.04(b)(10), Rule 402.04(b)(11).

3) 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.

Notice of Hearing at II.c.

Hearing Counsel bears the burden of proof by a preponderance of the evidence with respect to these issues. Rule 207.10. To present his case, Hearing Counsel provided Exhibits 1-7, 10-18, and testimony from Brittney Briggs, Ashley Daniels, and Michael Doucette.[1] The Licensee offered Exhibits A-D and the testimony of Whitney Ozkan, Samantha Jean, Lisa Warner, and the Licensee. Based upon the credible evidence presented at the hearing, the Board finds the following facts.

HEARING COUNSEL'S CASE-IN-CHIEF:

Brittney Briggs

Brittney Briggs testified that she had filed the complaint in this matter and was previously the Director of Nursing at Brightstar Care where she supervised the Licensee. According to Nurse Briggs' testimony, another nurse she supervised at Brightstar Care (Ashley Daniels) told her that several patients had alleged that the Licensee was soliciting medication from them and had failed to correctly administer infusions for them. Nurse Briggs explained that she followed up on these allegations by holding a disciplinary meeting with the Licensee, after which she filed the complaint against the Licensee with the Board. The complaint says the Licensee had committed multiple acts of misconduct, including "[f]alsifying clinical documentation, not following physician orders (i.e. not finishing fluids, not performing vital signs, increasing titration orders), soliciting drugs from a patient, and threatening and harassing of a client." Exh. 1 at HC 006.

The complaint also references the disciplinary meeting Nurse Briggs mentioned in her testimony, claiming the Licensee "… was brought in for disciplinary action on February 5th, 2021 on allegations above Admitted to the solicitation of drugs from a patient. Choose to voluntarily Resign." Exh. 1 at HC 007. The complaint form is also supported by a 02/09/21 letter from Nurse Briggs outlining her

[1] Hearing Counsel also had OPLC Investigator Brianna Miller (author of Exhibit 2,) available for questioning from the Licensee and Board.

conversations with Ashley Daniels, the patients who had made allegations against the Licensee to Nurse Daniels, and the Licensee. This letter additionally clarifies that the Licensee admitted to asking a patient for drugs, stating to Ms. Briggs "[y]es but she [the patient] offered them to me [Licensee] before for personal use." Exh. 1 at HC 010.

Nurse Briggs next turned to discussing the more specific allegations of some of the patients. According to her testimony, patient KB alleged the Licensee did not take KB's vitals throughout her infusions. Ms. Briggs testified that based upon this information, she would not expect that KB's vital sign record of 01/08/21 would show vital sign readings. Nonetheless, the record shows that the Licensee took multiple vitals for KB throughout the 01/08/21 infusion treatment. Exh. 7 at HC 103. Nurse Briggs described not taking vital signs throughout an infusion as a violation of Brightstar Care policy. Ms. Brigg's testimony also revealed she had concerns the Licensee was not following physician titration orders. To support this conclusion Ms. Brigg's stated that several patients had told her infusions were taking a very long time. According to Ms. Brigg's testimony, Exhibit 6, which is a Physician Infusion Order for KB dated 10/07/19, indicates that the titrations should not be taking as long as KB alleged. Ms. Briggs explained that not following a physician's order was also a violation of Brightstar Care policy.

On cross examination, Ms. Briggs testimony NELC patients transferring to Brightstar Care had a greater rate of complaints with staff because of the changes in policy and procedure they experienced. Nonetheless, Ms. Briggs clarified that the patient complaints relating to the Licensee's alleged conduct were "more concerning" than the generalized complaints of transitioning NELC patients to Brightstar Care. Nurse Briggs also acknowledged that Brightstar Care has general policies on infusions, but that those policies are then tailored at each corporate location to applicable state law. Nurse Briggs also agreed that she took over as Nursing Director at the Brightstar Care location where

the Licensee worked approximately 2 months before the alleged conduct occurred. She noted it was possible that the forms and/or policies used by her predecessor, Lisa Warner, could have differed from those in place when the alleged conduct occurred. Nurse Briggs also conceded that there were individuals reviewing the Licensee's infusion care paperwork whose jobs were to ensure there are no missing pages or information. According to her testimony none of these individuals raised any flags about the Licensee.

Upon Board questioning, Nurse Briggs clarified that Brightstar Care policies were provided to employees, who had to attest that they had read and would follow them. She stated that employees were required to attest to having read an employee manual when hired and then did an annual attestation of new and updated policies.

Ashley Daniels

Hearing Counsel's next witness was Nurse Ashley Daniels. Nurse Daniels testified that she worked at Brightstar Care and covered patient assignments for the Licensee in January and February of 2021. According to Ms. Daniel's testimony, she had, while covering one of the Licensee's assignments, called the Licensee to inquire why an infusion pump for one of the Licensee's patients was not programmed. Ms. Daniel's said the Licensee told her it was because the Licensee ran her patients how she wanted. Ms. Daniel's described having the pump programmed wrong was "unusual" because they are pre-programmed by the pharmacy.

Ms. Daniel's next turned her attention to her relationship she had with the Licensee before the Licensee voluntarily resigned from Brightstar Care. She described it as friendly and explained that the Licensee relayed to her information about her personal life at times. She testified that these conversations included discussions about a friend of the Licensee's named Tony. Ms. Daniels said that the Licensee had asked her to cover some the January and February 2021 shifts for her, so that she could drive Tony to

Florida. According to her testimony, the Licensee was helping Tony because he was a homeless substance user. She described the Licensee as being involved in the substance use prevention and assistance community because her former fiancé had died of an overdose. Ms. Daniels stated that she perceived the Licensee's relationship with Tony as being romantic and noted that the Licensee allowed him to live in her home and that she assisted him with many aspects of life, including food and detoxification. Ms. Daniels explained that the Licensee had informed her that Tony was a heroin addict and that she had driven Tony to Lawrence to get heroin, so there would be no withdrawal issues for him during the car ride to Florida. According to Ms. Daniels' testimony, the Licensee had said that once she and Tony arrived in Florida he would be detoxing.

Ms. Daniels testimony next addressed allegations that the Licensee had solicited patients for money. This portion of the hearing was held in non-public to protect the reputation of the patients and their patient information. For these same reasons the referenced exhibits were sealed. *See* RSA 310-A:1-l, I and RSAs 91-A:3(c) and (j). According to Ms. Daniel's, the Licensee had formed a non-profit foundation to assist individuals with substance use disorders to honor her fiancé. Ms. Daniels reviewed Exhibit 13, which is a printout of a Facebook page for the foundation showing comments from donors. Ms. Daniels identified the names of patients who had written in the comment section, indicating they had donated to the foundation.

On cross examination, Ms. Daniel's authenticated a text exchange between patient KB and the Ms. Daniels in which KB admits to giving the Licensee "a small amount of weed" but then says "Oh well then, I lied and never gave her anything" in response to the question "[y]ou didn't tell me you gave her anything. Just that she asked." Exh 2 HC 013. Ms. Daniels also agreed that, aside from some patient complaints that the Licensee did not do vital signs throughout infusions, she had no reason to not believe that the Licensee had recorded the forms for patient infusions that are contained in the medical record and

contained in the exhibits submitted by Hearing Counsel. She also conceded that variations in IV bag size can affect the timing of infusions. Ms. Daniels also described the Licensee's passion for the foundation and those it helped as genuine.

Michael Doucette

The last witness to testify for Hearing Counsel was Michael Doucette, who opened his testimony by explaining that he was the Director of Skilled Care at Brightstar Care. He testified that both he and Ms. Briggs were present for the disciplinary meeting with the Licensee that resulted in the filing of the complaint with the Board. He reviewed Exhibit 1 and identified a statement he had written after the disciplinary meeting. He affirmed that he was truthful in in his discussions with the OPLC Board Investigator in this matter, Brianna Miller. Mr. Doucette's statement says that the Licensee denied running infusions too quickly or neglecting post-hydrate physician's orders. Nonetheless, his statement says that the Licensee "… admitted to not taking vitals on multiple clients as a matter of habit, as well as not following safe vital signs monitoring on others." Exh. 1 at HC 012. The statement also elucidates that the Licensee admitted to asking a patient for drugs and that the patient had offered them to her before.

On cross examination, Mr. Doucette acknowledged that there were no identified issues with the Licensee's conduct at work before the issues described in the complaint came to light.

Brianna Miller, OPLC Investigator

Neither the Licensee nor the Board had questions for Ms. Miller. She did not testify.

LICENSEE'S CASE-IN-CHIEF:

Whitney Ozkan and Samantha Jean

Both Whitney Ozkan and Samantha Jean testified on behalf of the Licensee. They are former infusion patients of the Licensee. Both stated that the Licensee always took vital signs during the infusions and completed them. Ms. Ozkan stated the Licensee always provided her with fluids for the infusions.

Both witnesses testified that they became friends with the Licensee and became Facebook friends with her while living in New Hampshire and receiving infusion treatment from her. Ms. Jean testified that she was aware of the Licensee's foundation and had donated to it of her own accord, not through solicitation from the Licensee. She did recall that the Licensee had spoken to her about the foundation.

Lisa Warner

Lisa Warner was the next witness to testify for the Licensee. She stated that she was the Director of Nursing at Brightstar Care before Nurse Briggs. Ms. Warner authenticated and stood by the letter she wrote in relation to the Licensee's emergency hearing. *See* Exh. A. She stated she was aware of the patient complaints made against the Licensee and attributed them to the fact that at least some of the patients involved were unhappy NECL patients. She further explained that providing infusions for the chronically ill is a "delicate business". Ms. Warner next turned to the plan of care forms contained in Hearing Counsel's exhibits. Nurse Warner testified that she had created these forms and that under her supervision nurses used their judgment to decide whether to take vital signs during infusions. According to her testimony, she was unaware of any blanket Brightstar Care policy involving the taking of vital signs during infusions. Her testimony also revealed that the pharmacy pre-programmed the infusion pumps and it was not uncommon for IV bags to be overfilled.

Upon Board questioning, she acknowledged that nurses must follow both the plan of care and the corporate policy. She also noted that IVIG infusion is the only type of infusion for which vitals would be automatically required.

Brittney Briggs

Ms. Briggs briefly made herself available again for the Board after Ms. Warner's testimony. She reaffirmed her testimony regarding there always being a Brightstar Care policy in place for taking vitals

during infusions and following physician orders as stated. She could not recall exactly what the policy said.

Licensee

The Licensee began her testimony by explaining she founded her foundation in honor of her fiancé, who had passed away from an overdose in order to help others in similar situations. She expressed a great deal of love and devotion for her fiancé. She also described the purpose of the Facebook fundraisers for the foundation referenced during Ms. Daniel's and Ms. Brigg's testimony. According to her testimony, she wanted to spread the name of the foundation and raise money for its charitable purpose. The Licensee denied having solicited either patient KB or SJ from donating to the foundation. She said she promoted the fundraisers by reposting them and that KB and SJ were her Facebook friends. The Licensee briefly switched topics to mention that none of the patients at issue in Hearing Counsel's exhibits were IGIV patients.

The Licensee's testimony next shifted to her relationship with Tony. She stated that she was friends with Tony at the time of the alleged misconduct involving him, not lovers. She testified that she cared about him and never suggested or advocated for him to use drugs. According to her testimony, she had learned from these events what professional boundaries with clients should be and has taken continuing education courses related to that topic. She relayed that the entire experience has made her realize that she should not work in home health care. She represented that these things would not happen again if a similar situation arose because her life is not the same and she has suffered "extreme" consequences.

The Licensee also addressed the allegations of not taking vital signs as required, not hydrating per physician orders, not finishing infusions, and falsifying documentation. She denied most of these claims and explained that she took vitals when appropriate. The Licensee also explained that Tony was the one

who had texted KB from the unknown telephone number, not the Licensee. She testified that she had no knowledge that Tony was doing this, which she would not have condoned or allowed. She described herself as being furious at Tony for contacting the patient. *See also* Exh. 11.

On cross examination, Hearing Counsel asked a series of questions about the Licensee's involvement in driving Tony to Massachusetts to buy heroin, driving him down to Florida, and his detoxing there. She invoked her right against self-incrimination with respect to these questions. Hearing Counsel also asked a series of questions related to her having asked patient KB for and received from a patient KB prescribed Ativan and marijuana. The Licensee invoked her right against self-incrimination with respect to these questions.

On Board examination, the Licensee did not recall ever signing a specific vital signs or professional boundaries policy while at Brightstar Care. She candidly admitted that the professional boundary "lines were blurred for me" in home healthcare. She also reminded the Board that she was "very candid at the last hearing [emergency suspension hearing], *See* Exh. 11,[2] and as candid as she could be at this hearing in following the advice of counsel. She implored the Board to consider that she never had a past disciplinary history in 10 years as a nurse, made poor decisions because of the affect her fiancé's death had on her, has removed herself from the foundation, would never go back to working in home healthcare, and Tony has maintained sobriety for 20 months. The Licensee also explained that she does not have, and

[2] Hearing Counsel's Exhibit 11 is the Order on Emergency Suspension – 04/21/21 in this matter. According to the Order, the Licensee made the following admissions at that hearing: 1) "… she asked a patient for Ativan. She justified it by saying that they are good friends and she goes to their house often, but she knows that she is not supposed to cross that boundary and become friends." Exh. 11 at HC 078-79; 2) "Licensee solemnly states that she lost a close friend to heroin addiction and she currently lives with a roommate [Tony] who was going through opioid withdrawals. Licensee was seeking to help him avoid a relapse. Licensee's roommate was asking for "benzos," and Licensee admits that her rationale was "what can I do to prevent him from relapsing on heroin?" Exh. 11 at HC 0079; 3) "Licensee states that she was not trying to obtain drugs for him [Tony] to get high. Licensee admits that it was a lapse in judgment, but that she did it with the best of intentions." *Id.*; 4) "Licensee knows that acting as a 'middleman' for the purposes of obtaining drugs for her roommate is illegal, but that she runs a non-profit organization that helps addicts and she cares about the people she assists." *Id.*; 5) "Licensee admitted that she did not consider the consequences and that she was providing medical treatment outside her scope of knowledge/practice." *Id.*

never has had a substance use issue. She explained that she knows the signs to look for if Tony has a slip or relapse.

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

The notice of hearing contained two issues presented relating to alleged professional misconduct, although most of the testimony focused on only one of those issues. *See* Notice of Hearing at II.c. With respect to Issue II.c.2, which was the focus of the testimony, the Board finds that there is insufficient evidence to conclude that the Licensee has engaged in professional misconduct with respect to any of the allegations and counts contained therein. Very little (if anything) substantiates the allegation that the Licensee falsified records of infusion patients and failed to complete hydration for patients beyond multiple patients claims and an exhibit showing she took vitals for one of those patients on one occasion.[3] Likewise, very little (if anything) substantiates that she completed infusions for patients faster than prescribed, other than the claims of the patients and the conflicting (and often times contradictory) testimony of the various licensed nurses who discussed infusion practices, Brightstar Care policy, the Licensee's infusion practices, and the Licensee's documentation. Finally, the evidence was insufficient to support the patient claims that the Licensee failed to take vitals when appropriate. The Board heard from multiple nurses with training and experience in the practice of infusions and they provided conflicting (and at times contradictory) testimony on the subject. For these reasons, the Board makes no findings of professional misconduct with respect to Issue II.c.2 in the notice of hearing.

The Board next turns to Issue II.C.1 of the notice of hearing. After reviewing all the evidence, drawing all reasonable inferences therefrom, and accounting for the demeanor and credibility of the witnesses, the Board finds, by a preponderance of the evidence, that the Licensee committed professional

[3] The parties stipulated that the Licensee recorded the vitals on that occasion and the Licensee testified that she recorded the patient's vitals after having taken them.

misconduct. Based upon the evidence presented and the findings of fact made herein, the Board additionally finds and concludes as follows:

1) The Board makes an adverse inference from the Licensee's invocation of her right against self-incrimination to certain questions asked by Hearing Counsel at the adjudicatory proceeding;

2) The Licensee engaged in professional misconduct as defined at RSA 326-B:37, II(h) when she engaged in a non-professional friendship with patient KB while serving as her nurse.

3) The Licensee engaged in professional misconduct as defined at RSA 326-B:37, II(m) when she engaged in a non-professional friendship with patient KB while serving as her nurse.

4) The Licensee engaged in professional misconduct as defined at RSA 326-B:37, II(h) when she engaged in a non-professional friendship with SJ while serving as her nurse.

5) The Licensee engaged in professional misconduct as defined at RSA 326-B:37, II(m) when she engaged in a non-professional friendship with SJ while serving as her nurse.

6) The Licensee engaged in professional misconduct as defined at RSA 326-B:37, II(e) when, after developing a friendship with KB, she asked for and received KB's prescribed Ativan from KB to provide to Tony.

7) The Licensee engaged in professional misconduct as defined at RSA 326-B:37, II(g)[*See* RSA 326-B:12, I(f) and II) when, after developing a friendship with KB, she asked for and received KB's prescribed Ativan from KB to provide to Tony.

8) The Licensee engaged in professional misconduct as defined at RSA 326-B:37, II(n) when, after developing a friendship with KB, she asked for and received KB's prescribed Ativan from KB to provide to Tony.

9) The Licensee engaged in professional misconduct as defined at RSA 326-B:37, II(p)(1) when, after developing a friendship with KB, she asked for and received Ativan from KB to provide to Tony.

10) The Licensee engaged in professional misconduct as defined at RSA 326-B:37, II(q)(2) [*See* Rules 402.04(b)(5) and Rule 402.04(b)(6)] when, after developing a friendship with KB, she asked for and received Ativan from KB to provide to Tony.

11) The Licensee **DID NOT** engage in professional misconduct as defined at RSA 326-B:37, II (q)(2) [*See* Rule 402.04(b)(3)] where there is insufficient evidence that she violated care recipients' rights, confidentiality, privacy or records with respect to KB, SJ or Tony.

12) The Licensee engaged in professional misconduct as defined at RSA 326-B:37, II(e) when she assisted and oversaw her friend and roommate Tony detoxify from heroin by driving him to obtain heroin in Massachusetts that he was going to use for detoxing, driving him to Florida, and overseeing his detoxification in Florida.

13) The Licensee engaged in professional misconduct as defined at RSA 326-B:37, II(g)[*See* RSAs 326-B:12, I(f) and II) when she assisted and oversaw her friend and roommate Tony detoxify from heroin by driving him to obtain heroin in Massachusetts that he was going to use for detoxing, driving him to Florida, and overseeing his detoxification in Florida.

14) The Licensee engaged in professional misconduct as defined at RSA 326-B:37, II (h)(1) when she assisted and oversaw her friend and roommate Tony detoxify from heroin by driving him to obtain heroin in Massachusetts that he was going to use for detoxing, driving him to Florida, and overseeing his detoxification in Florida.

15) The Licensee engaged in professional misconduct as defined at RSA 326-B:37, II (m) when she assisted and oversaw her friend and roommate Tony detoxify from heroin by driving him to obtain heroin in Massachusetts that he was going to use for detoxing, driving him to Florida, and overseeing his detoxification in Florida.

16) The Licensee engaged in professional misconduct as defined at RSA 326-B:37, II(p)(1) when she assisted and oversaw her friend and roommate Tony detoxify from heroin by driving him to obtain heroin in Massachusetts that he was going to use for detoxing, driving him to Florida, and overseeing his detoxification in Florida.

17) The Licensee engaged in professional misconduct as defined at RSA 326-B:37, II(q)(2) when she assisted and oversaw her friend and roommate Tony detoxify from heroin by driving him to obtain heroin in Massachusetts that he was going to use for detoxing, driving him to Florida, and overseeing his detoxification in Florida.

18) Pursuant to RSA 326-b:37(III), the Board hereby imposes the following sanctions: If the Licensee seeks to reinstate, reapply, or apply for licensure with the Board, the Board reserves the right to deny, restrict, condition, or modify her licensure based upon these disciplinary findings. *See also* RSA 326-B:25 *and* RSA 326-B:16, IV.

19) In administering this discipline, the Board considered and weighed the factors enumerated in RSA 326-B:37(III) and Rule 402.04(g). The Board wishes to impress upon the Licensee that the offenses were extremely serious, *see* Rule 402.04(g)(1), the Board found that she knew what she was doing with respect to both offenses upon which the Board based its findings of professional misconduct, *see* Rule 402.04(g)(3), the purpose of the rules and statutes violated by the Licensee are to protect the public (including her patients and Tony), *see* Rule 402.04(g)(6), and the potential harm to the

public health and safety (especially Tony) were significant and could have resulted in death. Rule 402.04(g)(7). Based upon those factors, and even considering the Licensee's past acknowledgement of her wrongdoing, *see* Rule 402.04(g)(4), her past disciplinary record, Rule 402.04(g)(2), and current circumstances, it was clear to the Board that were the Licensee currently licensed it would have revoked her license to protect the public and deter both the licensee and other licensees from engaging in such misconduct in the future. *See* Rule 402.04(h).

VII. ORDERS:

Pursuant to RSA 326-B:37, and Rule 402, the Board hereby makes the herein findings of professional misconduct and reserves the right to deny, restrict, condition, or modify her licensure based upon these disciplinary findings if she reapplies for licensure. *See also* RSA 326-B:25 *and* RSA 326-B:16, IV.

DATED: 12/21/2022

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