STATE OF NEW HAMPSHIRE
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

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BOARD OF NURSING

In Re: Malissa Pascarelli, **MNA License # 042392-MNA**	Docket No.: 2022-NUR-0022 **FINAL DECISION AND ORDER – 10/27/22**

I. ATTENDEES

Samantha O'Neill, Board Chair
Joni Menard, Board Vice-Chair
Melissa Underhill, Board Member
Matthew Kitsis, Board Member
Maureen Murtaugh, Board Member via Zoom
Michele Melanson-Schmitt, Board Member
Wendy Stanley Jones, Board Member
Dwayne Thibeault, Board Member
Attorney Lauren Warner, OPLC Board Counsel
Jeanne Webber, OPLC Board Administrator
Talia Wilson, OPLC Board Administrator
Chris Horne, OPLC Board Administrator
Attorney Nikolas K. Frye, OPLC Hearings Examiner and Presiding Officer
Attorney Marissa Schuetz, OPLC Hearing Counsel
Attorney Jack Crisp, Counsel for Licensee
Malissa Pascarelli, Licensee

II. CASE SUMMARY/PROCEDURAL HISTORY

On or about 02/23/22, the Office of Professional Licensure & Certification, Division of Enforcement ("OPLC Enforcement") received, on behalf of the New Hampshire Board of Nursing ("Board"), a complaint from Kendal at Hanover ("Kendal") in Hanover, New Hampshire alleging that, while working as an MNA at Kendal, Malissa Pascarelli ("Licensee") had, over a period of four months: 1) given a resident an additional dose of medication without an order after she was instructed not to do so;

2) lied to her supervisor about her actions; and 3) took the medication from another resident. After investigation, the Board voted on 05/26/22 to commence an adjudicative/disciplinary proceeding in this matter. A Notice of Adjudicative Hearing followed, and the Board then held the adjudicatory hearing on 10/27/22 at 11:00 AM. 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. 02/23/21 Complaint
2. Facility Patient's Bill of Rights and Handbook
3. 04/21/21 Report of Investigation
4. 04/15/21 Response

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

A. 07/12/21 Letter from Lori Lintner, Bureau of Elderly and Adult Services- Claremont District Office
B. Various Letters of Reference for Malissa Pascarelli
C. Various Evaluations of Malissa Pascarelli performed by her Employers
D. 02/28/20 Kendal Notification of Perfect Attendance
E. Respondent's Resume

b. Sworn testimony was received from:

1. Ren Horne, OPLC Investigator (called by Hearing Counsel)
2. Licensee (called by Licensee)
3. Peter Doyle (called by Licensee)

IV. PRELIMINARY MATTERS

The parties had no objection to any of the exhibits that were filed. The Presiding Officer fully admitted them after determining they were material and relevant. The Presiding Officer instructed the Board that it should give no weight to any notes or highlighting contained on any of Hearing Counsel's Exhibits. (Hearing Counsel identified the specific exhibit(s) and pages where such markings existed.) The parties also submitted a 10/27/22 Joint Stipulation of Fact for the Board's consideration. At the

recommendation of the Presiding Officer, the Board also preliminary granted the assented to oral Motion to Strike Issue II.c.2.

Lastly, the parties requested the Presiding Officer rule upon Hearing Counsel's request to amend the Notice of Hearing/the scope of the hearing to include factual allegations related to the Licensee's administration of cholesterol medication to a patient after it was discontinued. Hearing Counsel argued her right to amend and/or introduce evidence related to this topic was controlled by *In re Bloomfield*, 166 N.H. 475, 483 (2014). She explained the original complaint contained the allegations, the Board voted to proceed with disciplinary action based upon that complaint, and said complaint and information relating to it was provided to the Licensee in discovery. The Licensee countered that *Bloomfield* did not stand for the proposition that Board's could substantively hear different factual allegations at the time of the hearing than were noticed in the notice of hearing. She contended that adopting such a reading of *Bloomfield* would be too broad and eradicate notice in its entirety under due process. The Presiding Officer took the matter under advisement until the close of evidence, so that he had an opportunity to review the case law and file. Hearing Counsel was allowed to present the factual allegations related to the administration of the cholesterol medication with the understanding that the Presiding Officer would decide on whether the Board could make a finding based upon that evidence before their deliberation.

The Presiding Officer's analysis starts with the procedural posture of this case. The parties held a prehearing conference on 10/04/22, during which they discussed a request by Hearing Counsel to amend the notice of hearing to include an issue presented addressing scope of practice. The Presiding Officer issued a lengthy, detailed order setting forth an analysis for considering requests to amend in the context of nursing cases and ultimately granted Hearing Counsel's motion. As part of that analysis, the Presiding Officer noted that "the Board rules clarify that "[t]he parties shall receive at least 15 days' notice and an opportunity to be heard on any amended issues." Rule 211.04(b).

Here, Hearing Counsel asked, at the start of the hearing, that the Board address substantive facts that are neither the focus of the report of investigation the Board considered when voting to initiate disciplinary action nor contained in the notice of hearing.[1] Hearing Counsel's request is untimely under Rule 211.04(b). In contrast, Licensee's objection that the facts pertaining to the cholesterol medication as being material and relevant in terms of an alternative theory of discipline for the Board to pursue in this matter is timely. *See Miller v. Slania Enterprises, Inc.*, 150 N.H. 655, 659-660 (2004).[2] The situation is also dissimilar to that in *State v. Summers*, 142 N.H. 429 (1997), which the Presiding Officer had cited in the prehearing conference order to make a broader point about the constitutional due process required in administrative proceedings versus criminal proceedings, as Rule 211.04(b) provides an additional layer to the analysis. Under the circumstances presented, regardless of *Bloomfield*, the Presiding Officer would have to waive Rule 211.04(b) to grant Hearing Counsel's request, as the rule is more restrictive than *Bloomfield*. The Board has no rule for procedural waiver. Therefore, the Presiding Officer looks to the New Hampshire Department of Justice Rules Part 800. *See* Notice of Hearing at II.b. According to the relevant rule:

> The presiding officer, upon his or her own initiative or upon the motion of any party, shall suspend or waive any requirement or limitation imposed by this chapter upon reasonable notice to affected persons when the proposed waiver or suspension appears to be lawful, and would be more likely to promote the fair, accurate and efficient resolution of issues pending before the agency than would adherence to a particular rule or procedure.
>
> Jus 803.03.

[1] The "Origin and Nature of Investigation" section of the Report of Investigation states: "[t]he complaint alleges that licensee Malissa Pascarelli of Windsor, VT. Violated Board of Nursing statute 326-B:14 Scope of Practice when she gave melatonin belonging to resident MF to another resident BD over a period of time encompassing the previous four months". Exh. 3 at HC016. While the Report of Investigation does reference the factual allegations raised by Hearing Counsel, it is done so in passing in discussing the issue with how the Licensee administered the melatonin. *See Id* at HC016-17.

[2] Affirming trial court's decision to allow tenant's constructive amendment to pleadings because the landlord failed to object to same during trial or in pleading.

Applying waiver on the day of the hearing under these specific circumstances is not reasonable notice within the meaning of Jus 803.03. The requested amendment includes substantively different factual allegations than those that are the focus of the report of investigation and contained in the notice of hearing. Further the Presiding Officer had previously provided the parties with clear written guidance on Nur Rule 211.04(b) and other law pertaining to amendment. Consequently, Hearing Counsel's 10/27/22 oral Motion to Amend the Notice of Hearing is respectfully denied.

V. CONDUCT OF THE HEARING AND EVIDENCE PRESENTED

On the remaining issues, Hearing Counsel bears the burden of proof by a preponderance of the evidence. Rule 207.10. To present her case, Hearing Counsel provided Exhibits 1 through 4 and testimony from OPLC Investigator Ren Horne.[3] A stipulation of fact was also presented by the parties and hereby adopted by the Board. Based upon the evidence presented at the hearing, the Board finds the following facts.

HEARING COUNSEL'S CASE-IN-CHIEF:

Stipulation of Fact

The parties submitted a 10/27/22 Joint Stipulation of Facts which states, in relevant part:

> The Board first granted Respondent a license to practice as a licensed nursing assistant in the state of New Hampshire on October 27, 2009. The Board then granted Respondent a license to practice as a medication nursing assistant on October 2, 2014. Respondent holds license numbers 042392-24 and 042392-MNA, which expire on August 25, 2023. In response to a complaint received on March 23, 2021, from Sarah Mack, RN of Kendal at Hanover ("Kendal"), the Board conducted an investigation and obtained information from various sources pertaining to the Respondent's conduct with administering medications to residents. Respondent was employed by Kendal at Hanover beginning in 2009 and continuing until February 23, 2021. During the relevant time period, Respondent was working in the Assisted Living unit of the facility. On four (4) separate occasions, between January and February 2021, Respondent administered to patient BD a 3mg pill of a non-narcotic medication, melatonin, from a supply purchased by and belonging to patient MF. Patient BD had orders for, and received, 5mg of melatonin nightly. Respondent did not have written or verbal orders to administer the additional 3mg of melatonin

[3] Much of the testimony regarding to the cholesterol medication is not included in this order because of the ruling on the 10/27/22 oral motion.

to BD. Respondent did not document the administration of the additional 3mg of melatonin in patient BD's medication records. Respondent administered the medication to BD with the intent to settle a "disruptive and restless patient" who had a tendency to wander at night. (Response pg 7). Respondent was terminated from Kendal on February 23, 2021 as a result of these actions. There is no evidence or allegations of patient harm as a result of these actions.

10/27/22 Joint Stipulation of Facts.

Ren Horne

The Board's file reflects that the Licensee is actively licensed as a Licensed Nursing Assistant, certified as a Medication Nursing Assistant ("MNA") in New Hampshire, with license number 042392-MNA. The first witness to testify was Ren Horne, who opened by explaining he is the OPLC investigator who was assigned to investigate this matter. Investigator Horne testified that he began his investigation by speaking with the complainant, Sarah Mack, RN, who was the facility administrator at Kendal at Hanover in Hanover, New Hampshire where the Licensee worked when the complaint against her was filed. *See also* Exhs. 1 and 3. According to the complaint, which is Exhibit 1, the complainant was concerned that the Licensee "… gave [sic] resident an additional dose of medication without a [sic] order to 'deal with [sic] resident', after she was instructed not to give medication. This was an ongoing event over months. When asked about [sic] error she lied to supervisor about actions and took medication from another resident." Exh. 1 at HC002-003. The Investigator's report, Exhibit 3, demonstrates that he interviewed the complainant, reviewed a response to the complaint submitted by the Licensee, spoke with the Licensee, and considered a narrative of events surrounding the complaint submitted by the complainant. His findings largely support the allegations contained in the complaint. *See* Exhs. 2, 3, and 4.

Upon Board questioning, Investigator Horne clarified that there was no evidence that there was a large amount of melatonin missing.

LICENSEE'S CASE-IN-CHIEF:

Stipulation of Fact

The relevant portions of the 10/27/22 Joint Stipulation of Fact described above is incorporated herein by reference.

Peter Doyle

Mr. Doyle testified that he is a research professor emeritus and the son of the woman to whom the Licensee had administered additional melatonin. He explained that even after reviewing all the discovery materials in this matter, he still believed that the Licensee provided excellent care to his mother. He noted he was surprised she was fired because she provided additional melatonin to his mother. According to his testimony, healthcare workers and/or providers at Kendal had told him his mother should be moved from the unit in which she was being cared, as she wanders.

Licensee

The Licensee started her testimony by referencing her resume, Exh. E, which shows her training and experience as an LNA/MNA. According to her testimony and resume, the Licensee has practiced as an LNA since approximately 2008, has no other disciplinary action, and has always received positive evaluations (*see also* Exhs. B, C and D). With respect to the complaint at issue in this proceeding, the Licensee provided Exhibit A, which is a 07/12/21 letter from the New Hampshire Bureau of Adult and Elderly Services notifying her that the "founded" determination that she had emotionally abused the patient related to this disciplinary proceeding had been overturned. Exh. A.

The Licensee also described what it was like caring for patients at Kendal when she worked there. She testified that the patient at issue tended to wander so much that the Licensee started staying on during her lunch breaks to ensure oversight. She noted she covered 15-20 patients by herself during her shifts, as well as patients in the adjoining unit occasionally. The Licensee then shifted her testimony to discuss

why she provided the additional melatonin to the patient. The Licensee said melatonin is a dietary supplement and that she gave it to the patient because she wanted to console and help the patient, who was agitated from ongoing construction in the unit. The Licensee contextualized her decision by telling the Board that two years ago a man in the unit had wandered outside and died. She also noted that after she was terminated, the patient at issue in this matter was found outside in the wintertime without a coat. She noted one needs a keycard to reenter the hospital unit.

The Licensee then turned to her meeting with Sarah Mack in which the missing melatonin was discussed. The Licensee testified that she had withheld the truth from her superiors and then went in the next day to admit to providing 1 3 mg melatonin on four separate occasions to the patient at issue. According to the Licensee's testimony, she has a passion and calling for nursing and took full responsibility for providing the additional medication to the patient. She stated: "she knew it was wrong" and clarified that she would not have taken this action with respect to any other patient medication. She reemphasized being concerned with the patient's safety because she was wandering, had cut-off her wandering tag previously, and the construction in the unit was aggravating her. The Licensee's testimony revealed that she has learned her lesson, and, in the future, would go to the doctor to explain the situation before acting. She explained that she had gone to two of her supervising nurses about the issue and was told that the patient was at her maximum dose. She finished her direct testimony by reflecting on her love for her work and her current employment at a dementia ward.[4]

On cross examination, the Licensee agreed that an MNA was never permitted to give dosing for any medications, she was aware of the patient bill of rights contained in Exhibit 2 and agreed that she violated the patient's bill of rights when she provided the additional dosages of melatonin to the patient at issue in this matter. On questioning from the Board, she agreed that she had acted outside of her scope of

[4] The Licensee alternatively argued that melatonin was not a medication. The Board draws on its training and expertise to address that issue. ." *See In the Matter of Bloomfield, DMV,* 166 N.H. 475, 486 (2014).

practice in providing the additional melatonin to the patient without consulting with and gaining the approval of the attending provider.

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

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

1) The Board finds and concludes based on its combined training and experience that melatonin is a medication within the meaning of RSA 326-B as it relates to the facts of this case.
2) The Board finds and concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(h) when, while working at Kendal in 2020 and 2021, she gave 3 mgs of melatonin prescribed for one resident to another on four separate occasions over a period of multiple months and originally failed to provide this information to her supervisors when asked.
3) The Board finds and concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(q)(2) (*See* Rule 404.12) when, while working at Kendal in 2020 and 2021, she gave 3 mgs of melatonin prescribed for one resident to another on four separate occasions over a period of multiple months and failed to immediately report same to her supervisor(s).
4) The Board finds and concludes that the Licensee committed professional misconduct, as that term is defined at RSA 326-B:37, II(q)(3) when, while working at Kendal in 2020 and 2021, she gave 3 mgs of melatonin prescribed for one resident to another on four separate occasions over a period of multiple months, contrary to the provider's orders for the patient receiving additional dosages.
5) Pursuant to RSA 326-b:37(III)(a), and upon a finding of misconduct under RSA 326-B:37, II, the Board **REPRIMANDS** the Licensee's license.

6) Pursuant to RSA 326-b:37(III)(c), and upon a finding of misconduct under RSA 326-B:37, II, the Board directs the Licensee to participate in ten (10) hours of program(s) of continuing education in the areas of medication administration within thirty (30) days of the signed date of this order. To document successful completion of the course(s), the Licensee shall provide the Board with written documentary proof issued/authored by the program offering the course(s). **Whether any program(s) meets the requirements of this section shall be determined by the Board. Therefore, the Licensee is strongly encouraged to seek the Board's pre-approval of program(s) before taking them.** The Licensee can submit information about proposed programs to the Board's Administrator, who shall present same to the Board for determination. The ten (10) hours of continuing education ordered hereunder shall be in addition to any normal continuing education required for licensure under Board statue and rules.

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

VII. ORDERS:

Pursuant to RSA 326-B:37, and Rule 402, the Board hereby makes the herein findings of professional misconduct. The Licensee is **REPRIMANDED** and subjected to further disciplinary action as stated herein.

DATED: 11/16/2022

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