STATE OF NEW HAMPSHIRE
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

BOARD OF NURSING

In Re: Jessica Diprizio, **RN Lic. # 049201-21**	Docket No.: 22-Nur-011 **ORDER DISMISSING EMERGENCY SUSPENSION – 04/05/22**

I. ATTENDEES:

Samantha O'Neill, Board Member and Chair
Joni Menard, Board Member and Vice Chair
Matthew Kitsis, Board Member
Gene Harkless, Board Member
Wendy Stanley Jones, Board Member
Ashley Czechowicz, Administrator
Nikolas K. Frye, Esq., Presiding Officer
Collin Phillips, Esq., Hearing Counsel
Janet Michael, Esq., Attorney for Licensee
Jessica Diprizio, Licensee

II. CASE SUMMARY/PROCEDURAL HISTORY:

On 03/24/22, the Office of Professional Licensure and Certification, Division of Enforcement ("OPLC Enforcement"), acting on behalf of the Board of Nursing ("Board"), received a complaint from Huggins Hospital in Wolfeboro, New Hampshire, alleging that Jessica Diprizio ("Licensee") had been diverting medications from patients at Huggins Hospital. On 03/24/22, the Board held an emergency meeting during its non-public session pursuant to RSA 541-A:30(III), RSA 326-B:37(IV), and N.H. Code Admin. R., Title Nur 402.03(a) ("Rules") and voted to suspend Licensee's license on an emergency basis. Pursuant to Rule 402.03(a), a 10-day follow up emergency hearing was held on 04/05/22 at 4:30 pm. This 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, labeled as follows:

1. New Hampshire Root Cause Report and supplemental documentation

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

a. None.

B. Testimony was received from:

1. Meghan Varhegyi, RN, Director of Quality and Risk Huggins Hospital
2. Jessica Diprizio, RN and Licensee

IV. CONDUCT OF HEARING AND EVIDENCE PRESENTED:

On 03/24/22, the Board suspended Licensee's license on an emergency basis. The Board's inquiry at this hearing was limited to whether that temporary suspension should remain in effect, pending a full disciplinary adjudication. Pursuant to Rule 207.10, Hearing Counsel has the burden of proving, by a preponderance of the evidence, that Licensee's license should remain suspended on an emergency basis, pending full adjudication in this matter. Licensee stipulated to the full admission of Hearing Counsel's Exhibit 1, which the Board accepted as a full exhibit. Licensee had no exhibits. The credible evidence presented at the hearing allows the Board to find the following facts.

The Licensee currently holds RN license #049201-21. On 03/24/22, the Board suspended her license on a temporary emergency basis due to concerns she had diverted medications, not provided patients prescribed medications, and falsified and/or made incorrect records related to the administration of the medications for patients. Although a lot of superfluous context was provided through the combined testimony of the witnesses, the heart of the case involves the Licensee's conduct between 03/04/22 and

03/05/22 and on 03/10/22. *See* Exhibit 1. As such, these periods of time are the primary focus of the Board's attention.

Hearing Counsel presented Meghan Varhegyi, RN, Director of Quality and Risk Huggins Hospital as his sole witness, who was sworn in under oath. She first testified to her training and experience in quality assurance and risk management at hospitals and explained that she regularly conducts investigations for Huggins Hospital related to risk assessment. As part of those responsibilities, she was tasked with investigating the allegations against the Licensee that the hospital reported to the Board on 03/24/22. Nurse Varhegyi's testimony consisted mainly of a summary and explanation of her report and the supplemental documents included with it, which were Attachment 1 (pictures of medications handed over to the Wolfeboro Police Department by Licensee's husband during a domestic dispute at Licensee's home on 03/07/22, along with medical information about each drug), Attachment 2 (Omnicell printout from the hospital showing Licensee's entries between 03/03/22 at 7:17 PM and 03/06/22 at 5:43 AM, and Attachment 3 (Inventory of Licensee's medication box brought by Licensee to the hospital on 03/10/22 during an interview). *See* Exhibit 1. She acknowledged her report was a draft that has since been updated, as the hospital's investigation is ongoing.

Ms. Varhegyi's report and testimony reflect that on 03/07/22, a Wolfeboro police officer came to the hospital with a baggy of patient labeled medications looking to speak with a nursing supervisor. The hospital identified that the medications in the baggy as appearing to pertain to three patients treated by the Licensee between 03/03/22 and 03/06/22, who were identified as patients 1, 2, and 3 during the hearing. According to the report and Nurse Varhegyi's testimony, the medication in the baggy for patient #1 was Trazadone 50mg x 2 tablets, Abilify 15mg, Propanolo 20mg, and Duloxetine 30mg; the medication belonging to patient #2 was Gabapentin 300mg; and the medicine for patient #3 was Concerta, half tablet. There also was an unknown (and believed to be) old Divalproex Na tablet not attributed to any patient.

Using the hospital's Omnicell medication record log and comparing it to the MAR, "it appear[ed] [to Nurse Varhegyi] that the evening that … [Licensee] pulled the medications from the Omnicell was 03/04 from 7:02 – 7:06pm."[1] Nurse Varhegyi further testified that the charts for patients 1, 2, and 3 and the Omnicell failed to document any omitted or refused medication, meaning there was no discrepancy between medications pulled and administered. There was also no documentation reflecting any issues with the patients. Consequently, Licensee was suspended from working at the hospital on 03/08/22.

Ms. Varhegyi's testimony further reveals that on 03/10/22, a couple days after being suspended, Licensee appeared at the hospital for an interview performed by Ms. Varhegyi, two members of HR, and the hospital's Director of Quality and Risk. When asked about what happened the night that the patients' medications were found by Licensee's husband at her home, Licensee told the interviewers she has a practice of emptying her pockets at the end of every shift into a box at her house if she brings something home by accident. She explained the baggy was brought home by accident, placed in the box, and later found by her husband during a spat between them on 03/07/22. She further reported having called the police on her husband during the spat because she could not manage his behavior. When the police arrived, her husband presented the baggy to them.

Ms. Varhegyi also explained that during the 03/10/22 interview Licensee had said if it is not her first time dealing with a patient, she will scan their sticker outside of the room and then scan their medication.[2] Ms. Varhegyi testified that on the night in question, Licensee claimed patient #1 was sleeping so she scanned the medications in anticipation of him waking up later, but he never did. Licensee also told Ms. Varhegyi she never gave a Heparin injection to that patient because he was sleeping, even though the records show she provided it. According to Ms. Varhegyi, the Licensee had stated she forgot the Heparin

[1] Nurse Varhegyi appears to be referencing the medication for patients 1-3 found in the baggy but not the old unidentified tablet.

[2] Wrist scanning is a hospital requirement. This bypasses that requirement.

for patient 1 was in her scrubs and brought it home by accident. Licensee claimed she placed it in the box at home where it was later found by her husband. Ms. Varhegyi further testified that Licensee brought the box with her to the 03/10/22 interview , where the four interviewers conducted an inventory of it.[3]

Ms. Varhegyi concluded her testimony by explaining that the MAR showed administration of the medications in question to patients 1, 2, and 3 between 7:43 pm and 8:24 pm on 03/04/22. She further noted that the proximity of the scans of medication for two of Licensee's patients indicate the possibility of her batch scanning medications. She surmised that the evidence indicated to her that Licensee "demonstrates unsafe medication administration practices, unsafe medication disposal practices, and was found to have falsely documented on several medications that the patient never received." Exhibit 1. According to the inventory in Exhibit 1, among the items contained in the box that Licensee brought to the interview were "several glass containers, pill packets, trash, medical supply materials, and pens/pencils." Exhibit 1.

Upon cross examination, Ms. Varghegyi noted that her report provided to the Board was not the most updated and that the investigation of Licensee was ongoing. She also contested the fact that there was only 1 vial of Heparin in the shoe box, though it was unclear from her testimony whether the other vials were empty. Finally, Ms. Varghegyi admitted there are some systems areas at the hospital that may have negatively impacted Licensee's practice on the night in question.

Licensee was sworn in as the sole witness for her case-in-chief. She testified to her training and experience, which included 20 years of experience as an RN, the vast majority of which she worked at Frisbie Memorial Hospital in Rochester, New Hampshire. She explained she has worked at Huggins

[3] The inventory is shown as attachment 3 in Exhibit 1.

Hospital since approximately October 2020. According to her testimony, she received excellent reviews at Frisbie and sufficient reviews at Huggins.[4]

The Licensee next explained the 03/07/22 domestic dispute with her husband. She confirmed that she was the one that called the police because her husband was out of control, and she had found two pills on the floor. She represented that he had a substance problem and when she had confronted him about the pills that night, he said they were hers. She claimed that during the confrontation he went through her purse and the boxes where she keeps her own medication and things that she has accidentally brought home from the hospital. After doing this, she said he accused her of stealing from the hospital. When the police came, he presented them with the baggy of medication from Licensee's shift overnight shift of 03/04/22 to 03/05/22 and told them it was from the hospital.

Licensee's testimony also clarified the factual allegations involving several concerns noted in Ms. Varhegyi's report. First, she testified that it is atypical for her to scan a bracelet while not in the patient's room. On the night in question, she explained she utilized this practice but double-checked with the patient's date of birth and the computer. She also acknowledged her decision was a lapse in judgment. She stated the patient in question had a rough previous night and she thought things would be smoother if she scanned for the medication then and let him sleep. She reiterated this was not her normal practice and she had fully intended to give him the medicine when he woke.

With respect to the Gabapentin the hospital associated as belonging to patient #2, Licensee testified it did not belong to the patient and that it was one of the medications she had found on the floor at her home on 03/07/22 and had asked her husband about.[5] Licensee indicated she was confident she gave Gabapentin to the patient as noted in the MAR. She also agreed that she took Patient #1's medications

[4] Licensee never testified to any prior discipline or investigation by this or any other licensing board, either on direct or cross examination.
[5] She claimed the other of the medication found on the floor was the divalproex found in the baggy.

home with her and failed to administer them as recorded but stated this was by accident and an isolated incident. She acknowledged she should have, as soon as possible, notified the hospital, corrected the records, and brought the medicine back. She also acknowledged that she should not have taken a fourth patient on the night in question given how many responsibilities she already had.

Licensee also testified about the 03/10/22 interview with Ms. Varhegyi and the three other individuals. She explained she brought the box from home to the interview because she wanted to be transparent. She testified it had six months of accumulation of things accidentally brought home from work but later clarified this did not mean the box had a significant number of items in it. She denied Ms. Varhegyis testimony that there were six vials of Heparin found in the box. She stated there was only one full vial, which was the one she accidentally brought home on the night in question, and which should have been administered to patient #1. She explained that prior to the night in question, she had never brought home a baggy with medications in it.

On cross examination, she additionally admitted to taking empty vials home from the hospital to recycle at the local landfill and estimated this happened about once per week. She stated she was unaware if there was a hospital policy against doing so. Hearing Counsel highlighted through her testimony that she had brought patient #1's medication and made it accessible to her husband. She also admitted that she did not have an option in administering a scheduled drug order, such as Heparin.

The Board's questioning of the witness helped clarify the scanning process she used on the night in question. The Licensee explained if she has already tripled checked the wrist band against the computer screen and sticker, she may scan periodically in a way that does not disturb the patients. She assured the Board she does all the checks before starting administration. She again admitted that she used this practice on the night in question with respect to patient #1 due to a lapse in judgment. Upon questioning, Licensee also admitted she should have written a note about why she did not administer the medications to patient

#1. She again clarified that she should have administered the Heparin and simply forgot. Board questioning also resulted in a clear picture of what was shown in the inventory in attachment 3 of Exhibit 1. Excepting the Heparin, most of the items were either the Licensee's medications, empty blister packets and/or vials, or random things one might bring home from work accidentally. The Board notes, and Licensee highlighted, that the hospital's director of pharmacy described the patient medications in the baggy as not being the type diverted for abuse. *See* Exhibit 1.

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

After reviewing all the evidence and accounting for the credibility and demeanor of the witnesses, the Board finds Hearing Counsel has not met his burden of proof by a preponderance of the evidence that the Licensee practicing pending adjudication poses an imminent danger to public health, safety, or welfare. RSA 326-B:37, IV. The Licensee's testimony, when juxtaposed against Ms. Varhegyi's and the report, does not demonstrate by a preponderance of the evidence a definitive pattern of the Licensee bringing patient medications home, either accidentally or intentionally. The evidence currently at its disposal instead suggests the night in question was an isolated incident that further "snowballed" due to the Licensee's poor decisions not to address it sooner. To be clear, the Board is nonetheless troubled by these events, as, among other things, they raise serious concerns about the Licensee's practice of medication administration. Additionally, the Board recognizes that the investigation is ongoing and reserves further judgment based upon all the evidence that investigation yields. What is apparent is this matter warrants scheduling a full disciplinary adjudicatory hearing to occur after completion of investigation by the OPLC Division of Enforcement.

VI. CONCLUSION AND DECISION:

Pursuant to RSA 326-B:27(IV), and Rule 402.03, the Board hereby vacates the emergency suspension of Jessica Diprizio's license as an RN in New Hampshire as of the date of this order. A Notice of Disciplinary Adjudicatory Hearing shall issue at a later date.

DATED: 04/07/22

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