STATE OF NEW HAMPSHIRE
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

BOARD OF NURSING

In Re: Mary Rose Thornton,
LPN License # 017353-22 (multi-state)
Expired

Docket No.: 2022-NUR-008

FINAL DECISION AND ORDER – 04/28/22

I. ATTENDEES

Samantha O'Neill, Board Chair
Joni Menard, Vice Chair
Melissa Tuttle, Board Member
Matthew Kitsis, Board Member
Maureen Murtaugh, Board Member
Gene Harkless, Board Member
Wendy Stanley Jones, Board Member
Michele Melanson-Schmitt, Board Member
Attorney Michael Haley, DOJ Board Counsel
Ashley Czechowicz, OPLC Board Administrator
Attorney Marissa Schuetz, OPLC Hearing Counsel
Attorney Nikolas K. Frye, OPLC Hearings Examiner and Presiding Officer
Attorney John Garrigan, OPLC Chief Prosecutor (Observing)
Attorney Michael Porter, OPLC Investigations Bureau Chief (Observing)
Hailey Weatherbee, Witness

II. CASE SUMMARY/PROCEDURAL HISTORY

On or about 02/15/19, the Board received a complaint from the Lebanon Center in Lebanon, New Hampshire alleging Mary Rose Thornton ("Licensee") forged a provider's signature for a seizure medication (a controlled substance) for a resident. After investigation, the Board voted on 01/27/22 to commence an adjudicative/disciplinary proceeding in this matter. A Notice of Adjudicative Hearing followed, and the Board then held the adjudicatory hearing on 04/28/22 at 9:00 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. Complaint involving Mary Thornton
2. Lebanon Police Department Incident Report involving Mary Thornton
3. Lebanon Center Investigation Report involving Mary Thornton
4. Mary Thornton's employment records from Lebanon Center
5. Grafton County Superior Court criminal case dispositions for Mary Thornton
6. 2020 Connecticut criminal case information for Mary Thornton

b. Testimony was received from:

1. Hailey Wetherbee

c. Proposed Findings of Fact and Conclusions of Law presented by Hearing Counsel.

All exhibits were admitted into evidence as full exhibits after the Presiding Officer determined they were material and relevant. The Board accepted Hearing Counsel's Proposed Findings of Fact and Conclusions of Law for its consideration.

IV. CONDUCT OF THE HEARING AND EVIDENCE PRESENTED

The Licensee failed to appear for the hearing, which was available via in-person attendance 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 at the last known address she provided to the Board more than 15 days before 04/28/22. 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. Based upon the following, the Board finds that the aforementioned complies with the services requirements under RSA 326-B:38, IX.

Nonetheless, the Post Office returned the certified mail with a sticker stating "Vacant, unable to forward". Therefore, the Board undertakes a due process analysis as well. The Board's file shows its

Administrator also sent copies of the notice to the Licensee via first class mail and email to the respective last known address and email address on file with the Board. The Board Administrator noted that the email was delivered but the first class mail was returned. The Board sought further information from Hearing Counsel as to any efforts she had made to inform the Licensee of this matter. Hearing Counsel stated that she had attempted to contact the licensee as follows: via telephone, email, and certified mail. Hearing Counsel was unable to reach Licensee at the telephone number but was able to leave one voicemail. Hearing Counsel had two email addresses for the Licensee. She tried communicating with her by both email addresses but never heard back. She noted that the Licensee had communicated with the previous Hearing Counsel in this matter through at least one of these email addresses as evidenced by the signed Preliminary Agreement Not to Practice and accompanying correspondence. Given exhibits submitted by Hearing Counsel indicated the Licensee may be incarcerated in Connecticut or New Hampshire, the Presiding Officer conducted inmate searches for the Licensee in New Hampshire and Connecticut on 04/28/22. Her name did not appear. The Presiding Officer also took administrative notice of the fact that the Licensee signed and returned a Preliminary Agreement Not to Practice in relation to this matter on or about 01/23/20.

Based upon the forgoing, the Board 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). Additionally, although not necessarily required in this situation, the Board finds the Board's 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).

The Board next proceeded to adjudicate the matter. Although the Licensee failed to appear, Hearing Counsel still held the burden of proof by a preponderance of the evidence. Rule 207.10. To make her case, Hearing Counsel provided Exhibits 1 through 6, which were accepted as full exhibits by the Board, and sworn testimony from Hailey Wetherbee, the complainant in this matter. Based upon the evidence presented at the hearing, the Board finds the following facts.

New Hampshire first issued a multi-state Licensed Practical Nurse ("LPN") license bearing #017353-22 to the Licensee on 08/30/17.[1] While still licensed, Licensee worked as an LPN at the Lebanon Center in Lebanon, New Hampshire from approximately 10/12/17 until her official letter of termination of 02/15/19. *See* Exh. 3. On 02/15/19, the Board received a written complaint from Hailey Wetherbee at the Lebanon Center, alleging that on 02/10/19 the Licensee "had forged the signature of a medical provider on a controlled substance prescription in order to re-fill a patient's anti-seizure medication instead of calling the on-call medical provider for assistance in sending a prescription." Exh. 1. After the Lebanon Center investigated the matter, Ms. Wetherbee notified the Licensee that she would be terminated, reported her conduct to the Lebanon Police Department, and filed the aforementioned complaint with the Board of Nursing. *See* Exh. 1, 2, and 3.

Submitted with the complaint were the following supporting documents: 1) a 2/11/19 signed written statement from Madeline Clerenger; 2) an 02/11/19 signed written statement from Hailey Wetherbee; 3) witness statements from Kristina Chase, Sharon Snide, and Diane Price, respectively dated 02/09/19, 02/09/19, and 02/11/19; 4) a copy of the original authentic prescription of Diane Price, APRN

[1]That license is now expired.

for the patient involved in the complaint; and 5) a copy of the alleged forged prescription of Diane Price, APRN for the patient involved in the complaint. Madeline Clerenger's statement is more or less an investigatory timeline of the events involved in this matter from her perspective: starting with her receiving a call from Krista Chase on 02/10/19 about witnessing the Licensee copying Diane Price's signature from a completed C2 to a blank C2; next collecting witness statements from Ms. Chase and Ms. Snide on 02/10/19; then confirming with Nurse Practitioner Price that she did not sign the alleged forged C2 on 02/11/19, and finally notifying the Licensee of her immediate suspension and requesting a statement from her on 02/11/22. Exhibit 3, which is the Lebanon Center's investigative report, indicates that based upon speaking with the Licensee, the witnesses, APRN Price, and reviewing the written documentation, the nursing home had concluded the Licensee forged a provider's signature. Exh. 3.

As previously noted, the complaint indicates Ms. Wetherbee contacted the Lebanon Police Department about this incident. That statement is corroborated by Exhibit 2, which is the police incident report involving this matter approved by the Lebanon Police Department in final form on 04/04/19 and originally reported by the complainant on 02/12/19. As the police report elucidates, the Licensee was arrested on a Felony B charge of Controlled Drug: Forger Prescription/Order pursuant to RSA 318-B:2, VIII. As Exhibit 5 shows, more charges were eventually brought against the Licensee stemming from this event, but she eventually plead guilty to a single Class A Misdemeanor for dealing and possessing prescription drugs. All other charges were nolle prossed by the Grafton County Attorney. Exhibit 5 also shows the Licensee was previously charged and plead guilty to a Class B Misdemeanor for issuing bad checks. That case resolved on or about 11/22/21. Additionally, records from the State of Connecticut indicate that the Licensee was previously charged and convicted of felony larceny on 11/07/19. Exh. 6. It also appears from Exhibit 6 that the Licensee had been charged with multiple counts of felony larceny and forgery charges between 05/20/16 and 02/03/17.

In addition to the presentation of the Exhibits 1 through 6, Hearing Counsel called Hailey Wetherbee to testify. Ms. Wetherbee testified that in February of 2019, she was working at the Lebanon Center as its nursing home administrator. Licensee was working at the Lebanon Center at that time as an LPN. Ms. Weatherbee explained she received a call from Lebanon Center's acting nurse supervisor, Madeline Clerenger, on 02/10/19. The supervisor relayed to Ms. Weatherbee that two nurses that had worked with the licensee on the night shift of 02/09/19 to 02/10/19 had called her to report that the Licensee had forged the signature of a nurse practitioner on a patient's prescription instead of utilizing an on-call provider. Ms. Weatherbee testified that the nurses told her they had witnessed the Licensee copying the prescription from a previous form onto a blank form, signing the blank form with that provider's signature, and then sending it to the pharmacy. She further explained that no one had asked the Licensee to copy the prescription and sign the practitioner's name. Ms. Weatherbee confirmed that the Licensee was suspended on 02/11/19 based upon the allegations and a preliminary investigation.

Ms. Weatherbee next explained that as part of the Lebanon Center's investigation, she and others interviewed the Licensee together. During this interview, the Licensee admitted that she forged the practitioner's signature on the form she copied because she did not like talking to the on-call providers on the weekend. The Licensee rationalized with the interviewers that her actions were the best way to ensure the patient received the prescription. Based upon this interview and the rest of the information obtained during the investigation, the Lebanon Center terminated the Licensee's employment and reported her conduct to the Lebanon Police Department and the Board. Ms. Weatherbee additionally testified that the Licensee had some previous work-related issues involving job performance and attendance and that the Licensee had failed to disclose that she had pending felony charges against her in Connecticut when she was hired by the Lebanon Center.

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. In addition to the findings of facts and rulings of law already made herein, the Board specifically finds the following facts and makes the following rulings of law based upon the evidence presented:

1) The Board finds, by a preponderance of the evidence, that on Licensee's night shift of 02/09/19 to 02/10/19 she used a previous prescription for a patient at the Lebanon Center signed by Diane Price, APRN to copy the information contained therein on to a blank prescription form for the same patient and then sign "Diane Price, APRN" on the line of the form titled "Provider's Signature." *See* Exhs. 1, 2, and 3 and the testimony of Hailey Wetherbee.
2) The Board finds, by a preponderance of the evidence, that the Licensee, filled out the blank prescription form and signed Nurse Practitioner Price's name to it without permission of Diane Price, APRN. *See* Exhs. 1, 2, and 3 and the testimony of Hailey Wetherbee.
3) The Board finds, by a preponderance of the evidence, that the Licensee has been previously criminally investigated and charged for forging a provider's signature in the state of Connecticut and this conduct was not reported to the Lebanon Center when she applied for her LPN position there despite it having occurred. *See* Exhs. 4, 6, and testimony of Hailey Wetherbee.
4) The Board finds, by a preponderance of the evidence that the facts contained in paragraphs 1, 2 and 3 above occurred while the Licensee was licensed in New Hampshire as an LPN. *See* Board's file on Licensee and testimony of Hailey Wetherbee.
5) The Board concludes the Licensee engaged in professional misconduct when she allegedly forged a provider's signature for a seizure medication (a controlled substance) for a resident in violation of RSA 326-B:37, II(h) and/or RSA 326-B:37, II(h)(1);

6) The Board concludes the Licensee engaged in professional misconduct when she allegedly forged a provider's signature for a seizure medication (a controlled substance) for a resident in violation of RSA 326-B:37, II(k);

7) The Board concludes the Licensee engaged in professional misconduct when she allegedly forged a provider's signature for a seizure medication (a controlled substance) for a resident in violation of RSA 326-B:37, II(m);

8) The Board concludes the Licensee engaged in professional misconduct when she allegedly forged a provider's signature for a seizure medication (a controlled substance) for a resident in violation of RSA 326-B:37, II (q)(2) (*see* Rules 402.04(b)(13), 501.02(a), 501.03(c), 501.03(d)), and/or RSA 326-B:37, II (q)(3);

9) The Board concludes the Licensee committed professional misconduct when she either plead guilty to or was convicted of a crime related to her having forged a provider's signature for a seizure medication (a controlled substance) for a resident patient in violation of RSA 326-B:37, II(c); and

10) The Board concludes the Licensee committed professional misconduct as defined at RSA 326-B:37, II (e), (h), (q)(2) when she either plead guilty to or was convicted of a felony and did not report the conviction to the Board in violation of RSA 326-B:22, II(b) and Rule 401.01(a)(4).

The Board next considers the appropriate discipline to administer, if any, pursuant to RSA 326-B:37(III)(b). In the instant case, the Licensee's license has expired. For this reason alone, the Board administers no sanction in relation to the above findings of professional misconduct. However, the Board wishes to make it clear that viewing the facts of this case in light of the factors enumerated in RSA 326-B:37(III) and Rule 402.04(g). Factors 1, 2, 5, 6, 7 and 8 of Rule 402.04(g) would have weighed heavily in favor of imposing significant discipline against the Licensee, whose misconduct can be concisely

described as egregious and a threat to the public safety, health, and welfare.[2] Were the Licensee still actively licensed, the Board would have indefinitely suspended her license or revoked it. *See* RSA 326-B:37, III(a) and (b).

VI. CONCLUSION AND DECISION:

Pursuant to RSA 326-B:37, and Rule 402, the Board hereby makes the herein findings of professional misconduct. No sanctions are administered for the reason stated in Section V of this Order.

DATED: 5/3/2022

___/s/ Nikolas K. Frye, Esq._____
Nikolas K. Frye, Esq., Hearings Examiner
Authorized Representative of the Board of Nursing-
New Hampshire Office of
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[2] The Board would have taken into consideration the fact that the Licensee signed a preliminary agreement not to practice but weighed that against her otherwise utter lack of disregard for participating in this disciplinary proceeding.