

**STATE OF RHODE ISLAND DEPARTMENT OF HEALTH
DIVISION OF CUSTOMER SERVICES
CENTER FOR PROFESSIONAL BOARDS AND LICENSING
BOARD OF NURSING REGISTRATION AND NURSING EDUCATION**

**IN THE MATTER OF: JODIE HAZARD
LICENSEE NO.: RN 43098
COMPLAINT ID #: C20-1335A**

SUMMARY SUSPENSION OF REGISTERED NURSE LICENSE

Jodie Hazard (“Respondent”) has been licensed as a Registered Nurse pursuant to R.I Gen. Laws §5-34-11 and the Rules and Regulations for Licensing of Nurses 216-RICR-40-05-3 since March 3, 2006. Complaint ID #C20-1335A (the “Complaint”) came before the Rhode Island Department of Health, Division of Customer Services, Center for Professional Boards and Licensing (“RIDOH”) alleging that Respondent had engaged in behavior that constituted “unprofessional conduct” against her Registered Nurse license pursuant to R. I. Gen. Laws § 5-34-24.

This Summary Suspension is issued related to the Complaint and pursuant to R. I. Gen. Laws § 42-35-14(c) and §5-34-26. After careful consideration and further investigation by RIDOH, the following constitute the findings of fact and conclusions of law with respect to the allegations against Respondent in the Complaint:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. That Respondent is a Registered Nurse licensed to practice in the State of Rhode Island under License Number RN43098 (the “License”).
2. That on or about September 7, 2020, Respondent was employed by AdCare Rhode Island located at 1950 Tower Hill Road, North Kingstown, Rhode Island.
3. That on September 10, 2020, RIDOH received a complaint from the Director of Nursing at AdCare Rhode Island in North Kingstown, Rhode Island. The complaint alleged that on September 7, 2020, the Respondent was working and exhibited signs and symptoms of a silent stroke, including being unable to keep her eyes open, slurring her words, acting confused, and being unsteady on her feet, which resulted in the facility calling 911 and the Respondent being transferred to the hospital for evaluation. The complaint further alleged that the facility video surveillance located in the medication room showed the Respondent taking different medications from the stock bottles and swallowing them. Respondent admitted to the Director of Nursing that she took stock medication that night.
4. That on or about September 15, 2020 the Respondent was terminated from her employment at Adcare.

5. That on about May 10, 2021, this matter came before the Investigative Committee of the Board of Nursing.
6. That on August 30, 2021, the Respondent entered into an Interim Consent Order with the Board.
7. The ratified Interim Consent Order dated August 30, 2021, states, in part, “...*Prior to rendering a final decision on this matter, the Board and Respondent reached accord on an interim course of action.*” The course of action states that the “*Respondent shall begin an evaluation for substance use disorder...*” and provide a copy of the provider report for the Board to review and consider at their next meeting.
8. Additionally, the Interim Consent Order states, “... *after review and consideration of the information contained in the said treatment records and evaluation, the Board will make a recommendation as to what sanctions, if any, are warranted, with respect to the Respondent’s professional practice... The terms of this Interim Consent Order Agreement shall remain in full force and effect pending further Order of the Board.*”
9. That on September 8, 2021, the Director of the Board of Nursing Registration and Education sent a letter to the Respondent instructing her to submit to an evaluation for substance abuse within one month following the date of execution of the Interim Consent Order, and to provide a copy of the evaluation report to the Board for review no later than two weeks after the completion date.
10. That on November 16, 2021, the Respondent’s Licensed Mental Health Counselor (LMHC) sent a letter (the “11/16/21 Letter”) to the Board stating that the Respondent had not attended scheduled counseling sessions since September 15, 2021.
11. The 11/16/21 Letter states that the Respondent was provided random toxicology screens until July 20, 2021, when she tested positive for unprescribed methadone. Screenings were then increased to twice weekly.
12. The Respondent failed to present for toxicology screening on September 21, 2021; September 24, 2021; and September 28, 2021.
13. The 11/16/21 Letter further states that throughout the course of assessment by the LMHC, the Respondent did not demonstrate any behavioral changes that would support substance abuse recovery or improve insight related to use.
14. The 11/16/21 Letter further states that “there is concern about the inconsistency in which she has provided screens, and the variable positive results. This could impair her ability to safely care for patients and affect her judgment to make prudent decisions regarding their treatment.
15. That the Respondent was scheduled to appear before the Board on January 10, 2022. On December 20, 2021 the Respondent requested to reschedule her January appearance. Her appearance was rescheduled for February 14, 2022 at 10:00AM.

16. That on February 7, 2022, the LMHC sent a letter (the “2/7/22 Letter”) to the Board stating that since the 11/16/21 letter, the Respondent had a positive toxicology screen for cannabis on January 21, 2022.
17. The 2/7/22 Letter stated that the Respondent failed to complete random toxicology screens on December 21, 2021; January 4, 2022; January 14, 2022; January 18, 2022; January 25, 2022, and January 28, 2022.
18. The 2/7/22 Letter further stated that the LMHC had no contact with the Respondent since September 15, 2021.
19. That the Respondent was scheduled to appear before the Board on February 14, 2022 and two hours prior to her scheduled appearance the Respondent requested another continuance.
20. That on March 30, 2022, the Respondent stated to RIDOH that she will be applying for a Massachusetts nursing license in April and hopes to begin working at Fuller Psychiatric Hospital.
21. That the Interim RIDOH Director (the “Director”) has reviewed the facts and conclusions in this case and finds the evidence indicates that the Respondent’s continuation in practice would constitute an immediate danger to the public, pursuant to the RI Gen. Laws§ 5-34-26.

ORDER

22. Based on the foregoing and pursuant to R. I. Gen. Laws §§ 5-34-26 and 42-35-14 (c) the License is hereby **SUSPENDED** until further Order of RIDOH Board of Nursing.

NOTICE OF HEARING

You are hereby given the opportunity for a hearing pursuant to R.I Gen. Laws§ 5-34-26. **This hearing will be held on Monday, April 11, 2022 in room 205 at 10:00 AM at the Cannon Building, Department of Health, Three Capitol Hill, Providence, Rhode Island, 02908.** This hearing will be held in accordance with the provisions of Chapters 42-35 of the General Laws and the “Rules and Regulations Governing the Practices and Procedures before the Department of Health.” You have the right to appear personally, to be represented by counsel or an authorized representative, and to respond and present evidence and argument, and to present witnesses and cross-examine other witnesses. If you fail to appear at the scheduled hearing, absent good cause, the Board will proceed with the hearing and enter an order based upon the evidence presented.

If you have any questions, please contact Legal Counsel for the Board, Lisa Bortolotti, at 401-222-2137.

Ordered this 1st day of April 2022

A handwritten signature in black ink, appearing to read "J.V. McDonald, M.D., M.P.H.", written in a cursive style.

James V. McDonald, M.D., M.P.H.
Interim Director
Rhode Island Department of Health
Cannon Building, Room 401
Three Capitol Hill
Providence, Rhode Island, 02908

CERTIFICATION

I hereby certify that a copy of this Order was delivered via constable to Jodie Hazard:

on this _____ day of _____, 2022.