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: KIMBERLY LEMIRE
LICENSEE NO.: RN 57711
COMPLAINT ID #'s: C22-0536 and C22-0580

SUMMARY SUSPENSION OF REGISTERED NURSE LICENSE

Kimberly Lemire ("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 June 30, 2017. Complaint ID #'s C18-1034 (Overlook Nursing and Rehabilitation Center), C18-1556 (Pine Grove Health Center), C20-1381 (Morgan Health Center), C20-1381, (Royal at Forest Farms), C22-0536 (Alpine Nursing Home) and C22-0580 (Riverview Healthcare) (the "Complaints") 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 Complaints 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 Complaints:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. That the Respondent holds a license (RN 57711) to practice as a registered nurse in the state of Rhode Island.

2. That on or about August 8, 2018, Overlook Nursing and Rehabilitation Center notified RIDOH of Narcotic Book and electronic medical record (EMAR) discrepancies by the Respondent (C18-1034).

3. That on or about July 8, 2019, the Board issued a Letter of Concern to the Respondent recommending she improve her documentation and organizational skills. The letter also recommended the Respondent follow protocols in place for the administration of narcotics. (C18-1034).

4. That on or about December 12, 2018, Pine Grove Health Center notified RIDOH of an Oxycodone blister pack missing a pill resulting in a discrepancy in the Narcotic Book (C18-1556).

5. RIDOH investigation revealed the Respondent was arrested by the Burrillville Police Department on December 15, 2018, for larceny of a controlled substance.

6. That on or about May 20, 2020, a Summary Suspension Order was issued to the Respondent by the Connecticut Board of Examiners for Nursing as they found the "Respondent's continued nursing practice presented a clear and immediate danger to public health and safety..." secondary to drug diversion and improper safeguard of narcotics and waste control.

7. That on or about August 18, 2020, the Respondent was employed by Norton Healthcare Agency as an agency nurse and was working at Royal at Forest Farm.

8. That on or about 8/28/2020, Royal Forest Farm notified RIDOH that on or about August 25,2020, the facility noted that 5 tablets of Oxycodone were missing. Additionally, they noted that the Respondent, who worked at the facility on 8/16/2020, had rewritten the Narcotic Book Index and failed to include the Oxycodone page for a Resident that was recently admitted to the hospital, resulting in a medication card of 28 Oxycodone unaccounted for (C20-1281).

9. That on November 8, 2021, in response to Complaint C20-1281, the Board sent the Respondent a non-disciplinary letter of concern recommending the Respondent "adhere policy and procedures for proper medication administration and documentation, improve on documentation timeline being accurate, ensure proper medication or narcotic count is documented per nursing facility policy."

10. That on April 12, 2021, the Board requested the Respondent to appear before the Board on May 10, 2021 and she failed to appear on this date. The respondent also failed to appear before the Board on June 14, 2021.

11. That on or about September 25, 2020, Morgan Health Center notified RIDOH that on or about September 22, 2020, the Respondent, who was employed by Favorite Healthcare and working shifts at the facility, was reported to have altered the Narcotic Book resulting in 6 Oxycodone 30 mg. pills being unaccounted for (C20-1381).

12. That on October 20, 2021, in response to Complaint C20-1381, the Board sent the Respondent a non-disciplinary letter of concern recommending the Respondent "adhere policy and procedures for proper medication administration and documentation, improve on documentation timeline being accurate, ensure proper medication or narcotic count is documented per nursing facility policy."

13. That on or about February 11, 2021, the Respondent applied for renewal of her Rhode Island nursing license.

14. That on the Respondent's February 11, 2021 license renewal application, the Respondent furnished false information by failing to report her Connecticut nursing license suspension.

15. That in response to the Respondent's answers on the renewal application for licensure, RIDOH issued a license renewal on February 12, 2021.

16. That in February 2022, the Respondent was employed by IntelyCare in Quincy, Massachusetts as an agency nurse and was working at Alpine Nursing Home.

17. That on February 10, 2022, the Respondent documented on page 102 of The Alpine Nursing Home Narcotic Book that Resident CH dropped her Oxycodone, 10 mg. on the floor which resulted in the Respondent wasting the medication. Above the Respondent's signature in the

Narcotic Book is an illegible signature for verification of the medication disposal. The illegible signature has the initials of "T.S.".

18. That on February 14, 2022, the Alpine Nursing Home Director of Nursing (DON) reviewed the Narcotic Book and identified that 18 Oxycodone pills from page 102 of the Narcotic Book were removed from the narcotic count on February 12, 2022. Upon further review of page 102, the DON discovered that the DON's signature was forged as being the nurse responsible for removing the medication for destruction. The facility was unable to account for the 18 missing Oxycodone pills.

19. That on February 16, 2022, the Alpine Nursing Home Manager notified the Coventry Police Department of alleged drug diversion by the Respondent. The DON notified police that as to the Oxycodone removal, the Respondent was the only second shift Registered Nurse (RN) working on February 12, 2022 with access to scheduled narcotics.

20. That on or about February 23, 2022, Alpine Nursing Home DON stated that she was not working on February 12, 2022, the date she alleges her signature was forged. The DON further denied signing the Narcotic Book for the Oxycodone destruction.

21. That on or about February 25, 2022, "T.S.", a Certified Medication Technician from Alpine Nursing Home, was interviewed by Coventry Police Department and denied co-signing for the disposal of Resident CH's medication on page 102 of the Narcotic Book.

22. That on or about March 11, 2022, the Respondent was arrested by Coventry Police Department for larceny of a controlled substance at Alpine Nursing Home.

23. That on or about March 10, 2022, the Respondent was employed by IntelyCare in Quincy, Massachusetts as an agency nurse and was working at Riverview Healthcare on the 11:00 PM-7:00 AM shift.

24. On or about April 19, 2022, RIDOH received a complaint by the Administrator of Riverview Healthcare alleging drug diversion by the Respondent (C22-0536).

25. That the Riverview Healthcare complaint states that on or about March 10, 2022, I.V. and A.A., both nurses on the day shift at Riverview Healthcare, alerted the DON that the Morphine concentrate appeared to be clear in color. Based on these findings, the Morphine was removed from the medication cart and sent for laboratory testing.

26. That on or about March 20, 2022, Riverview Healthcare notified Coventry Police Department of an alleged drug diversion by the Respondent.

27. That on or about April 25, 2022, the Riverview Healthcare LPN A.A. provided a witness statement for the Coventry Police Department stating that on March 9, 2022, A.A. performed narcotic count with the Respondent; A.A. stated that all narcotic counts were correct and both nurses signed the Narcotic Book at 11:30 PM.

28. Additionally, the Riverview Healthcare LPN A.A. stated she returned to work the day shift on March 10, 2022 and performed the narcotic count with the Respondent again. LPN A.A. stated that she had concerns with the Morphine concentration as the color was a much lighter blue than usual, but the bottle was full. There was also concern of a missing empty bottle. LPN A.A. stated that she asked the Respondent about the Morphine, and her response was not

logical. In turn, LPN A.A. stated that she refused to complete the narcotic count and called the DON and her assistant to report her concern.

29. That on or about April 25, 2022, the Riverview Healthcare DON provided a witness statement for the Coventry Police Department stating that on the morning of March 10, 2022, LPN A.A presented to Riverview Healthcare and notified her of the color of the Morphine concentrate and the appearance of the medication being tampered with, as the Morphine was clear in color and is normally a bright blue color. The Morphine was sent to the pharmacy for analysis.

30. That on April 18, 2022, Riverview Healthcare was notified that the Morphine was diluted. Based on these findings, RIDOH, the Attorney General's office and Coventry Police were notified of these findings by the Riverview Healthcare Administrator.

31. That on April 27, 2022, at approximately 4:00 PM, the Rhode Island Director of Nursing Registration and Education had a telephone conversation with the Respondent and discussed the false information on the license renewal application and the allegations from Riverview Healthcare. The Respondent stated she would present to RIDOH on April 29, 2022, at 9:00 AM to sign a Voluntary Surrender of her nursing license.

32. That on April 29, 2022, the Respondent failed to appear to sign the Voluntary Surrender. The Respondent also failed to answer a telephone call after not appearing.

33. That on April 29, 2022, Coventry Police Department issues a warrant for Larceny of a controlled substance for the Respondent. The warrant is pending.

ORDER

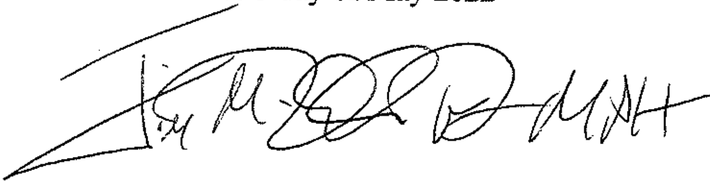
34. Based on the foregoing and pursuant to R. I. Gen. Laws §§ 5-34-26 and 42-35-14(c) the License is hereby SUSPENDED until further Order of RIDOH Board of Nursing.

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, May 9, 2022 in room 205 at 1:00 PM 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 **3** day of May 2022



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 Kimberly Lemire:

on this _______ day of __________, 2022.