



The Commonwealth of Massachusetts

Executive Office of Health and Human Services
Department of Public Health

Division of Health Professions Licensure

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September 22, 2015

VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED NO. 7012 3460 0001 7330 8272

Evelyn Aborgah

redact

RE: In the Matter of Evelyn Aborgah, Docket No. NUR-2012-0161
License No. LN63477

Dear Ms. Aborgah:

Please find enclosed the **Final Decision and Order** issued by the Board of Registration in Nursing on September 22, 2015 and effective **October 2, 2015**. This Decision imposes a Reprimand on your license and constitutes full and final disposition of the above-referenced complaint, as well as the final agency action of the Board. Your appeal rights are noted on page 2.

You may contact Vita Berg, Chief Board Counsel at (617) 973 – 0950 with any questions that you may have concerning this matter.

Sincerely

Amy Fein, RN, BSN, JD
Co-interim Executive Director,
Board of Registration in Nursing

Encl.

cc: Ann McLaughlin, Esq., Prosecuting Counsel

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, SS

BOARD OF REGISTRATION IN
NURSING

In the Matter of)
EVELYN ABORGAH)
License No. LN63477)
License expires: 9/3/15)

Docket No. NUR-2012-0161

FINAL DECISION AND ORDER

FINAL DECISION

On March 26 and March 27, 2014, the Board held a formal adjudicatory hearing in this matter before Administrative Hearings Counsel Maimoona Sahi Ahmad ("AHC Ahmad"). On July 21, 2015, successor Administrative Hearings Counsel Beverly Kogut ("AHC Kogut") issued a Tentative Decision containing findings of fact, credibility determinations, conclusions of law and a discussion with the participation of AHC Ahmad as detailed in the Tentative Decision on page 2, footnote 1. The Respondent has not filed written Objections to Tentative Decision within the time allotted under the standard rules of adjudicatory procedure at 801 CMR 1.01. The Board hereby adopts the Tentative Decision, including all findings of fact, credibility determinations, conclusions of law and discussion contained therein, as the Board's Final Decision.

ORDER

Based on its Final Decision, the Board orders a REPRIMAND of the Respondent's license to practice as a Licensed Practical Nurse in Massachusetts, License No. LN63477.

The Board voted to adopt the Tentative Decision as its Final Decision at its meeting held on September 9, 2015, by the following vote:

- In favor:* A. Alley, BSN, RN; M. Beal, RN/NM; P. Gales, RN; K. Gehly, RN; J. Killion, LPN; B. Levin, RN; A. Peckham, RN, MSN; C. Simonian, Pharm.D., R.Ph.; S. Taylor, MSN, RN; C. Urena, LPN
- Opposed:* None
- Abstained:* None
- Recused:* None
- Absent:* E. Richard Rothmund; C. Tebaldi, RN, MS

The Board voted to adopt the within Final Order by Default at its meeting held on September 9, 2015, by the following vote:

- In favor:* A. Alley, BSN, RN; M. Beal, RN/NM; P. Gales, RN; K. Gehly, RN; J. Killion, LPN; B. Levin, RN; A. Peckham, RN, MSN; C. Simonian, Pharm.D., R.Ph.; S. Taylor, MSN, RN; C. Urena, LPN
- Opposed:* None
- Abstained:* None
- Recused:* None
- Absent:* E. Richard Rothmund; C. Tebaldi, RN, MS

EFFECTIVE DATE OF ORDER

This Final Decision and Order by Default becomes effective upon the tenth (10th) day from the date it is issued (see "Date Issued" below).

RIGHT TO APPEAL

Respondent is hereby notified of the right to appeal this Final Decision and Order Default to a Superior Court with jurisdiction pursuant to M.G.L. c. 30A § 14. Respondent must file his appeal within thirty (30) days of receipt of notice of this Final Decision and Order.

Board of Registration in Nursing,

Date Issued: September 22, 2015 
Amy Fein, RN, BSN, JD
Board Authorized Signatory

Notified:

VIA FIRST CLASS AND CERTIFIED MAIL RETURN
RECEIPT REQUESTED NO. 7012 3460 0001 7330 8272
Evelyn Aborgah

redact

BY HAND DELIVERY
Ann McLaughlin, Esq.
Prosecuting Counsel
Department of Public Health
Division of Health Professions Licensure
239 Causeway Street
Boston, MA 02114

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION
IN NURSING

In the Matter of
Evelyn O. Aborgah
LN License No. 63477
LN License Exp. Date 9/3/15

Docket No. NUR-2012-0161

Tentative Decision

I. Procedural Background

On March 22, 2013, the Board of Registration in Nursing ("Board") issued an Order to Show Cause ("Show Cause Order") to Evelyn O. Aborgah ("Respondent"), a Licensed Practical Nurse ("LN") (LN License No. 63477) licensed by the Board, directing her to appear and show cause why her license, or right to renew her license, should not be suspended or revoked pursuant to, among other provisions, Massachusetts General Laws ("G.L.") Chapter 112, § 61, Board regulations at 244 CMR 9.03 *et seq.* (Standards of Conduct for Nurses), and for engaging in conduct that undermines public confidence in the integrity of the profession. On or about April 9, 2013, Respondent filed an answer and request for hearing. On May 23, 2013, the Board issued an Amended Show Cause Order removing one allegation from the original Show Cause Order. The Amended Show Cause Order alleged that Respondent failed to appropriately administer medication to a patient under her care and interacted with a patient in an unprofessional, hostile and abusive manner.

On May 23, 2013, the Administrative Hearings Counsel ("AHC") issued a scheduling order and set the hearing for November 19 and 21, 2013. On September 24, 2014, Prosecuting Counsel withdrew her appearance. That same date, successor Prosecuting Counsel filed a notice of appearance and a motion to continue the hearing, which the AHC granted for good cause shown. On December 16, 2014, the successor Prosecuting Counsel withdrew his appearance and on December 20, 2014, a second successor Prosecuting Counsel filed a notice of appearance in the case. On February 12, 2014, upon motion of the second successor Prosecuting Counsel, and for good cause shown, the AHC again continued the hearing dates. The AHC held a Pre-Hearing Conference on February 26, 2014. On March 6, 2014, Prosecuting Counsel filed a Pre-Hearing Memorandum. Respondent did not file a Pre-Hearing Memorandum.

The formal adjudicatory hearing was held before Administrative Hearings Counsel Maimoona Sahi Ahmad on March 26 and March 27, 2014, pursuant to G.L. c. 30A and 801 CMR 1.01 *et seq.* Respondent was present and testified at the hearing. Respondent appeared *pro se*. Prosecuting Counsel Ann McLaughlin appeared on behalf of the Board. Six (6) witnesses, including Respondent, testified. Ten (10) exhibits were entered into the record. The Board made an audio recording of the hearing, consisting of three (3) cassettes. No post-hearing briefs were filed.¹

II. Witnesses

The following witnesses testified at the formal adjudicatory hearing:

A. Prosecution Witnesses

1. Jessica Lemieux, RN
2. Alicia Santos, CNA
3. Maryanne Donahue, RN
4. Richela Strader, RN
5. Patricia Normandin, RN, DNP, Expert Witness

B. Respondent Witnesses

6. Evelyn Aborgah, LN
Respondent

III. Exhibits

The following exhibits were entered into the administrative hearing record.

¹ Ms. Ahmad, as Administrative Hearings Counsel, was employed by the Department of Public Health, Division of Health Professions Licensure ("DHPL"). Ms. Ahmad terminated her employment with the DHPL in early August 2014, before drafting the Tentative Decision in the instant matter. Therefore, in accordance with pertinent law, including 801 CMR 1.01 (11) (e), the Tentative Decision has been drafted by a successor Administrative Hearings Counsel, Beverly Kogut, with meaningful participation from Ms. Ahmad. Pursuant to a limited contract of employment with the Department of Public Health, Ms. Ahmad reviewed a drafted Tentative Decision and concurred with the decision, including, but not limited to, findings related to credibility. Ms. Ahmad's determinations were based on her observations of the witnesses who testified at the hearing and her review and evaluation of the testimonial and documentary evidence presented at the hearing.

1. Order to Show Cause, dated April 22, 2013
2. Answer of Respondent, filed on or about April 9, 2013
3. Amended Order to Show Cause, dated May 23, 2013
4. Record of Standing for Respondent
5. Fax Cover Sheet, Long Term Care Report Form, and Letter from Flore H. Couillard, RN, DON at Oxford Rehabilitation and Nursing Care Center
6. Statement of Patient 1, written by Maryanne Donahue, RN
7. DPH-Division of Health Care Quality, Investigation Report by Surveyor Ricki Strader, RN
8. Investigation Report of DPH, Division of Health Professions Licensure, Board of Registration in Nursing
9. Medication Administration Policy from Oxford Rehabilitation and Nursing Care Center
10. Curriculum Vitae of Patricia A. Normandin, RN, DNP

IV. Findings of Fact

The Board finds the following facts established by a preponderance of the evidence. Matters not specifically discussed in these findings do not justify a change in the result.

1. On or about August 28, 2002, the Board issued Respondent a license to engage in the practice of nursing as a Licensed Practical Nurse in the Commonwealth of Massachusetts (LN License No. 63477). Respondent's license is current and expires on September 3, 2015. (Board records of which the Board takes administrative notice.)
2. On or about March 15, 2011, Respondent was employed as a Licensed Practical Nurse at Oxford Rehabilitation and Nursing Center in Haverhill, Massachusetts (hereinafter "the facility" or "The Oxford") (Prosecuting Counsel Pre-Hearing Memorandum: Agreed Facts; Exhibit 7).
3. On March 14-15, 2011, Respondent worked as a Licensed Practical Nurse on the night shift, 11 p.m. – 7 a.m., and was assigned to provide nursing care for Patient 1. (Prosecuting Counsel Pre-Hearing Memorandum: Agreed Facts; Exhibit 7).

4. Patient 1 was 44 years old, alert and oriented to month, day and year and had no problems with recall. She was independent with all of her activities of daily living. She had physician's orders for Prilosec CR 20 milligrams, twice a day, scheduled for 6:30 a.m., and Lactulose 40 millimeters, every four hours around the clock, scheduled for 6 a.m. Patient 1's medications were prepared and administered by the facility staff. (Exhibits 5 and 7)

Lemieux Testimony

5. Jessica Lemieux, RN, a staff nurse at The Oxford at all relevant times, testified at the hearing. On the morning of March 15, 2011, Lemieux went to Patient 1's room around 7:30 a.m. to obtain Patient 1's blood sugar level and found two medication cups with medication in them on the bedside table, which she recognized as Lactulose and Prilosec and which appeared to be from the previous shift. Patient 1 appeared to be asleep. (Testimony of Jessica Lemieux [hereinafter "Lemieux Testimony"])
6. Lemieux left the room, went to the nurse's station and told the Unit Manager, Maryanne Donahue, RN, that the medications had been left on the bedside table. Lemieux returned to Patient 1's room. (Lemieux Testimony)
7. Shortly after Lemieux returned to Patient 1's room, Respondent entered the room. Patient 1 was sitting on the bed and Lemieux was standing next to Patient 1, obtaining Patient 1's blood sugar level. Lemieux witnessed Respondent, with an angry face and frustrated manner, speak in an angry loud voice to Patient 1. Lemieux observed Respondent reprimand Patient 1 and blame Patient 1 for the medication still being at the bedside. She witnessed Respondent say to Patient 1 in a tone that was louder than normal: "You can get my license taken away. You can't leave meds at the bedside. You need to take them. Do you want me to lose my license?" Lemieux testified that she would not want anyone to speak to her family members in the tone of voice used by Respondent. Lemieux saw that Patient 1 did not verbally respond to Respondent or make eye contact. Lemieux did not recall if Patient 1 ingested the medications. (Lemieux Testimony)
8. After Respondent left the room, Lemieux reassured Patient 1 that it was not Patient 1's fault. She observed that Patient 1 was very sad. Lemieux then returned to the nurse's station and immediately reported to Donahue what had just happened. (Lemieux Testimony)

Santos Testimony

9. Alicia Santos, CNA (Certified Nurse's Aid), was a CNA at the Oxford at all relevant times and testified at the hearing. Santos was in the room at the

time of the incident and was providing care to another resident. Santos testified that the privacy curtain was pulled around her and the resident she was caring for, but when she heard Respondent raise her voice, she was concerned so she pulled the curtain open to see if other staff were in the room. She saw Lemieux and Respondent. Respondent was pointing at Patient 1, scolding her and saying, "If you don't want me to lose my license, you need to take your pills." Santos observed that Respondent's tone and words were inappropriate and that Respondent was being rude to Patient 1. Respondent appeared upset and frustrated. Santos saw Patient 1's reaction and demeanor. Patient 1 was not answering back, she had her head down, and looked upset and intimidated by the way that Respondent was speaking to her. After Respondent left the room, Santos was concerned about Patient 1 and went over to Lemieux and Patient 1, to make sure Patient 1 was okay. (Testimony of Alicia Santos [hereinafter "Santos Testimony"])

10. Santos left the room, reported the incident to Donahue and then returned to Patient 1 again to check on her. Patient 1 was very upset, had her head down, and was speaking angrily about the situation. Santos stayed with Patient 1 for a few minutes to further comfort her. While Santos was in the room, Donahue came to check on Patient 1 and to take her statement. (Santos Testimony)

Donahue Testimony

11. Donahue, the Unit Manager at The Oxford at all times relevant to this matter, testified at the hearing. Donahue testified that as soon as Lemieux told her that medications were left at Patient 1's bedside, she went to Patient 1's room, where she saw the pills on the bedside table, removed the medications, brought them back to the nurse's station where Respondent was working, and showed them to Respondent. Donahue testified that on seeing the medications, Respondent said, "Oh my God, did I do that?" in an apologetic tone and indicated that she would go to Patient 1 and administer the medications. (Testimony of Maryanne Donahue [hereinafter "Donahue Testimony"])
12. Shortly thereafter that same morning, Lemieux and Santos, separately, reported to Donahue that they were concerned with how Respondent had just spoken to Patient 1 regarding the medications. Donahue immediately notified Flore H. Couillard RN, the Director of Nurses ("DON") and went to check on and reassure Patient 1. The facility began investigating by obtaining witness statements. The DON directed Donahue to take a statement from Patient 1. (Donahue Testimony)
13. That day, March 15, 2011, Donahue went to Patient 1's room, asked her if she would like to give a statement, and then wrote down what Patient 1

said. Patient 1 dictated her statement to Donahue, and then signed it. (Donahue Testimony; Exhibit 6).

14. Patient 1's statement provides:

Patient 1 Statement Written by M. Donahue

3/15/11

5:40 a.m., woke up to get pain meds, and then went back to bed. Nurse said she woke me up this morning and I don't remember. Nurse said it's my fault (Patient 1) that she got into trouble because I didn't take my meds. Said it was my responsibility to take meds. Would you like me to get fired because you didn't take meds. [Patient 1] feels that nurse should wait for her to take her pills and it's not my fault if Respondent gets fired.

[Patient 1's name]

I felt very intimidated when Nurse was upset with me this a.m.

Statement as told to MA Donahue, RN. (Exhibit 6)

Strader Testimony and Investigation Report

15. Richela Strader, RN, a health facility inspector employed by the Department of Public Health Bureau of Health Care Quality and Safety (Bureau), testified at the hearing. Strader graduated from law school in 1989. In March 2011, Strader was a surveyor in the complaint department of the Bureau. In that role she conducted an on-site investigation at The Oxford in this matter on March 22, 2011. (Testimony of Richela Strader [hereinafter "Strader Testimony"]); Exhibit 7)
16. In conducting the investigation, Strader interviewed: Flore Couillard, RN, the Director of Nurses; Donahue, the Unit Manager; Patient 1; Lemieux; Santos; and Respondent. She reviewed the following documents: Patient 1's clinical record; facility policies and procedures; the Investigative file; Respondent's personnel file; time sheets schedules and documentation of inservice. Strader prepared an Investigation Report documenting her investigation, which was entered into the record as Exhibit 7. (Strader Testimony; Exhibit 7)
17. **Strader's Interview of Respondent.** Strader testified as to her interview of Respondent on March 22, 2011 and the admissions that Respondent made to her in that interview. Strader testified that Respondent said that

on the morning of March 15, 2011, Donahue told Respondent that Lemieux had just reported that two medications, Lactulose and Prilosec, had been left at Patient 1's bedside; Respondent told Strader that she thought that Patient 1 had taken the medications. Respondent further told Strader that she had awakened Patient 1 to take the medications and that she saw Patient 1 have the Lactulose in her hand and saw Patient 1 put the paper cup containing the medications up to her mouth, but didn't see her take the medication. Respondent said that she did not see Patient 1 ingest the medications. She also admitted that she did not administer the medications. She further admitted that medications should not be left at a patient's bedside and that she had not followed The Oxford's policy or the standards of nursing practice for medication administration. (Strader Testimony; Exhibit 7)

18. Respondent further said to Strader that after Donahue informed her about the medications at Patient 1's bedside, Respondent went to Patient 1's room where Patient 1 was sitting on the bed and Lemieux was taking Patient 1's blood sugar level. Respondent said that she told Patient 1 that if you leave medication at the bedside and don't take it, she (Patient 1) can get Respondent in trouble. Respondent reported that Patient 1 replied, "Do you mean you can lose your nursing license?" and that Respondent replied, "Yes, I am in big trouble." Respondent told Strader that Patient 1 then said, "Oh" and took the medications. (Strader Testimony; Exhibit 7)

19. In speaking with Strader, Respondent denied that she spoke to Patient 1 in a reprimanding manner and denied that she scolded or raised her voice at Patient 1. Respondent said that she was informing and educating Patient 1 that it's important to take the medication and that if it's left at the bedside the nurse can get in trouble. Respondent explained that it's her manner of speaking to gesture with the hands, point and speak loudly. Respondent told Strader that she thanked Patient 1 for taking the medications and thanked Lemieux for reporting that medications were left at the bedside. (Strader Testimony; Exhibit 7)

20. Strader's Interview of Patient 1. Strader testified as to her March 22, 2011 interview of Patient 1. At the time of the interview, Patient 1 was alert, oriented, and verbal, was understood and able to understand others, and had no problems with recall. Regarding the March 15, 2011 incident, Patient 1 told her that she had been asleep and had not been wakened that morning for her medication. She said that it had happened before, when Respondent was working, that she did not get her medications at the appropriate time. Patient 1 told Strader that Respondent came into the room and was angry, loud and harsh, and intimidating. Respondent said that she (Respondent) had offered Patient 1 the medications. Patient 1 felt like she was being blamed for the lapse. Patient 1 told Strader that

Respondent said that she (Respondent) could lose her license or job and that it would be her (Patient 1's) fault. Patient 1 said she felt she had done something wrong, even though she knew she hadn't and it wasn't her responsibility. She was fearful because she thought Respondent might retaliate against her. Patient 1 told Strader that she cried after she was alone after the incident. (Strader Testimony; Exhibit 7).

- 21. Strader Interview of Lemieux.** Strader testified as to her March 22, 2011 interview of Lemieux. Lemieux recounted to Strader that she observed the medication at Patient 1's bedside, reported it to Donahue, and returned to the room to continue providing care to Patient 1. Lemieux told Strader that Respondent positioned herself at the end of the bed, leaned forward, pointed at Patient 1 and spoke in a harsh, angry voice, saying that Patient 1 should have taken her medications and that she could lose her license or her job because they weren't taken. Lemieux told Strader that she wouldn't want her family members treated that way. She told Strader that she reported the incident to Donahue and then returned to the room to reassure Patient 1 that she was safe. (Strader Testimony; Exhibit 7)
- 22. Strader's Findings as to Donahue.** Strader interviewed Donahue on March 11, 2011. Strader's Investigation Report states her findings as to that interview, as follows: Donahue told Strader that Lemieux reported to her that the 6 a.m. medications had been left at Patient 1's bedside. Donahue took the medications to the nurses' station, showed them to Respondent, who said, "Oh my God, did I do that?" (meaning not given the medications). Respondent said she would take care of the situation. Shortly thereafter, Lemieux reported to Donahue that Patient 1 was upset because Respondent had spoken harshly to Patient 1 about not taking the medications. Lemieux told Donahue that Patient 1 said that Patient 1 did not like the way Respondent had spoken to Patient 1, Patient 1 felt badly about the incident, was uncomfortable, felt intimidated and was worried about retaliation from Respondent. Donahue then reported the incident to the Director of Nurses.
- 23. Strader's Findings as to Santos.** Strader's Investigation Report found that based on Santos's March 15, 2011 witness statement and Strader's March 22, 2011 interview of Santos that: Santos was providing care to another patient in Patient 1's room at the time of the incident. Santos was behind a curtain, which was pulled. When Santos heard Respondent raising Respondent's voice, Santos was concerned and opened the curtain to see if other staff were in the room. Santos said Lemieux was present, and Respondent was leaning over Patient 1 saying if you don't want me to lose my license, you need to take your pills. Santos said Respondent's tone was inappropriate and that Respondent was being

rude to Patient 1. Santos said she reported the incident to Donahue. (Exhibit 7)

24. Strader's Investigation Report found that (1) according to Couillard, RN, the Director of Nurses, Respondent refused to write a description of the alleged incident; and (2) that Patient 1 declined to provide a self-written statement because of hand tremors. (Exhibit 7)

25. Strader testified that the facility suspended Respondent the day of or the day following the incident and then terminated her employment on March 22, 2011 because of the incident. (Strader Testimony; Exhibit 7)

Respondent Testimony

26. Respondent testified at the hearing. She said that "It was a set-up and I believe strongly that they put her there" and that they put the medicine there as well. She testified that Donahue, Lemieux, Santos and Patient 1 are lying. She testified that Patient 1 came for pain medication at 5:40 that morning, so that if she came for pain medication, she would have gotten the other medication. She explained that that's how Patient 1 takes her medications, that she would get all of her medication with the pain medicine. She testified that Patient 1 was not her patient – that "they" set her up and all of a sudden moved Patient 1 to her side (of the facility) for "only a few days", "about a week or two." (Testimony of Respondent [hereinafter "Respondent Testimony"])

27. Respondent testified she was almost out of the building that morning when Donahue ran up to her and told her that she had left medication on the bedside table. She testified that she trusted Donahue. She replied to Donahue, "Oh, my God," and went to Patient 1. (Respondent Testimony)

28. Respondent testified that when she went in to Patient 1's room, she stood at the foot of the bed and "talked to her in a very nice way." Respondent testified, "I saw somebody behind the curtain just touching the third patient's sheet. She was just touching it. You could see that she was not doing anything there because she was just touching it." She testified that Lemieux was standing there facing Respondent. She testified that there was no way somebody could go in front of a patient and point at the patient's face to force the patient to take medication. (Respondent Testimony)

29. Respondent testified that at that time she believed Lemieux and Donahue when they said that the medication was left at the bedside, and for that reason administered it to Patient 1. She testified, "And from the look of things, I'm even thinking maybe she (Patient 1) probably got two times.

That's how I feel now, that she probably got two times." (Respondent Testimony)

30. Respondent was asked on cross-examination what motivation Donahue, Lemieux, Santos and Patient 1 had for lying. Respondent replied that, "They put themselves together, and they set it up." "This is what they want to do so they will be happy," and "This is what they are looking for." When Prosecuting Counsel pressed further as to what would be their motive to lie, Respondent testified that, "Because Jessica have done something and I showed her what to do, and then, she and I, I don't know, they got themselves together." (Respondent Testimony)

31. On cross-examination, Prosecuting Counsel posed the question, "I'm asking you why would Ms. Strader lie and make things up that the patient said that you spoke to her in a loud tone of voice, that you were reprimanding, that you made her feel like it was her fault for not taking the medications, that you said, 'don't you know I can lose my license over this?' If the patient did not say that to Ms. Strader, why would she make it up? Explain that to the Board." (Hearing)

32. As set forth in the record, this colloquy followed:

Aborgah: "Who made it up?"

Prosecuting Counsel: "Why would a patient make up, make that up if it didn't really happen?"

Aborgah: "And do you -- I also, I know that the patient have a right to refuse. I wouldn't force a patient or go on the face like they're saying, so they're lying."

Prosecuting Counsel: "I'm talking about --"

Aborgah: "That's 100 percent lie."

Prosecuting Counsel: "How you spoke to the patient."

Aborgah: "This is what I just explained to you."

Prosecuting Counsel: "So the patient is lying too?"

Aborgah: "She's lying."

(Hearing)

33. When asked on cross-examination if Strader was lying, she said that Strader is only testifying as to what others told her. (Respondent Testimony)

34. Respondent testified that she is the only one telling the truth. (Respondent Testimony)

Patricia Normandin Testimony

35. Patricia Normandin ("Normandin") testified at the hearing and, without objection, was qualified to testify as Prosecuting Counsel's expert witness on accepted standards of care in the practice of nursing, including, but not limited to, whether Respondent's conduct in administering medication to Patient 1 fell below the accepted standard of care and whether Respondent's interaction with Patient 1 fell below the accepted standard of care and constitutes patient abuse. (Testimony of Patricia Normandin [hereinafter "Normandin Testimony"]; Ex. 10)

36. Normandin has been a licensed RN in the Commonwealth for approximately thirty eight (38) years, since 1978. Ms. Normandin received a Bachelor of Science degree in Nursing from the University of Massachusetts ("UMASS") at Lowell in 1978 and subsequently earned a Post-Masters Nurse Education Certificate in 2005 from Regis College. Ms. Normandin received a Master of Science degree in Nursing Administration from the University of Massachusetts at Lowell in 1993. She received a Doctor of Nursing Practice Degree in 2010 from Regis College. (Normandin Testimony)

37. She holds certifications in the areas of emergency nursing, pediatric nursing, and advanced life support. Normandin is also certified as an instructor in pediatric advanced life support, adult and pediatric cardiopulmonary resuscitation and advanced cardiac life support. (Normandin Testimony)

38. Since 1999, she has been employed at the Tufts Medical Center as a staff nurse in the emergency department. As staff nurse, Normandin provides direct patient care and is a preceptor and mentor of staff, including medical and nursing students. She is also a per diem employee at Brigham and Women's Hospital, where she provides direct patient care in the occupational health department as well as in multiple Intensive Care Unit ("ICU") settings. Until recently, she was employed per diem at the Boston Children's Hospital as a nursing staff development instructor and urgent care nurse. Normandin has practiced in various long-term care and acute care facilities, including Saints Memorial Medical Center in Lowell, MA, Winchester Hospital in Winchester, MA, Boston University

Medical Center in Boston, MA, and Lahey Clinic Medical Center in Burlington, MA. (Normandin Testimony)

39. Normandin teaches and has taught as an adjunct professor, lecturer and clinical instructor at various educational and health care institutions in the Commonwealth, including the following: Northeastern University (14 years as clinical nursing instructor); Regis College (12 years as clinical nursing instructor); University of Massachusetts, Lowell (7 years as pediatric clinical instructor); Brigham and Women's Hospital (Occupational Health and Advanced Cardiac Life Support instructor); Boston Children's Hospital Medical Center (staff development instructor); Simmons College (12 years as clinical nursing instructor) and Boston College (pediatric clinical nursing instructor). (Normandin Testimony)
40. Normandin has also published numerous scholarly articles in the area of nursing. She has testified, and been qualified to testify, as an expert on accepted standards of nursing practice on several occasions before this Board. (Normandin Testimony)
41. In preparation for this hearing, Ms. Normandin reviewed the exhibits admitted into evidence in this matter. (Normandin Testimony; Exhibits 1-10)
42. Normandin testified as to her understanding of what occurred as reported by multiple witnesses, as follows: The day nurse found medication pills in a cup by Patient 1's bedside and reported it to the nurse manager; Patient 1 was Respondent's patient; the medication was Prilosec and Lactulose; Respondent acknowledged that she did not watch Patient 1 ingest the medication and that she had left the medication at the bedside; Respondent then spoke to Patient 1 in a loud, angry, intimidating manner and told Patient 1 that Respondent was going to lose her job because Patient 1 did not take her pills; and Patient 1 experienced feelings of humiliation, intimidation, guilt, fear of retaliation, and tearfulness as a result of the incident. (Normandin Testimony)
43. Patient 1's past medical history includes a diagnosis of post-traumatic stress disorder, meaning that at some point in her past she had a traumatic event that has negatively affected her ever since. Prilosec is used to settle the stomach so the patient doesn't get a reflex or gastric sort of ulcer from the stress. Prilosec is one of the medications that a doctor would order so that Patient 1 would not get an ulcer. (Normandin Testimony)
44. Patient 1 had cirrhosis, a disease of the liver. Lactulose is prescribed to assist the body in excreting ammonia, which is a toxin that can build up in the system of a person with cirrhosis. If ammonia does not get out of the

body, it can cause confusion and brain damage. Lactulose is given frequently. It can be given three to four times a day. If the ammonia level goes too high, a person cannot live. If Patient 1 did not receive her scheduled morning dose of these two medications, there could be negative consequences to her health. (Normandin Testimony)

45. There are multiple dangers in leaving medications at a patient's bedside in a nursing home situation. First, the patient would not have received the medication that the doctor prescribing thought the patient was getting, and if the doctor did not see an improvement, the doctor may prescribe more or a higher level of medication. Second, if the patient did not get the medication, the patient is not getting the treatment prescribed to make him or her better. Third, another patient could steal the medication and the patient taking it could be allergic to it. Fourth, a patient could hoard it and do an overdose if the patient wanted to, and could possibly kill him or herself. Fifth, someone could switch it with another medication, such as switching Oxycodone with Tylenol.
46. The accepted standards of nursing practice require a nurse to watch a patient ingest the medication that he or she administers. The nurse must stay there while the patient takes the pills. A nurse can never leave the pills. If the patient refuses the medication, the nurse must take the pills with him or her. After the nurse physically sees the patient take the pills, the nurse must document the administration of the pills. (Normandin Testimony)
47. Based on Normandin's education, training, and experience, she testified that in her professional opinion, Respondent violated the accepted standards of nursing practice when she administered medications to Patient 1. The standards require that a nurse see the patient take the medication and never leave it unattended or at the bedside. Respondent failed to comply with these standards. (Normandin Testimony)
48. The accepted standards of nursing practice require that a nurse treat a patient with respect and dignity and that a nurse not humiliate or reprimand a patient, or blame a patient for not taking medication. (Normandin Testimony)
49. Normandin testified that it would never be appropriate for a nurse to reprimand a patient. Respondent reprimanded Patient 1. Normandin explained that if a nurse was attempting to educate a patient about a medication issue, the nurse should do it in a therapeutic, caring, compassionate, supportive manner. (Normandin Testimony)
50. Normandin testified that Respondent's conduct of speaking to Patient 1 in a loud, angry tone was unprofessional and inappropriate. She

emphasized that it was not Patient 1's responsibility to take the medication, because it should never have been left at the bedside, so the patient did nothing wrong. If a nurse feels stressed out and angry with a patient, the nurse should step away from the situation – a nurse should never lash out or say what the nurse is feeling, because the nurse is the professional to the patient. (Normandin Testimony)

51. Based on Normandin's education, training, and experience, she testified that in her professional opinion the manner in which Respondent interacted with and spoke to Patient 1 was unprofessional, inappropriate and constituted patient abuse. Respondent's conduct constitutes patient abuse because patients have a bill of rights and they have a right to be treated with respect and dignity and not be humiliated. (Normandin Testimony)

Credibility Determinations

52. Jessica Lemieux, RN testified that she discovered medications left at Patient 1's bedside and reported the discovery to the Unit Manager, Donahue. Lemieux was in the room with Respondent and Patient 1 when Respondent and Patient 1 interacted that morning. She heard what Respondent said to Patient A and witnessed the tone of voice and gestures used by Respondent. She observed Patient 1's reaction in response to Respondent's conduct. Lemieux was an eye-witness to the key events, and her account was credible, persuasive, forthright, and clear. When Lemieux found the medication at the bedside, she immediately reported it to Donahue. When Lemieux saw how unprofessionally Respondent spoke to Patient 1, Lemieux again immediately reported it to Donahue. Donohue corroborated Lemieux's testimony that twice that morning Lemieux went to Donahue and reported to Donahue what she had just observed. Lemieux's testimony as to the interaction between Respondent and Patient 1 was corroborated by the credible eye-witness testimony of Alicia Santos, CNA, who was also in the room during the incident. Lemieux's testimony at the hearing was also consistent with the interview she gave to the DPH investigator on March 22, 2010. The AHC credits Lemieux's testimony as stated in the findings of fact, given the above.
53. Alicia Santos, CNA, who was in the room during the incident, testified as to her eye-witness observations of Respondent's interaction with Patient 1 and Patient 1's reaction to Respondent. Santos's testimony was detailed, credible, persuasive, and corroborated by Lemieux's testimony. The AHC credits Santos's testimony as stated in the findings of fact, given the above.

54. Maryanne Donahue, RN, testified credibly that Lemieux reported to her that Lemieux discovered the medications left at Patient 1's bedside, that she, Donahue, observed the medications at the bedside and then spoke with Respondent about the matter, and that shortly thereafter Lemieux and Santos both reported to her that Respondent had spoken inappropriately to Patient 1. Donahue further testified about her own interactions with and observations of Patient 1, and of her interview of Patient 1 and preparation of Patient 1's written statement. Donahue's testimony was corroborated by the testimony of Lemieux and Santos and was consistent with other reliable evidence in the record. When testifying, she answered the questions carefully, and where she no longer had a recollection of what occurred, she was forthright in saying so. Donahue's testimony is credited as stated in the findings of fact.
55. Richeia Strader testified credibly regarding her investigation of the incident, her preparation of the Investigation Report entered into the record as Exhibit 7, and her interviews of Patient 1, Lemieux, and Respondent, including admissions made by Respondent. Her testimony as to those interviews was forthright where she had a recollection of what occurred. At times, in testifying, she no longer had a full recollection of what occurred and provided a summary or partial description. Her testimony was supported by the Investigation Report, which she prepared close to the time of the incident, and which provided a thorough, clear, straight-forward description of her investigation, including detailed written descriptions of the salient details of her document review and her interview of witnesses and Respondent.
56. Lemieux, Santos, Donahue, Patient 1 and Strader had no discernible bias against Respondent or motive to lie. The testimony of each witness, or as in the case of Patient 1, the witness statement, was corroborated in pertinent parts by testimony of the other witnesses.
57. Prosecuting Counsel's expert, Dr. Patricia Normandin, was a knowledgeable witness, with extensive pertinent experience as a practitioner and teacher. Her testimony was clear and informed. Her responses to questions were direct and, where appropriate, supported by cogent explanations. Normandin's testimony was credible, and her testimony was reliable. She testified credibly regarding her familiarity with the accepted standards of nursing practice as applied to Respondent's conduct in this matter. She testified credibly as to her opinion that Respondent's conduct was not consistent with the accepted standards of nursing care and constituted patient abuse.
58. Respondent was not credible in testifying about key aspects related to her care of and interaction with Patient 1. The Board does not credit Respondent's testimony or prior statements as to salient facts where

Respondent's testimony or prior statements conflict with the reliable testimony of the other witnesses. Given the credible, forthright, detailed, and consistent eye-witness testimony of the key events by other witnesses, the AHC finds Respondent's account of what occurred to be self-serving and unpersuasive.

Applicable Nursing Board Regulations

1. Nursing Board Regulation 244 CMR 9.03 (5) entitled Adherence to Standards of Nursing Practice provides that a nurse shall engage in the practice of nursing in accordance with accepted standards of nursing practice.
2. Nursing Board Regulation 244 CMR 9.03 (15) entitled Patient Abuse, Neglect, Mistreatment, Abandonment, or Other Harm provides that "A nurse licensed by the Board shall not abuse, neglect, mistreat, abandon, or otherwise harm a patient." The Definition section of the Nursing Board Regulations found at 244 CMR 9.02 defines abuse as: "[A]ny impermissible or unjustifiable contact or communication with a patient which in any way harms or intimidates, or is likely to harm or intimidate, a patient. Abuse may be verbal or non-verbal, and may cause physical, sexual, mental, or emotional harm."
3. Nursing Board Regulation 244 CMR 9.03 (47) entitled Other Prohibited Conduct provides that a nurse "shall not engage in any other conduct that fails to conform to accepted standards of nursing practice or in any behavior that is likely to have an adverse effect upon the health, safety, or welfare of the public."

V. Conclusions of Law

1. Based on Finding of Fact at ¶ 1, the Board concludes that it has jurisdiction to hear this matter.
2. Based on Findings of Fact at ¶¶ 1-58, the Respondent's conduct of (a) failing to appropriately administer medication to Patient 1 while she was under Respondent's care and (b) interacting with Patient 1 in an abusive manner which caused the patient to become upset and fearful constitutes gross misconduct in the practice of nursing, warranting disciplinary action by the Board pursuant to G.L. c. 112, § 61.
3. Based on Findings of Fact at ¶¶ 1-58, the Respondent's conduct of (a) failing to appropriately administer medication to Patient 1 while she was under Respondent's care and (b) interacting with Patient 1 in an abusive manner which caused the patient to become upset and fearful violates 244 CMR 9.03(5) for

failing to engage in the practice of nursing in accordance with accepted standards of nursing practice.

4. Based on Findings of Fact at ¶¶ 1-58, the Respondent's conduct of interacting with Patient 1 in an abusive manner which caused the patient to become upset and fearful violates 244 CMR 9.03(15) for abusing, neglecting, mistreating, abandoning, or otherwise harming a patient.

5. Based on Findings of Fact at ¶¶ 1-58, the Respondent's conduct of (a) failing to appropriately administer medication to Patient 1 while she was under Respondent's care and (b) interacting with Patient 1 in an abusive manner which caused the patient to become upset and fearful violates 244 CMR 9.03(47) for engaging in any other conduct that fails to conform to accepted standards of nursing practice or in any behavior that is likely to have an adverse effect upon the health, safety or welfare of the public.

6. Based on Findings of Fact at ¶¶ 1-58, the Respondent's conduct of (a) failing to appropriately administer medication to Patient 1 while she was under Respondent's care and (b) interacting with Patient 1 in an abusive manner which caused the patient to become upset and fearful constitutes conduct which undermines public confidence in the integrity of the nursing profession. *Sugarman v. Board of Registration in Medicine*, 422 Mass. 338, 342 (1996); *Kvitka v. Board of Registration in Medicine*, 407 Mass. 140, cert. denied, 498 U.S. 823 (1990); *Raymond v. Board of Registration in Medicine*, 387 Mass. 708, 713 (1982).

VI. Discussion

Massachusetts General Laws Chapter 112, § 61 authorizes the Board to discipline the license of an LN for gross misconduct in the practice of the profession. Section 61 reads in relevant part:

... [E]ach board of registration . . . after a hearing, may . . . suspend, revoke or cancel any certificate, registration, license or authority . . . if it appears . . . that the holder of such certificate, registration, license or authority, . . . is guilty of deceit, malpractice, gross misconduct in the practice of his profession, or of any offense against the laws of the commonwealth relating thereto . . .

G.L. c. 112, § 61

The term "gross misconduct" has been interpreted broadly. *Leigh v. Board of Registration in Medicine*, 395 Mass. 670, 675 (1985). The Supreme Judicial Court has allowed agencies to exercise discretion in determining what misconduct constitutes gross misconduct. *Dlugosz v. Board of Registration in Nursing*, Supreme Judicial Court, No. 1996-0500, May 24, 2002 (Memorandum and Order), at 9 - 10 (professional's misconduct "taken as a whole" used in

determining whether it amounts to "gross misconduct".) Gross misconduct is willed and intentional improper conduct ... a lack of concern for one's conduct amounting to a heedless and palpable violation of a legal duty respecting the others. *Hellman v. Board of Registration in Medicine*, 404 Mass. 800, 804 (1989).

In addition, the Board has established regulatory standards for the conduct of nursing, the violation of which subjects a nurse's license to discipline. (Standards of Conduct for Nurses, 244 C.M.R. § 9.03.) Pursuant to 244 C.M.R. § 9.03, nurses "shall have knowledge and understanding" of these standards. The specific relevant regulatory subsections are cited in the Conclusions of Law above.

Moreover, this Board has broad authority to regulate the conduct of the nursing profession. This authority includes sanctioning nurses for conduct which undermines public confidence in the integrity of the profession. *Sugarman v. Board of Registration in Medicine*, 422 Mass. 338, 342 (1996); *Kvitka v. Board of Registration in Medicine*, 407 Mass. 140, cert. denied, 498 U.S. 823 (1990); *Raymond v. Board of Registration in Medicine*, 387 Mass. 708, 713 (1982) (board has authority to protect the image of the profession).

This matter is before the Board for a determination of whether the record establishes by a preponderance of the evidence that Respondent, as alleged in the Amended Order to Show Cause, (a) failed to appropriately administer medication to a patient under her care and (b) interacted with a patient in an unprofessional, hostile, and abusive manner.

The persuasive and credible evidence presented at the hearing clearly demonstrates that: On the morning of March 15, 2011, Respondent left Patient 1's medications, Prilosec and Lactulose, at Patient 1's bedside; Lemieux, RN found the medication pills in a cup by Patient 1's bedside and reported it to Donahue, RN, the Unit Manager; Respondent returned to Patient 1's room and reprimanded Patient 1 with an angry face and in a loud voice, while leaning toward Patient 1 and pointing at her, for not taking the medications and potentially causing Respondent to lose her license or her job; and Patient 1 experienced feelings of humiliation, intimidation, guilt, fear of retaliation and tearfulness as a result of the incident.

Lemieux testified credibly that she discovered the medications left at Patient 1's bedside and reported the discovery to the Unit Manager, Donahue. Donahue testified credibly that she went to Patient 1's room, saw the medication on the bedside table, took the medication to the nurses' station, and showed it to Respondent, who said, "Oh my God, did I do that?" in an apologetic tone and indicated that she would go to Patient 1 and administer the medications.

Lemieux and Santos, two eye-witnesses who were in Patient 1's room at the time of Respondent's interaction with Patient 1, testified credibly at the hearing that Respondent, with an angry face and in a frustrated manner, spoke in an angry, loud voice to Patient 1 and reprimanded Patient 1 and blamed Patient 1 for the medication still being at the bedside. Lemieux witnessed Respondent say to Patient 1 in a tone that was louder than normal: "You can get my license taken away. You can't leave meds at the bedside. You need to take them. Do you want me to lose my license?" Santos' testimony was similar. She testified that Respondent, who appeared angry and frustrated, was pointing at Patient 1, scolding her and saying, "If you don't want me to lose my license, you need to take your pills." Lemieux and Santos observed Patient 1's reaction and demeanor in response to Respondent's conduct. Patient 1 did not answer back; she had her head down and looked upset and intimidated by the way that Respondent was speaking to her.

Patient 1's account of what occurred was established by Strader's testimony at the hearing of her March 22, 2011 interview of Patient 1. Her account was also established by Patient 1's own witness statement, which was prepared on March 15, 2011, the day of the incident, and entered into the record as Exhibit 6. Strader's testimony at the hearing and Strader's Investigation Report (Exhibit 7) both recite what Patient 1 told Strader when Strader interviewed Patient 1 at the facility on March 22, 2011. (Strader Testimony; Exhibit 7) Strader testified that Patient 1 told her that: She had been asleep and had not been wakened that morning for her medication. She said that it had happened before, when Respondent was working, that she did not get her medications at the appropriate time. Respondent came into the room and was angry, loud and harsh, and intimidating; Respondent said to Patient 1 that she (Respondent) had offered Patient 1 the medications; Patient 1 felt like she was being blamed for the situation; Respondent said that she (Respondent) could lose her license or job and that it would be her (Patient 1's) fault. Patient 1 told Strader that she felt she had done something wrong, even though she knew she hadn't and it wasn't her responsibility. She told Strader that she was fearful because she thought Respondent might retaliate against her. Patient 1 told Strader that she cried after she was alone after it happened. Patient 1's written statement, prepared the day the incident occurred, recounts salient details of what occurred and is consistent with what she told Strader. Patient 1 did not write her March 15, 2011, statement herself because of her hand tremors. Instead, she dictated it to Donahue and then signed it. Moreover, Patient 1's account is corroborated on all pertinent points by the testimony of Lemieux, Santos, Donahue, and Strader. The AHC finds Patient 1's account, as set out above, to have sufficient indicia of credibility and to be reliable. (Donahue Testimony; Exhibit 6; Exhibit 7). (Strader Testimony; Exhibits 6 and 7)

On March 22, 2011, shortly after the incident, Strader interviewed Respondent. During the interview Respondent made numerous admissions to Strader. The AHC credits Strader's testimony and finds that Respondent made,

among others, the following admissions: She admitted that she told Patient 1 that if Patient 1 did not take the medications and they were left at the bedside, that Respondent could lose her job or license or be in big trouble. Respondent admitted to Strader that it is her manner of speaking to gesture with the hands, point and speak loudly. Respondent admitted to Strader that she did not watch Patient 1 ingest the medication and that she had left the medication at the bedside. She also admitted that she did not administer the medications. She further admitted that medications should not be left at a patient's bedside and that she had not followed The Oxford's policy or the standards of nursing practice for medication administration. (Exhibit 7) At the hearing, Respondent did not deny that she made the admissions to Strader. Instead, she testified as to her own account of what occurred.

Respondent testified that she spoke to Patient 1 "in a very nice way" and that Lemieux, Santos, Donahue and Patient 1 are lying. (She did not controvert Strader's testimony.) When asked repeatedly what motive they had to lie, Respondent testified that: "It was a set-up," and "They put themselves together and they set it up... this is what they want to do, so they will be happy." When pressed further to reveal any motivation they had to lie, Respondent testified that, "Because Jennifer [Lemieux] have done something and I showed her what to do and then, she and I don't know, they got themselves together." When asked why Patient 1 would lie, Respondent repeatedly evaded answering the question and responded with a non-responsive reply, "I know that the patient have a right to refuse [medication]. I wouldn't force a patient or go on the face like they're saying, so they're lying." Respondent asserts that "they", which the AHC assumes refers to Lemieux, Santos, and Donahue, set her up by moving Patient 1 to her side of the facility a few days or a week ahead of time and then staged a scenario to lead Respondent to believe that she had left the medication at the patient's bedside when in fact she had not. Respondent presented no credible evidence of her assertion that these witnesses are lying and that they staged this ruse. Respondent testimony on this point was brief, vague, speculative and conclusory. Respondent had the opportunity to cross-examine Lemieux, Santos, Donahue and Strader when they testified at the hearing, but she didn't raise the topic and adduced no evidence in support of her assertion that they were lying, that they set her up, or that they had any reason to lie. The AHC does not credit Respondent's testimony as to the salient facts of the case. Where her testimony conflicts with the testimony of the other witnesses, the AHC credits the testimony of the other witnesses.

The weight of the credible, reliable evidence clearly demonstrates that (a) the events occurred as described by Lemieux, Santos, Patient 1, Donahue, and Strader and not as described by Respondent; and (b) Respondent interacted with Patient 1 in an unprofessional, inappropriate, and abusive way.

The AHC also credits the expert testimony of Normandin that in her professional opinion, Respondent violated the accepted standards of nursing

practice when she administered medications to Patient 1. In support of her opinion, she explained that the standards, which are driven by patient safety concerns, require that a nurse see the patient take the medication and never leave it unattended or at the bedside, and that Respondent failed to comply with these standards.

The AHC further credits Normandin's expert opinion that the manner in which Respondent interacted with and spoke to Patient 1, and the resulting humiliation and intimidation the interaction caused Patient 1, was not consistent with accepted standards of nursing practice, was unprofessional, inappropriate and constitutes patient abuse. In support of her opinion, Normandin explained that Respondent's conduct constitutes patient abuse because patients have a bill of rights and they have a right to be treated with respect and dignity and not be humiliated.

The Board concludes that Respondent's conduct (a) in administering medications to Patient 1, specifically, not watching Patient 1 ingest the medication and leaving the medication at the bedside, fell below the accepted standards of nursing care. The Board further concludes that Respondent's conduct of interacting with Patient 1 in an unprofessional, hostile and abusive manner constitutes patient abuse and fell below the accepted standards of nursing practice. Respondent's conduct as to both matters violates the laws and regulations cited in the Conclusions of Law section above, which are not repeated here. ²

² See *In the Matter of Christine Mucci*, Board of Registration in Nursing Docket No. RN-05-192 (June 11, 2008), at 50 (working with difficult patient population, nurse's stress and fatigue do not "in any way justify inappropriate conduct and abusive behavior").

Conclusion

Respondent's conduct as established by the evidence of record at hearing violates applicable statutes, regulations and laws. The Board has an obligation to protect the public health, safety and welfare. *Levy v. Board of Registration in Medicine*, 378 Mass. 519 (1979). It also has broad discretion to determine the proper sanctions for misconduct..." *Sugarman v. Board of Registration in Medicine*, 422 Mass. 338, 347-8 (1996); *Kvitka v. Board of Registration in Medicine*, 407 Mass. 140, 143 (1990). The Board imposes the following sanctions on Respondent's license based on its experience and discretion and careful consideration of the facts and mitigating circumstances before it.

(Order to be entered by the Board)

Board of Registration in Nursing

By: Beverly Kogut
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Tentative Decision Issued and Filed: July 21, 2015

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