The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure
239 Causeway Street, Suite 500, Boston, MA 02114

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MARYLOU SUDDERS
Secretary

EILEEN M. SULLIVAN
Acting Commissioner

January 21, 2015

BY FIRST CLASS AND CERTIFIED MAIL RETURN
RECEIPT REQUESTED NO. 7012 3460 0001 7331 4563
Heather L. Bunnell
redact

RE: In the Matter of Heather Lynne Bunnell, LN License No. 85865
Board of Registration in Nursing Docket No. NUR-2013-0061 & NUR-2013-0062

Dear Ms. Bunnell:

Enclosed is the *Final Decision and Order by Default ("Final Decision")* issued by the Board of Registration in Nursing ("Board") in connection with the above-referenced matter. The effective date of the Board's Order is ten (10) days from the date appearing on page 6 of the *Final Decision* ("Date Issued"). Your appeal rights are noted on page 6 of the *Final Decision.*

Sincerely,

Rula Harb, MSN, RN
Executive Director
Board of Registration in Nursing

Enc.

cc: Michelle Fentress, Prosecuting Counsel
Patricia Blackburn, Administrative Hearings Counsel

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION
IN NURSING

In the Matter of **HEATHER LYNNE BUNNELL** LN License No. 85865 License Expired 9/25/2013	Docket Nos. NUR-2013-0061 NUR-2013-0062

FINAL DECISION AND ORDER BY DEFAULT

On September 30, 2014 and October 14, 2014, the Board of Registration in Nursing ("Board") issued and duly served on Heather Lynne Bunnell ("Respondent"), an Order to Show Cause ("Show Cause Order") [1] related to a complaint filed regarding Respondent's license. In addition to stating the allegations against Respondent, the Show Cause Order notified Respondent that an Answer to the Show Cause Order ("Answer") was to be submitted within 21 days of receipt of the Show Cause Order.[2] The Show Cause Order also notified Respondent of the right to request a hearing on the allegations[3] and that any hearing request ("Request for Hearing") was to be submitted within 21 days of receipt of the Show Cause Order.[4] Respondent was further notified that failure to submit an Answer within 21 days "shall result in the entry of default in the above-captioned matter" and, if defaulted, "the Board may enter a Final Decision and Order that assumes the truth of the allegations in the Show Cause Order and may revoke, suspend, or take other disciplinary action against [Respondent's] license...including any right to renew [Respondent's] license." A copy of the

I do hereby certify the foregoing to be a true and certified copy of the document on file with the Massachusetts Board of Registration in Nursing.

3/2/15

Authorized Signature Date

[1] Pursuant to 801 CMR 1.01(6)(a).
[2] In accordance with 801 CMR 1.01(6)(d)(2).
[3] Pursuant to G.L. c. 112, §61.
[4] Respondent was also notified that failure to timely submit a Request for Hearing would constitute a waiver of the right to a hearing.

Show Cause Order is attached to this Final Decision and Order by Default and is incorporated herein by reference.

As of the date of this Final Decision and Order by Default, Respondent has failed to file either an Answer or a Request for Hearing.

The Board has afforded Respondent an opportunity for a full and fair hearing on the allegations in the Show Cause Order as required by G.L. c. 30A, §10, and sufficient notice of the issues involved to afford Respondent reasonable opportunity to prepare and present evidence and argument as required by G.L. c. 30A, §11(1). The Board has also notified Respondent of the obligation under 801 CMR 1.01(6)(d) to file an Answer to the Show Cause Order within 21 days of its receipt and of the consequences of failing to file an Answer or otherwise respond.

As authorized by G.L. c. 30A, §10(2), the Board may make informal disposition of any adjudicatory proceeding by default. Upon default, the allegations of the complaint against Respondent are accepted as true. *Danca Corp. v. Raytheon Co.*, 28 Mass. App. Ct. 942, 943 (1990).

Based on the foregoing, the Board enters a default in the above-captioned matter and, consequently, the allegations in the Order to Show Cause are deemed to be true and Respondent has waived the right to be heard. In accordance with the Board's authority and statutory mandate, the Board orders as follows:

ORDER

Based on its Final Decision by Default, the Board **Revokes** Respondent's Right to Renew her Massachusetts License to practice as a Licensed Practical Nurse, LPN License No. 85865.

If Respondent renews her license to practice as a Licensed Practical Nurse in Massachusetts before the Effective Date of this Final Decision and Order by Default, the Board Revokes said license, LPN License No. 85865.

Respondent is hereby ordered to return any nursing license issued to her by the Board, whether current or expired, to the Board's office at 239 Causeway Street, Boston, Massachusetts 02114, by hand or by certified mail, within five (5) days of the Effective Date set forth below.

Respondent shall not practice as a Licensed Practical Nurse in Massachusetts on or after the Effective Date of this Order. "Practice as a Licensed Practical Nurse" includes, but is not limited to, seeking and accepting a paid or voluntary position as a Licensed Practical Nurse or in any way representing herself as a Licensed Practical Nurse in Massachusetts. The Board shall refer any evidence of unlicensed practice to appropriate law enforcement authorities for prosecution as provided by G.L. c. 112, §§ 65 and 80A.

Respondent may petition the Board in writing for relicensure after five (5) years and when she can provide documentation satisfactory to the Board demonstrating her ability to practice nursing in a safe and competent manner. Such documentation shall include evidence that Respondent has been in stable and sustained recovery from all substances of abuse for the three (3) years immediately preceding any petition for relicensure. Accordingly, Respondent shall with any petition for relicensure have submitted **directly to the Board**:

1) the results of random supervised urine tests for substances of abuse for Respondent, collected no less than fifteen (15) times per year, according to the requirements outlined in Attachment A, during the two (2) years immediately preceding the petition for relicensure, all of which are required to be negative;

2) documentation that Respondent obtained a sponsor and regularly attended Alcoholics Anonymous (AA) and/or Narcotics Anonymous (NA) meetings at least three (3) times per week during the two (2) years immediately preceding any petition for license reinstatement, such documentation to include a letter

of support from the Respondent's sponsor and weekly signatures verifying this required attendance;

3) documentation verifying that she has regularly attended group or individual counseling or therapy, or both, during the two (2) years immediately preceding any petition for relicensure;[5]

4) reports from Respondent's primary care provider and any specialist(s) whom Respondent may have consulted verifying that Respondent is medically able to resume the safe and competent practice of nursing, which meets the requirements set forth in Attachment B 1.

5) if employed during the year immediately preceding Respondent's petition for relicensure, have each employer from said year submit on official letterhead an evaluation reviewing Respondent's attendance, general reliability, and overall job performance;[6]

6) certified Court and/or Agency documentation that there are no pending actions or obligations, criminal or administrative, against the Respondent before any court or Administrative Agency including, but not limited to:

   a. Documentation that *at least one (1) year prior to any petition for reinstatement* the Respondent satisfactorily completed all court requirements (including probation) imposed on her in connection with

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[5] Such documentation shall be completed by each licensed mental health professional seen by Respondent, and shall be written within thirty (30) days preceding any petition for relicensure. Further, such documentation shall include: a summary of Respondent's progress in therapy and her full, sustained recovery from substance abuse, dependence and addiction; a statement of the frequency and length of therapy; and specific treatment recommendations for Respondent's full, sustained recovery from substance abuse, dependence and addiction.

[6] If Respondent wasn't employed at all during this period, submit an affidavit so attesting.

any criminal matter and a description of those completed requirements and/or the disposition of such matters;[7] and

b. Certified documentation from the state board of nursing of each jurisdiction in which the Respondent has ever been licensed to practice as a nurse, sent directly to the Massachusetts Board identifying her license status and discipline history, and verifying that her nursing license is, or is eligible to be, in good standing and free of any restrictions or conditions.

7) documentation satisfactory to the Board of her successful completion of all continuing education equivalent to the continuing education required by Board regulations for the two (2) license renewal cycles immediately preceding any petition for relicensure.

The Board's approval of Respondent's petition for relicensure shall be conditioned upon, and immediately followed by, probation of Respondent's nursing license for a period of two (2) years with continued random urine screens, as well as other restrictions and requirements that the Board may then determine are reasonably necessary in the best interests of the public health, safety, and welfare.

The Board may choose to relicense Respondent if the Board determines that relicensure is in the best interests of the public at large.

The Board voted to adopt the within Final Decision by Default at its meeting held on January 14, 2015 by the following vote: **In favor:** Anthony Alley, BSN, RN, M.

[7] The Respondent shall also provide, if requested, an authorization for the Board to obtain a Criminal Offender Record Information (CORI) Report of the Respondent conducted by the Massachusetts Criminal History Systems Board and a sworn written statement that there are no pending actions or obligations, criminal or administrative, against the Respondent before any court or administrative body in any other jurisdiction.

Beal, RN/NM, P. Gales, RN, K. Gehly, RN, S. Kelly, RN/NP, J. Killion, LPN, B. Levin, RN, A. Peckham, RN, MSN, C. Simonian, PharmD, R.Ph., S. Taylor, MSN, RN, C. Tebaldi, RN, MS, **Opposed**: None **Abstained**: None **Absent**: E. Richard Rothmund Cheryl Urena, LPN.

The Board voted to adopt the within Final Order by Default at its meeting held on January 14, 2015 by the following vote: **In favor:** Anthony Alley, BSN, RN, M. Beal, RN/NM, P. Gales, RN, K. Gehly, RN, S. Kelly, RN/NP, J. Killion, LPN, B. Levin, RN, A. Peckham, RN, MSN, C. Simonian, PharmD, R.Ph., S. Taylor, MSN, RN, C. Tebaldi, RN, MS, **Opposed**: None **Abstained**: None **Absent**: E. Richard Rothmund Cheryl Urena, LPN.

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 by Default to the Supreme Judicial Court within thirty (30) days of receipt of notice of this Final Decision pursuant to M.G.L. c. 112, § 64.

Board of Registration in Nursing

Date Issued: January 21, 2015

Rula Harb, MSN, RN
Executive Director

Bunnell, H.
NUR-2013-0061, 0062

Notified:

VIA FIRST CLASS AND CERTIFIED MAIL RETURN

RECEIPT REQUESTED NO. 7012 3460 0001 7331 4563

Heather L. Bunnell

redact

BY HAND DELIVERY

Michelle Fentress, Esq.

Prosecuting Counsel

Board of Registration in Nursing

239 Causeway Street

Boston, MA 02114

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure
Office of General Counsel
239 Causeway Street, Suite 500, Boston, MA 02114

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GOVERNOR

JOHN W. POLANOWICZ
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October 14, 2014

BY FIRST CLASS AND CERTIFIED MAIL
7012 0470 0001 3611 9842

Ms. Heather Lynne Bunnell
redact

RE: In the Matter of Heather Lynne Bunnell, LN License No. 85865
Board of Registration in Nursing, Docket Nos. NUR-2013-0061 and NUR-2013-0062

Dear Ms. Bunnell:

The Massachusetts Board of Registration in Nursing ("Board") within the Department of Public Health, Division of Health Professions Licensure ("Division"), has completed its investigation of the above-listed complaints against your license to practice as a Licensed Practical Nurse. For the reasons set forth in the attached Order to Show Cause, the Board is proposing to suspend, revoke or impose other discipline against your license as a Licensed Practical Nurse (LN License No. 85865).

The Order to Show Cause and any subsequent hearing are governed by G.L. c. 30A, the State Administrative Procedure Act, and the Standard Adjudicatory Rules of Practice and Procedure, 801 CMR 1.01 *et. seq*. You must submit an Answer to the Order to Show Cause **and** you have a right to request a hearing by filing a written request for a hearing, as specified in the Order to Show Cause.

Your failure to submit an Answer to the Order to Show Cause within twenty-one (21) days of receipt of the Order to Show Cause *shall result in the entry of default* in the above-referenced matters. Your failure to submit a written request for a hearing within twenty-one (21) days of receipt of this Order to Show Cause *shall constitute a waiver of the right to a hearing* on the allegations therein and on any Board disciplinary action. Notwithstanding the earlier filing of an Answer and/or request for a hearing, your failure to respond to notices or correspondence, failure to appear for any scheduled status conference, pre-hearing conference or hearing dates, or failure to otherwise defend this action shall result in the entry of default.

If you are defaulted, the Board may enter a Final Decision and Order that assumes the truth of the allegations in this Order to Show Cause, and may revoke, suspend, or take other disciplinary action against your license to practice as a Licensed Practical Nurse in Massachusetts, including any right to renew your license.

The request for a hearing and your Answer must be filed with Michelle D. Fentress, Prosecuting Counsel, at the following address:

Michelle D. Fentress
Prosecuting Counsel
Department of Public Health
Office of the General Counsel
239 Causeway Street, Suite 500
Boston, Massachusetts 02114

If you are represented by an attorney in this matter, all communications should be made through your attorney.

You may contact me at (617) 973-0979 if you have any questions regarding this matter.

Sincerely,

Michelle D. Fentress
Prosecuting Counsel

Encl: Order to Show Cause
Certificate of Service

This is an important notice. Please have it translated.
Este é um aviso importante. Queira mandá-lo traduzir.
Este es un aviso importante. Sirvase mandarlo traducir.
ĐÂY LÀ MỘT BẢN THÔNG CÁO QUAN TRỌNG
XIN VUI LÒNG CHO DỊCH LẠI THÔNG CÁO ẤY
Ceci est important. Veuillez faire traduire.
本通知很重要。请将之译成中文。
 នេះគឺជាដំណឹងល្អ សូមមេត្តាបកប្រែជូនផង
ΠΡΟΣΟΧΗ, ΑΥΤΟ ΕΙΝΑΙ ΣΗΜΑΝΤΙΚΟ. ΠΑΡΑΚΑΛΘ ΜΕΤΑΦΡΑΣΤΕ
Questo è un 'avviso importante. Si pregadi farlo tradurre.

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION
IN NURSING

In the Matter of **HEATHER LYNNE BUNNELL** LN License No. 85865 License Expired 9/25/2013	Docket Nos. NUR-2013-0061 NUR-2013-0062

ORDER TO SHOW CAUSE

HEATHER LYNNE BUNNELL you are hereby ordered to appear and show cause why the Massachusetts Board of Registration in Nursing ("Board") should not suspend, revoke, or otherwise take action against your license to practice as a Licensed Practical Nurse, in the Commonwealth of Massachusetts, License No. 85865 or your right to renew such license, pursuant to G.L. c. 112, §61 and Board regulation 244 CMR 9.03, based upon the following facts and allegations:

Factual Allegations

1. On or about August 5, 2009, the Board issued to you a license to engage in the practice of nursing as a Licensed Practical Nurse ("LPN") in the Commonwealth of Massachusetts. Your license has expired.

2. On various dates between September 2012 and October 2012, while you were licensed to practice as an LPN in Massachusetts and working at Mt. Greylock Extended Care Facility ("Greylock") in Pittsfield, Massachusetts, you misappropriated personal belongings of several patients under your care; you worked while impaired; you failed to properly document your removal, waste, and administration of narcotics and benzodiazepines; and you were observed attempting to gain access to the secured Fentanyl disposal container. You were also arrested and charged with Shoplifting and Possession of various Controlled Substances. Your conduct included, but was not limited to, the following:

Criminal Activity

3. On January 8, 2013, you were arrested for shoplifting from a Walmart Store and you were found to be in possession of several pills. You were arraigned in the Pittsfield District Court, Docket No. 1327CR0034, for Shoplifting over $100; Possession of a Class B Substance (four (4) Oxycodone pills); three (3) counts of Possession of a Class C Substance (two (2) Diazepam pills, one (1) Clonazepam pill, and one and one-half (1½) Hydrocodone Pills); and Possession of a Class E Substance (two (2) Sucralfate pills).

4. On April 1, 2014, you entered a guilty plea on the Shoplifting charge referenced in Paragraph 3 and you admitted to sufficient facts related to the charges of: Possession of a Class B Substance; Possession of a Class E substance; and three (3) counts of Possession of a Class C Substance. You were sentenced to serve 120 days in the House of Correction for the Shoplifting charge.

5. On or about February 21, 2013, you were arraigned in the Pittsfield District Court, Docket No. 1227CR002368 on two (2) counts of Receiving Stolen Property.

6. The two counts of Receiving Stolen Property referred to in Paragraph 5 relate to the jewelry you stole from Greylock patients and later pawned in exchange for money, without the knowledge or consent of the Greylock patients.

7. The Commonwealth elected not to prosecute the charges referred to in Paragraph 5 by filing a nolle prosequi.

Impairment

8. On or about October 13, 2012 while you were working at Greylock, another Greylock employee ("GE") observed you consume pills and shortly thereafter GE observed you to be very lethargic, speaking with slurred speech, unsteady on your feet, walking and weaving back and forth, and your eyes were half opened and red.

9. On or about October 13, 2012, while you were working at Greylock, a delivery driver observed you to be unsteady on your feet. You put your arm around the delivery driver's body to brace yourself from falling.

10. You were slurring your words when you spoke with the delivery driver referred to in Paragraph 9 and you asked him the same question three (3) times.

11. On or about October 14, 2012, while you were working at Greylock, you were observed weaving back and forth while standing at the nurse's station, you were easily distracted while providing report, and your speech was slurred.

Patient A

12. On diverse dates in October 2012, you were responsible for providing care to "Patient A" who had physician's orders to receive one (1) 25 microgram ("mcg") Fentanyl patch (Schedule II Controlled Substance) ("Patch" or "Patches"), every 72 hours.

13. On October 11, 2012, you wrote two (2) entries at 20:00 hours in Patient A's record for Controlled Substance Removals ("CSR") from the medication cart. The first entry indicated that you removed one (1) Patch from the medication cart, wasted an "old [P]atch," and that the "wasted patch [was] destroyed." The second entry in Patient A's CSR indicated that you removed one (1) additional Patch from the medication cart.

14. On October 11, 2012, you wrote an entry in the designated space on the front of Patient A's Medication Administration Record ("MAR") indicating that you applied one (1) Patch on Patient A; however, neither the space designated on the back of Patient A's MAR for Nurse Medication Notes ("NMN"), nor Patient A's Nurses' Progress Notes ("NPN" or "NPNs"), has any written entries prepared by you setting forth the clinical reasons why you removed from the medication cart the two (2) Patches referred to in Paragraph 13 and why you wasted one (1) new Patch at 20:00.

15. On October 23, 2012, at 19:30 hours, a Nurse ("Nurse A") wrote an entry in Patient A's CSR indicating that one (1) Patch was removed from the medication cart and, in Patient A's MAR, Nurse A wrote an entry indicating that a Patch was applied on Patient A's right shoulder on October 23, 2012 during the 3pm to 11pm shift.

16. On October 26, 2012, at 20:00 hours you wrote an entry in Patient A's CSR indicating that you removed one (1) Patch from the medication cart and wasted one (1) "old [P]atch," and on the same date, you wrote an entry in Patient A's MAR indicating that you applied a Patch on Patient A during the 3pm to 11pm shift. Patient A's NMN and Patient A's NPNs do not have any written entries prepared by you demonstrating that you applied or wasted Patches at any time on October 26, 2012.

17. According to the physician's orders referred to in Paragraph 12, after your application of the Patch referred to in Paragraph 16, an old Patch would not have had to be removed, and a new Patch applied, until October 29, 2012.

18. On October 27, 2012, at 22:00 hours you wrote an entry in Patient A's CSR indicating that you removed one (1) Patch from the medication cart and wasted one (1) Patch; however, Patient A's MAR does not have any written entry prepared by you demonstrating that you applied a Patch on Patient A, and Patient A's NMN and Patient A's NPN do not have any written entries prepared setting forth the clinical reasons why you removed or wasted the Patches at or around 22:00.

19. On October 28, 2012, at 20:00 hours you wrote an entry in Patient A's CSR indicating that you removed one (1) Patch from the medication cart and wasted one (1) "old [P]atch," and on Patient A's MAR, you wrote an entry indicating that you applied a new Patch on Patient A during the 3 pm to 11 pm shift on October 28, 2012.

20. Patient A's NMN and Patient A's NPNs do not have any written entries prepared by you on October 28, 2012, setting forth the clinical reasons why you removed or wasted the Patches referred to in Paragraph 19.

21. On October 28, 2012, you applied a new Patch on Patient A, contrary to the physician's orders referred to in Paragraph 12; you did not wait for seventy-two hours to elapse before you applied a new Patch.

22. Between October 11, 2013 and October 28, 2012, during report, you told other nurses that the new and used Patches that were applied on Patient A had been falling off and that

you had to remove new Patches from the medication cart and apply them on Patient A; however, you failed to document any of those occurrences in any incident reports.

23. Between October 11, 2012 and October 28, 2012, you failed to write any entries in Patient A's NPNs or Patient A's NMN setting forth the clinical reasons why you removed, applied, or wasted Patches.

24. Between October 11, 2012 and October 28, 2012, you applied and wasted Patches, and you removed Patches from the medication cart without having any clinical justification for doing so.

25. Between October 11, 2012 and October 28, 2012, you failed to apply the Fentanyl Patches on Patient A as directed by the authorized prescriber.

Patient B

26. On diverse dates in October 2012, you were responsible for providing care to "Patient B," who had physician's orders to receive, by mouth, one (1) tablet of Ativan (Schedule IV Controlled Substance) at bedtime.

27. On October 13, 2012, you wrote an entry in Patient B's CSR indicating that you removed Ativan from the medication cart; however, you failed to properly document the following information in the designated areas on Patient B's CSR: (a) the time at which you removed the tablet; (b) the amount of Ativan you used; (c) the method by which the tablet of Ativan was to be administered to Patient B; (d) the quantity of tablets left after you removed Ativan from the medication cart; and (e) your signature.

28. Your entries in the designated areas on Patient B's CSR referred to in Paragraph 27, were as follows: you wrote "13" in the time column; "one" in the amount on hand column; "po" in the amount used column; "12" in the method column; and you signed your name in the amount left and nurse's signature columns.

29. On October 14, 2012, you wrote an entry in Patient B's CSR indicating that you removed one (1) tablet of Ativan from the medication cart; however, you failed to properly document the following information in the designated areas on Patient B's CSR: (a) the method by which the tablet was to be administered to Patient B; (b) the quantity of tablets left after you removed one (1) tablet; and (c) your signature.

30. Your entries in the designated areas on Patient B's CSR referred to in Paragraph 29, were as follows: you wrote "11" in the method column and you signed your name in the amount left and nurse's signature columns.

31. On October 15, 2012, you wrote an entry in Patient B's CSR indicating that you removed one (1) tablet of Ativan from the medication cart; however, you failed to properly document the following information in the designated areas on Patient B's CSR: (a) the

method by which the tablet was to be administered to Patient B; (b) the quantity of tablets left after you removed one (1) tablet; and (c) your signature.

32. Your entries in the designated areas on Patient B's CSR referred to in Paragraph 31, were as follows: you wrote "10" in the method column and you signed your name in the amount left and nurse's signature columns.

33. Between October 13, 2012 and October 15, 2012, you failed to make complete and accurate entries in Patient B's CSR.

34. Between October 13, 2012 and October 15, 2012, you failed to write any entries in Patient B's MAR, Patient B's NMN, or Patient B's NPNs demonstrating any administration or waste of the tablets of Ativan that you removed from the medication cart.

Patient C

35. On diverse dates in October 2012, you were responsible for providing care to "Patient C," who had the following physician's orders: (a) to receive one (1) tablet of Percocet 5/325 (Schedule II, Controlled Substance), every four (4) hours as needed for pain; (b) to receive two and one-half (2 ½) 5 milligram ("mg") tablets of Valium (Schedule IV Controlled Substance) in the morning and three and one-half (3 ½) 7.5 mg tablets of Valium at bedtime; and (c) to receive one (1) 20 mg tablet of Oxycontin (Schedule II Controlled Substance) twice daily.

36. On October 13, 2012, you wrote two (2) separate entries in Patient C's CSR indicating that you removed a total of two (2) tablets of Percocet from the medication cart; however, Patient C's MAR, Patient C's NMN, and Patient C's NPNs do not have any written entries prepared by you demonstrating that you administered or wasted the tablets on October 13, 2012.

37. One of the entries in Patient C's CSR referred to in Paragraph 36 was illegible; the listed time was written over the previously recorded time.

38. On October 14, 2012, you wrote an entry in Patient C's CSR indicating that you removed one (1) tablet of Percocet from the medication cart at 16:00 hours and one (1) tablet of Percocet at 22:00 hours ("second tablet"). You documented in Patient C's MAR that you administered one (1) tablet of Percocet at 16:00 hours on October 14, 2012; however, Patient C's MAR, does not have any written entry prepared by you demonstrating that you administered the second tablet at or around 22:00 hours on October 14, 2012.

39. Patient C's NMN, and Patient C's NPNs do not have any written entries prepared by you demonstrating that you administered or wasted the tablets of Percocet referred to in Paragraph 38.

40. On October 15, 2012, you wrote an entry in Patient C's CSR indicating that you removed one (1) tablet of Percocet from the medication cart; however, Patient C's MAR, Patient C's NMN, and Patient C's NPNs do not have any written entries prepared by you demonstrating that you administered or wasted the tablet on October 15, 2012.

41. On October 18, 2012, you wrote an entry in Patient C's CSR indicating that you removed one (1) tablet of Percocet from the medication cart at 16:30 hours and one (1) tablet of Percocet at 22:00 hours ("second tablet"). You documented in Patient C's MAR that you administered one (1) tablet of Percocet at 16:30 hours on October 18, 2012; however, Patient C's MAR does not have any written entry prepared by you demonstrating that you administered the second tablet at or around 22:00 hours on October 18, 2012.

42. Patient C's NMN, does not have any written entries prepared by you demonstrating that you administered or wasted the tablets of Percocet referred to in Paragraph 41.

43. Between October 13, 2012 and October 18, 2012, you documented in Patient C's CSR that you removed a total of eight (8) Percocet tablets from the medication cart; however, Patient C's MAR, has only three (3) written entries prepared by you demonstrating that you administered Percocet tablets; Patient C's NPNs have only two (2) written entries prepared by you demonstrating that you administered Percocet tablets, and Patient C's NMN does not have any written entries prepared by you demonstrating that you administered or wasted any of the tablets of Percocet you removed for Patient C.

44. On October 22, 2012, you wrote an entry in Patient C's CSR indicating that you removed three (3) tablets of Valium from the medication cart. You documented in Patient C's MAR that you administered Valium on October 22, 2012; however, neither Patient C's NMN, nor Patient C's NPNs has any written entries prepared by you demonstrating that you administered or wasted the tablets you removed for Patient C.

45. Your written entry referred to in Paragraph 44, failed to legibly document the following information: (a) the time at which the tablets were administered, and (b) the amount of tablets that were on hand before your administration of Valium tablets to Patient C.

46. On October 29, 2012, you wrote two (2) separate entries in Patient C's CSR, each indicating that you removed one (1) tablet of Oxycontin from the medication cart at 20:00 hours. You then crossed out the second notation, but you did not document why you wrote or crossed out the second notation.

47. On October 29, 2012, you documented in Patient C's MAR that you administered Oxycontin to Patient C; however neither Patient C's NMN, nor Patient C's NPNs has any written entries prepared by you demonstrating that you administered or wasted the tablets you removed for Patient C on October 29, 2012.

48. Between October 13, 2012 and October 29, 2012, you wrote entries in Patient C's CSR demonstrating that you removed Controlled Substances from the medication cart on nineteen occasions; however, Patient C's NPNs have only one (1) entry prepared by you

demonstrating that you administered Percocet twice on October 18, 2012, and Patient C's NMNs do not have any entries prepared by you demonstrating that you administered or wasted any of the Controlled Substances you removed for Patient C.

49. On October 22, 2012 and October 29, 2012, you failed to make legible entries in Patient C's CSR.

Patient D

50. You made illegible entries on the NPN for "Patient D" On October 13, 2012.

Patient E

51. On diverse dates in October 2012, you were responsible for providing care to "Patient E," who had physician's orders to receive at bedtime one (1) .5 mg tablet of Alprazolam, also known as Xanax, (Schedule IV Controlled Substance).

52. On or about October 1, 2012, you wrote an entry in Patient E's CSR indicating that you removed one (1) tablet of Xanax from the medication cart; however, Patient E's MAR, Patient E's NMN, and Patient E's NPNs do not have any written entries prepared by you demonstrating that you administered or wasted the tablet on October 1, 2012.

53. Your entry referred to in Paragraph 52 is illegible; you wrote over the pre-existing amounts in the "amount on hand" and the "amount left" columns in the CSR.

54. On October 2, 2012, you wrote an entry in Patient E's CSR indicating that you removed one (1) tablet of Xanax from the medication cart; however, Patient E's MAR, Patient E's NMN, and Patient E's NPNs do not have any written entries prepared by you demonstrating that you administered or wasted the tablet on October 2, 2012.

55. On October 3, 2012, you wrote an entry in Patient E's CSR indicating that you removed one (1) tablet of Xanax from the medication cart; however, Patient E's MAR, Patient E's NMN, and Patient E's NPNs do not have any written entries prepared by you demonstrating that you administered or wasted the tablet on October 3, 2012.

56. On October 5, 2012, you wrote an entry in Patient E's CSR indicating that you removed one (1) tablet of Xanax from the medication cart; however, Patient E's MAR, Patient E's NMN, and Patient E's NPNs do not have any written entries prepared by you demonstrating that you administered or wasted the tablet on October 5, 2012.

57. On October 11, 2012, you wrote an entry at 16:30 hours in Patient E's NPN indicating that you administered Xanax to Patient E and you wrote an entry at 20:00 hours in Patient E's CSR indicating that you removed one (1) tablet of Xanax from the medication cart. You did not document in Patient E's CSR that you removed Xanax at any time prior to 20:00 on October 11, 2012.

58. Neither Patient E's MAR, nor Patient E's NMN, has any written entries prepared by you demonstrating that you administered or wasted Xanax at any time on October 11, 2012.

59. Patient E's NPN does not have any written entries prepared by you demonstrating that you administered or wasted any amount of Xanax at or around 20:00 hours on October 11, 2012.

60. On October 13, 2012, you wrote an entry in Patient E's CSR indicating that you removed one (1) tablet of Xanax from the medication cart at 21000 hours; however, "21000" is not a unit of time, and Patient E's MAR, Patient E's NMN, and Patient E's NPNs do not have any written entries prepared by you demonstrating that you administered or wasted the tablet on October 13, 2012.

61. On October 14, 2012, you wrote an entry in Patient E's CSR indicating that you removed one (1) tablet of Xanax from the medication cart; however, Patient E's MAR, Patient E's NMN, and Patient E's NPNs do not have any written entries prepared by you demonstrating that you administered or wasted the tablet on October 14, 2012.

62. On October 15, 2012, you wrote an entry in Patient E's CSR indicating that you removed one (1) tablet of Xanax from the medication cart; however, Patient E's MAR, Patient E's NMN, and Patient E's NPNs do not have any written entries prepared by you demonstrating that you administered or wasted the tablet on October 15, 2012.

63. On October 22, 2012, you wrote an entry in Patient E's CSR indicating that you removed one (1) tablet of Xanax from the medication cart; however, Patient E's MAR, Patient E's NMN and Patient E's NPNs do not have any written entries prepared by you demonstrating that you administered or wasted the tablet on October 22, 2012.

64. On October 26, 2012, you wrote an entry in Patient E's CSR indicating that you removed one (1) tablet of Xanax from the medication cart; however, Patient E's MAR, Patient E's NMN, and Patient E's NPNs do not have any written entries prepared by you demonstrating that you administered the tablet to Patient E on October 26, 2012.

65. On October 27, 2012 at 16:00 hours, you wrote an entry in Patient E's NPN indicating that you administered Xanax to Patient E and you wrote an entry at 20:00 hours in Patient E's CSR indicating that you removed one (1) tablet of Xanax from the medication cart. You did not document in Patient E's CSR that you removed Xanax at any time prior to 20:00 hours on October 27, 2012.

66. Neither Patient E's MAR, nor Patient E's NMN, has any written entries prepared by you demonstrating that you administered or wasted Xanax at any time on October 27, 2012

67. Patient E's NPN does not have any written entries prepared by you demonstrating that you administered or wasted any amount of Xanax at or around 20:00 hours on October 27, 2012.

68. On October 28, 2012, you wrote an entry in Patient E's CSR indicating that you removed one (1) tablet of Xanax from the medication cart. You documented in Patient E's MAR that you administered Xanax to Patient E; however, neither Patient E's NMN, nor Patient E's NPNs has any written entry prepared by you demonstrating that you administered or wasted Xanax on October 28, 2012.

69. On October 29, 2012, you wrote an entry in Patient E's CSR indicating that you removed Xanax from the medication cart; however, the time you wrote is illegible.

70. On October 29, 2012, you documented in Patient E's MAR that you administered Xanax to Patient E; however, neither Patient E's NMN, nor Patient E's NPNs, has any written entry prepared by you demonstrating that you administered or wasted the tablet on October 29, 2012.

71. Between October 1, 2012 and October 29, 2012, you documented in Patient E's CSR that you removed a total of thirteen Xanax tablets from the medication cart; however, both Patient E's MAR and Patient E's NPNs have only two (2) entries demonstrating that you administered Xanax to Patient E, and Patient E's NMNs do not have any written entries prepared by you demonstrating that you administered or wasted any of the tablets of Xanax you removed for Patient E.

Patients F and G

72. You made illegible entries on the NPN for "Patient F" on October 13, 2012.

73. You made illegible entries on the NPN for "Patient G" on October 14, 2012.

Tampering with Fentanyl Patch Disposal Container

74. On or about October 30, 2012, several Greylock employees observed video surveillance of you tampering with the Duragesic ("Fentanyl") Patch disposal container. Specifically, the Greylock employees observed you: attempting to open the lid to the container; shaking the container upside down; and trying to pry the lid open. As a result of your actions, the lid was cracked, thereby making the disposed Fentanyl Patches accessible.

Grounds for Discipline

A. Your conduct as alleged, warrants disciplinary action by the Board against your license to practice as an LPN pursuant to Board regulation 244 CMR 9.03(5), because you failed to engage in the practice of nursing in accordance with accepted standards of practice.

B. Your conduct as alleged, warrants disciplinary action by the Board against your license to practice as an LPN pursuant to Board regulation 244 CMR 9.03 (31), because you knowingly falsified, or attempted to falsify, any documentation or

information related to any aspect of licensure as a nurse, the practice of nursing, and the delivery of nursing services.

C. Your conduct as alleged, warrants disciplinary action by the Board against your license to practice as an LPN pursuant to Board regulation 244 CMR 9.03(36), because you practiced nursing while impaired.

D. Your conduct as alleged, warrants disciplinary action by the Board against your license to practice as an LPN pursuant to Board regulation 244 CMR 9.03 (37), because you unlawfully obtained or possessed controlled substances.

E. Your conduct as alleged, warrants disciplinary action by the Board against your license to practice as an LPN pursuant to Board regulation 244 CMR 9.03 (38), because you failed to refrain from administering any prescription drug or non-prescription drug to any person in the course of nursing practice except as directed by an authorized prescriber.

F. Your conduct as alleged, warrants disciplinary action by the Board against your license to practice as an LPN pursuant to Board regulation 244 CMR 9.03 (39), because you failed to document the handling, administration, and destruction of controlled substances in accordance with all federal and state laws and regulations in a manner consistent with accepted standards of nursing practice.

G. Your conduct as alleged, warrants disciplinary action by the Board against your license to practice as an LPN pursuant to Board regulation 244 CMR 9.03 (44), because you failed to make complete, accurate and legible entries in all records required by federal and state laws and regulations and accepted standards of nursing practice.

H. Your conduct as alleged, warrants disciplinary action by the Board against your license to practice as an LPN pursuant to Board regulation 244 C.M.R. 9.03 (47), because you failed to refrain from 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.

I. Your conduct as alleged warrants disciplinary action by the Board against your license to practice as a LPN pursuant to G.L. c. 112, §74A for lack of the good moral character required for initial licensure and license renewal.

J. Your conduct as alleged also constitutes unprofessional conduct and conduct that undermines public confidence in the integrity of the nursing profession. *Sugarman v. Board of Registration in Medicine*, 422 Mass. 338, 342 (1996); see also *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).

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You have a right to an adjudicatory hearing ("hearing") on the allegations contained in the Order to Show Cause before the Board determines whether to suspend, revoke, or impose discipline against your license. G.L. c. 112, §61. Your right to a hearing may be claimed by submitting a written request for a hearing *within twenty-one (21) days of receipt of this Order to Show Cause.* You must also submit an Answer to this Order to Show Cause in accordance with 801 CMR 1.01 (6)(d) *within twenty-one (21) days of receipt of this Order to Show Cause.* The Board will give you prior written notice of the time and place of the hearing following receipt of a written request for a hearing.

Hearings shall be conducted in accordance with the State Administrative Procedure Act, G.L. c. 30A, §§10 and 11, and the Standard Adjudicatory Rules of Practice and Procedure, 801 CMR 1.01 and 1.03, under which you are granted certain rights including, but not limited to, the rights: to a hearing, to secure legal counsel or another representative to represent your interests, to call and examine witnesses, to cross-examine witnesses who testify against you, to testify on your own behalf, to introduce evidence, and to make arguments in support of your position.

The Board will make an audio recording of any hearing conducted in the captioned matter. In the event that you wish to appeal a final decision of the Board, it is incumbent on you to supply a reviewing court with a "proper record" of the proceeding, which may include a written transcript. *New Bedford Gas and Light Co. v. Board of Assessors of Dartmouth,* 368 Mass. 745, 749-750 (1975). Upon request, the Board will make available a copy of the audio recording of the proceeding at your own expense. Pursuant to 801 CMR 1.01 (10)(i)(1), upon motion, you "may be allowed to provide a public stenographer to transcribe the proceedings at [your] own expense upon terms offered by the Presiding Officer." Those terms may include a requirement that any copy of the transcript produced must be sent promptly upon completion and on an ongoing basis directly to the Presiding Officer by the stenographer or transcription service. The transcript will be made available to the Prosecutor representing the Board. Please note that the administrative record of the proceedings, including but not limited to, the written transcript of the hearing is a public record and subject to the provisions of G.L. c. 4, §7 and G.L. c. 66, §10.

Your failure to submit an Answer to the Order to Show Cause within 21 days of receipt of the Order to Show Cause *shall result in the entry of default* in the above-captioned matter. Your failure to submit a written request for a hearing within 21 days of receipt of this Order to Show Cause *shall constitute a waiver of the right to a hearing* on the allegations herein and on any Board disciplinary action.

Notwithstanding the earlier filing of an Answer and/or request for a hearing, your failure to respond to notices or correspondence, failure to appear for any scheduled status conference, pre-hearing conference or hearing dates, or failure to otherwise defend this action shall result in the entry of default.

If you are defaulted, the Board may enter a Final Decision and Order that assumes the truth of the allegations in this Order to Show Cause, and may revoke, suspend, or take

other disciplinary action against your license to practice as a Licensed Practical Nurse in the Commonwealth of Massachusetts, including any right to renew your license.

Your Answer to the Order to Show Cause and your written request for a hearing must be filed with Michelle Fentress, Prosecutor at the following address:

Michelle D. Fentress, Esq.
Prosecuting Counsel
Department of Public Health
Office of the General Counsel
239 Causeway Street, Suite 500
Boston, MA 02114

You or your representative may examine Board records relative to this case prior to the date of the hearing during regular business hours at the office of the Prosecutor. If you elect to undertake such an examination, then please contact Prosecuting Counsel in advance at (617) 973-0979 to schedule a time that is mutually convenient.

BOARD OF REGISTRATION IN NURSING,
Rula F. Harb, MSN, RN
Executive Director

By: _____
Michelle D. Fentress, Esq.
Prosecuting Counsel
Department of Public Health

Date: October 14, 2014

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing Cover Letter, Order to Show Cause and Certificate of Service were served upon the Respondent, Heather Lynne Bunnell, at the following address of record with the Board:

Ms. Heather Lynne Bunnell
redact

by first class mail, postage prepaid, and certified mail no. 7012 0470 0001 3611 9842

This 14th day of October, 2014.