



Sincerely,

A handwritten signature in black ink, appearing to read "Amy S. Fein". The signature is fluid and cursive, with the first name "Amy" and last name "Fein" clearly distinguishable.

Amy S. Fein, RN, BSN, JD  
Co-Interim Executive Director  
Board of Registration in Nursing

Enc.

cc: Eugene Langner, Prosecuting Counsel

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION  
IN NURSING

In the Matter of  
David Kent Moorman III  
LPN License No. 89211  
License Expires 10/24/15

Docket Nos. NUR-2013-0213  
NUR-2014-0239

FINAL DECISION AND ORDER BY DEFAULT

On June 17 and 26, 2015, the Board of Registration in Nursing (Board) issued and duly served on David Kent Moorman III (Respondent) an Order to Show Cause (Show Cause Order)<sup>1</sup> related to complaints 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<sup>2</sup>. The Show Cause Order also notified Respondent of the right to request a hearing on the allegations<sup>3</sup>, and that any hearing request (Request for Hearing) was to be submitted within 21 days of receipt of the Show Cause Order.<sup>4</sup> Respondent was further notified that failure to submit an Answer within 21 days "shall result in the entry of default in the 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 Show Cause Order is attached to this Final Decision and Order by Default and is incorporated herein by reference.

On July 16, 2015, Prosecuting Counsel sent notice to Respondent to file an Answer and a Request for Hearing by July 24, 2015. On July 20, 2015, Prosecuting Counsel sent notice to Respondent to file an Answer and a Request for Hearing by July

<sup>1</sup> Pursuant to 801 CMR 1.01(6)(a). Each of the Show Cause Orders was sent to a distinct address.

<sup>2</sup> In accordance with 801 CMR 1.01(6)(d)(2).

<sup>3</sup> Pursuant to M.G.L. c. 112, s. 61.

<sup>4</sup> Respondent was also notified that failure to timely submit a Request for Hearing would constitute a waiver of the right to a hearing.

27, 2015. The notices again advised Respondent that if defaulted, the Board might enter a Final Decision and Order that assumes the truth of the allegations stated in the Show Cause Order and impose license discipline, including discipline on any right to renew.

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 Massachusetts General Laws (G.L.) c. 30A, s. 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, s. 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 M.G.L. c. 30A, s. 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 Show Cause Order 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 and Order by Default, the Board revokes the Respondent's license to practice as a Licensed Practical Nurse in Massachusetts, LN89211 for a minimum of three (3) years. The Board further revokes the Respondent's right to renew his license.

If Respondent renews his 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, LN89211.

Respondent is hereby ordered to return any nursing license issued to him 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 ten (10) 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 himself 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.

The Board may choose to reinstate Respondent's license if the Board determines in its sole discretion that reinstatement is in the best interests of the public health, safety and welfare.

Respondent may petition the Board in writing for relicensure when he can provide documentation satisfactory to the Board demonstrating his 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 Respondent has regularly attended group or individual counseling or therapy, or both, during the two (2) years immediately preceding any petition for relicensure;<sup>5</sup>

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<sup>5</sup> 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

- 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) A comprehensive mental health evaluation of the Respondent conducted by a licensed mental health provider which meets the requirements set forth in Attachment B2
- 6) 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;<sup>6</sup>
- 7) 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/him in connection with any criminal matter and a description of those completed requirements and/or the disposition of such matters;<sup>7</sup> 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.
- 8) documentation satisfactory to the Board of Respondent's 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.
- 9) after the Effective Date of this Order, certified documentation of the successful completion of the following Continuing Education Hours:
  - i. Six (6) contact hours of continuing education on the topic of Medication Administration and Documentation in Nursing including the topic of Maintaining the Security of Medications.

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therapy; and specific treatment recommendations for Respondent's full, sustained recovery from substance abuse, dependence and addiction.

<sup>6</sup> If Respondent was not employed during this period, submit an affidavit so attesting.

<sup>7</sup> 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.

David Kent Moorman III  
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- ii. Three (3) contact hours of continuing education on the topic of Legal and Ethical Aspects of Nursing.
- iii. Three (3) contact hours of continuing education on the topic of Pain Management in Nursing.
- iv. Three (3) contact hours of continuing education on the topic of Critical Thinking and Judgment in Nursing Practice.

The Board may condition its approval of respondent's petition for reinstatement upon the respondent entering into a Consent Agreement for Probation of Respondent's nursing license for a period of time, with such restrictions and requirements that the Board may at that time and in its sole discretion determine are reasonably necessary to protect the public health, safety, and welfare.

The Board voted to adopt the within Final Decision 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; A. Peckham, RN, MSN; C. Simonian, Pharm.D., R.Ph.; S. Taylor, MSN, RN; B. Levin, RN; C. Urena, LPN, **Opposed:** None, **Abstained:** None, **Recused:** None, **Absent:** C. Tebaldi, CNP; E. Richard Rothmund.

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; A. Peckham, RN, MSN; C. Simonian, Pharm.D., R.Ph.; S. Taylor, MSN, RN; B. Levin, RN; C. Urena, LPN, **Opposed:** None, **Abstained:** None, **Recused:** None, **Absent:** C. Tebaldi, CNP; E. Richard Rothmund.

#### EFFECTIVE DATE OF ORDER

This Final Decision and Order by Default becomes effective upon the tenth (10<sup>th</sup>) 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 either the Supreme Judicial Court pursuant to M.G.L. c. 112, § 64 or to a superior Court with jurisdiction pursuant to M.G.L. c. 30A §§ 12. Respondent must file his appeal within thirty (30) days of receipt of this notice of Final Decision and Order by Default.

Board of Registration in Nursing



Amy S. Fein, RN, BSN, JD  
Co-Interim Executive Director  
Board of Registration in Nursing

Date Issued: September 22, 2015

Notified:

**VIA FIRST CLASS AND CERTIFIED MAIL RETURN RECEIPT**  
**REQUESTED NO. 7014 0510 0001 0375 2398**

David Kent Moorman III

redact

**VIA FIRST CLASS AND CERTIFIED MAIL RETURN RECEIPT**  
**REQUESTED NO. 7014 0510 0001 0375 2435**

David Kent Moorman III

redact

**VIA FIRST CLASS AND CERTIFIED MAIL RETURN RECEIPT**  
**REQUESTED NO. 7014 0510 0001 0375 2442**

David Kent Moorman III

redact

David Kent Moorman III  
LPN License No. 89211  
Docket Nos. NUR-2013-0213 and NUR-2011-0239

**BY HAND DELIVERY**

**Eugene Langner, Esq.  
Prosecuting Counsel**

David Kent Moorman III  
LPN License No. 89211  
Docket Nos. NUR-2013-0213 and NR R-2011-0239

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION  
IN NURSING

In the Matter of )  
David Kent Moorman III )  
LPN License No. 89211 )  
License Expires 10/24/15 )

Docket Nos. NUR-2013-0213  
NUR-2014-0239

**ORDER TO SHOW CAUSE**

David Kent Moorman III, 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 (LPN) in the Commonwealth of Massachusetts, License No. 89211, or your right to renew such license, pursuant to Massachusetts General Laws (G.L.) chapter 112, § 61 and Board regulation 244 CMR 9.03, based upon the following facts and allegations:

**Factual Allegations**

1. On or about July 12, 2012, the Board issued to you a license to engage in the practice of nursing as an LPN in the Commonwealth of Massachusetts, License No. 89211. Your license is current, and expires on October 24, 2015.

**NUR-2013-0213**

2. On multiple occasions in August and September of 2013, while you were employed as an LPN at Cape Heritage Rehabilitation Center in Sandwich, Massachusetts (Cape Heritage), you engaged in a pattern of conduct in your removal, administration, handling, documentation and wasting of controlled substances that constituted a failure to comply with accepted standards of nursing practice. Your conduct included, but was not limited to, the following:

***Patient 1***

3. On September 15, 2013, a Cape Heritage patient (Patient 1) had a physician's order for the administration of 5 mg of Percocet, a Schedule II Controlled Substance, every six (6) hours as needed for pain.
4. At 6:00 a.m. on September 15, 2013, you documented administering a 5 mg dose of Percocet to Patient 1.
5. At 7:00 a.m. on September 15, 2013, you documented having withdrawn in error two (2) 5 mg tablets of Percocet for Patient 1.

6. You documented administering the Percocet identified in the preceding paragraph to another Cape Heritage patient, whom you failed to identify.

*Patient 2*

7. Between September 11 and 15, 2013, a Cape Heritage patient (Patient 2) had a physician's order for the administration of 5 mg of oxycodone, a Schedule II Controlled Substance, every four (4) hours as needed.

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8. Between September 12 and 14, 2013, you withdrew the following doses of oxycodone for Patient 2:

- a. 5 mg at 12:00 a.m. on September 12, 2013;
- b. 5 mg at 6:00 a.m. on September 12, 2013;
- c. 5 mg at 12:00 a.m. on September 13, 2013;
- d. 5 mg at 4:30 a.m. on September 13, 2013;
- e. 5 mg at 11:00 p.m. on September 14, 2013; and
- f. 5 mg at 3:30 a.m. on September 14, 2013.

9. You failed to document the administration of the dose of oxycodone identified in Paragraph 8(d) above on the front of Patient 2's Medication Administration Record (MAR).
10. You documented having withdrawn and administered the dose of oxycodone identified in Paragraph 8(f) above in error.
11. You did not document in Patient 2's nursing notes any change in her condition justifying her need for oxycodone.

*Patient 3*

12. On September 15, 2013, a Cape Heritage patient (Patient 3) had the following physician's orders for the administration of oxycodone:

- a. 5 mg every six (6) hours as needed for moderate pain; and
- b. 10 mg every six (6) hours as needed for severe pain.

13. On September 15, 2013, you withdrew the following doses of oxycodone for Patient 3:

- a. 10 mg at 12:00 a.m.;
- b. 10 mg at 7:00 a.m.;
- c. 5 mg at 7:00 a.m.; and
- d. 5 mg at 1:00 p.m.

14. You used two (2) variations of your signature in connection with the withdrawals identified in the preceding paragraph.
15. After documenting the withdrawal of 10 mg of oxycodone for Patient 3 at 7:00 a.m. on September 15, 2013 as described in Paragraph 13(b) above, you then documented "Resident changed mind only took/one oxycodone with tylenol [sic]/one oxycodone 5 mg tab adm'd at 7A. one/destroyed by two nurses."
16. You did not document the identity of the second nurse referenced in the preceding paragraph.
17. At 7:00 a.m. on September 15, 2013, you documented the following with respect to the withdrawal identified in Paragraph 13(c) above: "transcription error/one popped in error destroyed by/two nurses."
18. You documented administering two (2) 10 mg doses of oxycodone to Patient 3 on the front of Patient 3's MAR on September 15, 2013, while documenting administering only one (1) 10 mg dose of oxycodone on the back of Patient 3's MAR.

*Patient 4*

19. On September 13, 2013, a Cape Heritage patient (Patient 4) had a physician's order for the administration of 100 mg of Fioricet, a Schedule VI controlled substance, twice daily as needed for headache.
20. At 7:00 a.m. on September 13, 2013, you withdrew 100 mg of Fioricet for Patient 4.
21. At 7:00 a.m. on September 13, 2013, you documented that Patient 4 changed her mind, refused the Fioricet you withdrew as described in the preceding paragraph, and requested Tylenol.
22. You documented that the Fioricet you withdrew as described in Paragraph 20 above was wasted into a sharps container, but did not document the identity of any witness to the wasting.
23. You documented administering 100 mg of Fioricet to Patient 4 on the front of Patient 4's MAR, whereas you documented that the administration was in error on the back of Patient 4's MAR.
24. At 7:00 a.m. on September 15, 2013, you documented in Patient 4's narcotic book that there were only forty-eight (48) tablets of Fioricet on hand for Patient 4, but then, with the co-signature of two (2) other nurses, signed an entry that there were fifty (50) tablets of Fioricet on hand for Patient 4.

25. At 7:00 a.m. on September 15, 2013, you documented on the back of Patient 4's MAR that you administered two (2) tablets of Fioricet to Patient 4 for headache, but then crossed that entry out and documented that the Fioricet was not administered.
  26. At 3:00 a.m. on September 16, 2013, you documented withdrawing two (2) tablets of Fioricet for Patient 4, leaving forty (46) tablets.
  27. Also at 3:00 a.m. on September 16, 2013, you documented that the entry referenced in the preceding paragraph was a transcription error, and that the amount of Fioricet left after your withdrawal of two (2) tablets was forty-eight (48).
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*Patient 5*

28. On August 16, 2013, a Cape Heritage patient (Patient 5) had the following physician's orders for the administration of oxycodone:
  - a. 5 mg every three (3) hours as needed for mild pain;
  - b. 10 mg every three (3) hours as needed for moderate pain; and
  - c. 15 mg every three (3) hours as needed for severe pain.
29. At 6:00 a.m. on August 16, 2013, you documented withdrawing 15 mg of oxycodone for Patient 5.
30. At 6:00 a.m. on August 16, 2013, you documented that the entry referenced in the preceding paragraph was a transcription error, that 5 mg of oxycodone had been withdrawn in error, and that the 5 mg withdrawn in error had been wasted by you and another nurse into the sharps bin.
31. At 6:30 a.m. on August 16, 2013, despite having documented the wasting described in the preceding paragraph, you documented administering 15 mg of oxycodone to Patient 5 on the front and back of Patient 5's MAR.

*Wareham District Court*

32. On or about August 30, 2013, an officer of the Wareham Police Department was dispatched to an apartment occupied by your partner.
33. Upon their arrival at your partner's apartment, the police officer found you lying on the floor, not breathing.
34. At the police officer's request, your partner's mother, who stated she was in a health career, operated an ambu bag to apply rescue breaths to you, while the officer connected an automated external defibrillator (AED) to you.

35. The AED advised not to apply electric shock to you, but to continue rescue breaths, which was done until your care was transferred to responders from the Wareham Fire Department.
36. Upon the transfer of your care as described in the preceding paragraph, the police officer located on a dresser a bag with a white powdery substance, another bag with two (2) items identified by your partner as doses of suboxone, two bags of a green leafy substance, believed to be marijuana, and a spoon and needles.
37. On or about September 27, 2013, in connection with the events described in Paragraphs 32 through 36 above, you were charged in Wareham District Court Docket No. 1360CR002146 with one (1) count of Possession of a Class A Controlled Substance, to wit, White Heroin, and one (1) count of Possession of a Class B Controlled Substance, to wit, Suboxin [sic] in violation of G.L. c. 94C, § 34.
38. On or about December 12, 2013, in connection with the charges described in the preceding paragraph, you were placed on pre-trial probation until June 12, 2014, and you were ordered during that time to remain drug free and to undergo a drug evaluation, counseling, and drug screening.
39. On or about March 13, 2014, the matter referenced in Paragraph 37 above was dismissed pursuant to the "Good Samaritan Law," G.L. c. 94C, § 34A.

**SARP**

40. On or about December 18, 2013, in response to your inquiry to the Board, you were sent a letter explaining the process for applying for admission to the Board's Substance Abuse Rehabilitation Program (SARP).
41. The letter referenced in the preceding paragraph instructed you that, upon your submission of your SARP admission application, you would be referred to a designated provider who would perform a SARP admission assessment
42. On or about January 1, 2014, you submitted your SARP admission application.
43. In signing the application referenced in the preceding paragraph, you acknowledged that you had a substance abuse problem, and that your substance abuse impaired your competency to practice nursing
44. Thereafter, SARP staff attempted on the following occasions, without success, to contact you to arrange for the referral described in Paragraph 41 above:
  - a. January 23, 2014, via e-mail;
  - b. March 14, 2014, via e-mail; and
  - c. April 8, 2014, by telephone.

45. On or about April 8, 2014, as a result of your failure to respond to the communications described in the preceding paragraph, your application for admission to the SAJRP was terminated.

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*Orleans District Court*

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- ~~46. On or about September 4, 2014, you were observed by two (2) officers of the Provincetown Police Department to be intoxicated, as evidenced by your smelling of alcohol, having bloodshot and glassy eyes, flailing your arms and spinning, and having walked into a street sign.~~
47. Based on the officers' observations as described in the preceding paragraph, you were deemed a danger to yourself and others, and were taken into protective custody and transported to the Provincetown Police Department.
48. Upon your arrival at the Provincetown Police Department, you were booked and your property was inventoried, whereupon a clear plastic vial with a black cap containing an unknown clear liquid was found in your right front pocket.
49. A NarkII Field Test Kit # 15 was conducted on a small amount of the liquid identified in the preceding paragraph, which tested positive for 3,4-Methylenedioxymethamphetamine (MDMA) (Ecstasy).
50. Subsequent to the test referenced in the preceding paragraph, you were transported to Cape Cod Hospital, where you were found to be at moderate risk for falls, were observed to twitch occasionally, and tested positive for amphetamines.
51. On or about September 9, 2014, as a result of the positive test referenced in Paragraph 49 above, you were charged in Orleans District Court Docket No. 1426CR001296 with one (1) count of Possession of a Class B Controlled Substance, to wit: Amphetamines/Methamphetamine: MDMA Ecstasy, in violation of G.L. c. 94C, § 34.
52. On or about February 26, 2015, the matter referenced in the preceding paragraph was dismissed upon your payment of three hundred dollars (\$300.00) in court costs.

*Seashore Point*

53. On or about October 6, 2014, while you were employed per diem at Seashore Point Wellness and Rehabilitation in Provincetown, Massachusetts (Seashore

Point), you reported a breaking and entering of your apartment to the Provincetown Police Department.

54. When two (2) officers of the Provincetown Police Department arrived at your apartment, they encountered the person reported to have broken into the apartment (the subject), on a couch covered with a green blanket covering his (the subject's) entire body.
55. Pursuant to Provincetown Police Department policy for safety, one of the officers (Officer A) removed the blanket referenced in the preceding paragraph, ordered the subject to put his hands behind his back, and placed the subject in handcuffs.
56. Officer A read the subject his Miranda rights, during which time the subject yelled that he didn't want his rights. Officer A finished reading the subject his Miranda rights to ensure that he (the subject) understood them.
57. The subject informed Officer A that you had invited the subject over, telling him he could "break in."
58. The subject told Officer A that he had entered the apartment through an unlocked rear slider, to which Officer A observed no apparent damage.
59. To confirm the subject's claim that he had been invited to the apartment, Officer A asked to see the subject's phone, but the subject was unable to find it.
60. In an effort to find the phone, Officer A had dispatch call the subject's cell phone number but was still unable to locate the phone, which the subject accused you of stealing, along with other personal items, including a tablet.
61. The subject was able to find his black and blue courier bag under a pile of laundry, but neither the phone nor the tablet was in the bag.
62. During the search described in Paragraphs 59 through 61 above, the subject relayed the locations of narcotics and paraphernalia in the apartment, which he uncovered and presented to the officers on his own accord.
63. The items referenced in the preceding paragraph were identified as Lidocaine, syringes, and a glass tube with white powder residue.
64. Upon the discovery of the items referenced in the preceding paragraph, you informed the officers that you had inadvertently brought the Lidocaine home from Seashore Point.
65. Due to the circumstances of the subject's arrest, no criminal charges were filed against you regarding the events described in Paragraphs 53 through 64 above.

66. The officers reported the discovery of an unopened bottle of Lidocaine at your apartment to Seashore Point.
67. Based on the report referenced in the preceding paragraph, Seashore Point conducted an investigation that revealed that a bottle of Lidocaine was missing from an emergency antibiotic kit.
68. As a result of the investigation referenced in the preceding paragraph, your employment at Seashore Point was terminated, effective October 4, 2014.

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Legal Basis for Discipline

- A. Your conduct as alleged warrants disciplinary action by the Board against your license to practice as an LPN pursuant to G.L. c. 112, § 61 for being guilty of deceit, malpractice, gross misconduct in the practice of the profession, or of any offense against the laws of the Commonwealth relating thereto.
- B. Your conduct as alleged reflects a lack of the "good moral character" required for initial licensure as an LPN and license renewal under G.L. c. 112, § 74A.
- 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 for violation of Standards of Conduct for Nurses, namely:
  1. Your conduct as alleged violates 244 CMR 9.03(5) for failing to engage in the practice of nursing in accordance with accepted standards of nursing practice.
  2. Your conduct as alleged violated 244 CMR 9.03(35) for failing to maintain the security of controlled substances that were under your responsibility and control.
  3. Your conduct as alleged violates 244 CMR 9.03(37) for unlawfully obtaining or possessing controlled substances.
  4. Your conduct as alleged violates 244 CMR 9.03(39) for failing to document the handling, administration, and destruction of controlled substances in accordance with all federal and state laws and regulations and in a manner consistent with accepted standards of nursing practice.
  5. Your conduct as alleged violates 244 CMR 9.03(44) for failing to make complete, accurate, and legible entries in all records required by federal and state laws and regulations and accepted standards of nursing practice.
  6. Your conduct as alleged 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.

- D. Your conduct as alleged also constitutes unprofessional conduct and conduct which undermines public confidence in the integrity of the 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 other 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 ordered by the Presiding Officer." Those terms may include a requirement that any copy of the transcript produced must be sent immediately 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 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 herein and on any Board disciplinary action. 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 captioned matter.

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

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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 nursing in the Commonwealth of Massachusetts, including any right to renew your license.

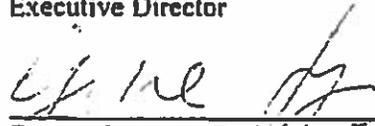
Your Answer to the Order to Show Cause and your written request for a hearing must be filed with Eugene Langner, Prosecuting Counsel, at the following address:

Eugene Langner, Esq.  
Prosecuting Counsel  
Department of Public Health  
Office of the General Counsel  
239 Causeway Street, 5<sup>th</sup> Floor  
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 Prosecuting Counsel. If you elect to undertake such an examination, then please contact Prosecuting Counsel in advance at (617) 973-0838 to schedule a time that is mutually convenient.

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

By:

  
\_\_\_\_\_  
Eugene Langner, Esq.  
Prosecuting Counsel  
Department of Public Health

Date: June 26, 2015

**CERTIFICATE OF SERVICE**

I hereby certify that a copy of the foregoing Order to Show Cause was served upon the Respondent:

**David Kent Moorman III**

redact

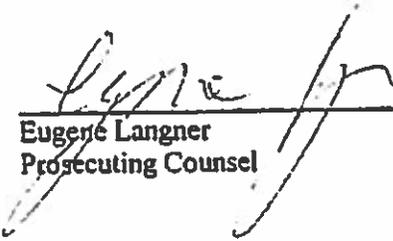
by first class mail, postage prepaid, and by Certified Mail No. 7014 0510 0001 0374 7073

**David Kent Moorman III**

redact

by first class mail, postage prepaid, and by Certified Mail No. 7014 0510 0001 0374 7080

This 21<sup>st</sup> day of June, 2015.

  
\_\_\_\_\_  
Eugene Langner  
Prosecuting Counsel