The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

MAURA T. HEALEY
Governor

KIMBERLEY DRISCOLL
Lieutenant Governor

KATHLEEN E. WALSH
Secretary

ROBERT GOLDSTEIN, MD, PhD
Commissioner

Tel: 617-624-6000
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January 12, 2024

Via First Class and Certified Mail No. 9589 0710 5270 0876 5995 13
Return Receipt Requested;

Andra J. Hutchins, Esq.
Kerstein Coren & Lichtenstein, LLP 60
Walnut Street
Wellesley, MA

Re: In the Matter of Chantale Perry
Docket No. NUR-2020-0026
License No. RN2308061; LN89092 (Exp.)

Dear Attorney Hutchins:

Enclosed please find the Final Decision and Order after Sanction Hearing issued by the Board of Registration in Nursing on January 12, 2024 and **effective January 22, 2024**. This constitutes full and final disposition of the above-referenced Complaint, as well as the final agency action of the Board. Your client's appeal rights are noted on page 4.

You may contact Meghan Bresnahan, Board Counsel at Meghan.bresnahan@mass.gov with any questions that you may have concerning this matter.

Sincerely,

Heather Cambra BSN, RN, JD

Heather Cambra, BSN, RN, JD
Acting Executive Director
Board of Registration in Nursing

Encl.
cc: Administrative Magistrate Diane Barry
Stephen Pleva, Esq., Prosecuting Counsel

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION
IN NURSING

Board of Registration in Nursing, Petitioner	)	
v.	)	
CHANTALE PERRY License No. RN2308061 License Expires 07/25/2024 License No. LN89092 (Exp.) License Expired 07/25/2017 Respondent	)	Docket No. NUR-2020-0026

FINAL DECISION AND ORDER AFTER SANCTION HEARING

PROCEDURAL HISTORY

On April 8, 2022, the Board of Registration in Nursing ("the Board") issued an *Order to Show Cause* ("OTSC") in the above-referenced matter. Respondent filed an Answer to the OTSC on June 1, 2022. On February 10, 2023, Prosecuting Counsel filed a Pre-Hearing Memo and on February 11, 2023, Respondent's Counsel filed their Pre-Hearing Memo. A Pre-Hearing Conference was held on May 15, 2023.

On June 16, 2023, parties filed a Joint Status Report Requesting Sanction Hearing. A Sanction Hearing was held on September 6, 2023, where Prosecuting Counsel, Respondent's Counsel, and Respondent were all present.

On October 5, 2023, Administrative Magistrate Barry issued a *Tentative Decision After Sanction Hearing ("Tentative Decision").* The Board has carefully considered the *Tentative Decision* and hereby adopts the *Tentative Decision*, including all findings of fact, conclusions of law and credibility determinations. The *Tentative Decision* is attached hereto and incorporated herein by reference.

DISCUSSION

The Board is charged with protecting the public health, safety, and welfare and, to this end, the Board has broad authority to regulate the conduct of nursing professionals including the ability to sanction professionals for conduct that undermines public confidence in the integrity of the profession. *See* 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).

The incidents giving rise to this Complaint filed against Respondent's license occurred at Royal Rehab and Nursing Facility ("Royal"). At the time of the incident, Respondent had worked at Royal for only a few months and was placed on a floor where most of the patients were Russian speakers who spoke no English. Respondent was also working a back-to-back shift. According to Respondent's Testimony at the Sanction Hearing, every interaction required a translator, which took extra time to request and properly employ. Respondent further stated that the patients on that floor needed a lot of care, and due to the language barriers, all ordinary patient related tasks took much longer than normal.

As stipulated by the parties, during Respondent's shift in question, Respondent removed Oxycodone from Patient A's Narcotic Sheet at 8:00 a.m., 2:00 p.m., and 8:00 p.m. However, Respondent did not document administering the Oxycodone on Patient's A Medication Administration Record. Respondent did document that Patient A had no pain at 2:00 p.m. and 7:00 p.m.

Respondent alleges that "At the time when the medication was signed out of the Narcotics Book and was administered to Patient A, Patient A was displaying unmistakable signs of pain and was clearly requesting the medication. The assessment note and the administration of the pain medication took place at different points in time, and the assessment note in no way indicates that it was inappropriate for Respondent to administer the Oxycodone at the point in time when it was administered."

Prosecution alleges that "It is not possible from the documentation available to assess whether or not Respondent properly cared for Patient A." Prosecution further states that due to Respondent's failure to document the administration time for each of the three doses, it is impossible to access whether Respondent properly observed the 6-hour

interval ordered between administrations. However, the Director of Nursing ("DON") at Royal who investigated this matter noted that Respondent was attentive to Patient A's needs throughout the day, and that Respondent acted appropriately. She further noted that she did not consider this even reportable. There are no allegations or evidence that Respondent did not provide adequate care to this patient in question, or all the other patients she was caring for that day while working a double shift. There are also no allegations or evidence of diversion or impaired practice, or that Respondent has ever had a substance abuse issue now or in the past. The issue strictly falls on the failure to document three doses of oxycodone, which was an isolated incident in Respondent's otherwise clean nursing career.

Based on the summary of the presentation of the Sanction Hearing and the findings contained in the *Tentative Decision*, it appears that Respondent's conduct was unintentional, and represents a sole lapse in Respondent's care due to mitigating factors of Respondent's situation on the day in question and the overall environment at the facility.

The Board voted to adopt the within **Final Decision** at its meeting held on January 10, 2024, by the following vote:

In favor:	*A. Alley, K.A. Barnes, K. Crowley, M. Harty, A. Joseph, L. Kelly, L. Keough, M. McAuliffe, J. Monagle, D. Nikitas, V. Percy, R. Reynolds*
Opposed:	
Abstained:	
Recused:	
Absent:	*A. Sprague, L. Wu*

ORDER

The Board has reviewed and carefully considered the *Tentative Decision*. Based on its Final Decision and on the rationale outlined above, the Board hereby imposes a

REPRIMAND on Respondent's nursing license, RN2308061 and LN89092. The Board believes this sanction will serve to notify the public and future employers of Respondent's practice breakdown related to the events on December 17, 2019. Further, Respondent acknowledged her errors and agrees she must do better in the future.

The Board voted to adopt the within **Final Order** at its meeting held on January 10, 2024, by the following vote:

In favor:	*A. Alley, K.A. Barnes, K. Crowley, M. Harty, A. Joseph, L. Kelly, L. Keough, M. McAuliffe, J. Monagle, D. Nikitas, V. Percy, R. Reynolds*
Opposed:	
Abstained:	
Recused:	
Absent:	*A. Sprague, L. Wu*

EFFECTIVE DATE OF ORDER

This Final Decision and Order becomes effective upon the tenth (10^{th}) day from the date issued (see "Date Issued" below).

RIGHT TO APPEAL

Respondent is hereby notified of the right to appeal this Final Decision and Order to the Supreme Judicial Court pursuant to M.G.L. c. 112, §64. Respondent must file any appeal within thirty (30) days of receipt of this notice of Final Decision and Order.

Board of Registration in Nursing,

Heather Cambra BSN, RN, JD

Heather Cambra, BSN, RN, JD
Acting Executive Director
Board of Registration in Nursing

Date Issued: January 12, 2024

Notified:

By first-class and certified mail no. 9589 0710 5270 0876 5995 13
Return receipt requested;
And Via Electronic Mail to:
Andra J. Hutchins, Esq.
Kerstein Coren & Lichtenstein, LLP
60 Walnut Street
Wellesley, MA
ahutchins@kcl-law.com

By inter-office mail
Stephen Pleva, Esq.,
Department of Public Health
Office of General Counsel
250 Washington Street, 2nd Floor
Boston, MA 02108

By inter-office mail
Administrative Magistrate Diane Barry
Department of Public Health
Office of General Counsel
250 Washington Street, 2nd Floor
Boston, MA 02108

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION IN NURSING

Board of Registration in Nursing)	
Petitioner)	
v.)	
Chantel Perry)	Docket No. NUR-2020-0026
RN Lic. No. 2308061)	
RN Lic. Expires 07/25/22)	
LN Lic. No. 89092)	
LN Lic. Expired)	
Respondent)	

ORDER TO SHOW CAUSE[1]

Chantel Perry 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 Registered Nurse (RN) License No. RN2308061 and your license to practice as a Licensed Practical Nurse (LN) License No. 89092 in the Commonwealth of Massachusetts, or your right to renew such licenses, pursuant to Massachusetts General Laws (G.L.) chapter 112, § 61, and Code of Massachusetts Regulations (CMR), Title 244, § 9.03 based upon the following facts and allegations:

Factual Allegations

1. On or about May 25, 2016, the Board issued to you a license to engage in the practice of nursing as an RN in the Commonwealth of Massachusetts, License No. RN2308061. This license expires on July 25, 2022.

2. On or about May 22, 2012, the Board issued to you a license to engage in the practice of nursing as an LN in the Commonwealth of Massachusetts, License No. LN89092. This license expired on July 25, 2017.

[1] It is well-settled administrative law that due process requires that "notice must be given that is reasonably calculated to apprise an interested party of the proceeding and to afford him an opportunity to present his case;" due process does not require Prosecuting Counsel to provide a detailed description of evidence they intend to introduce at a disciplinary hearing. *Langlitz v. Board of Registration of Chiropractors*, 396 Mass. 374, 376-377 (1985). *See Lapointe v. License Board of Worcester*, 389 Mass. 454, 458 (1983) ("Due process requires notice of the grounds on which the board might act rather than the evidentiary support for those grounds"). Certainly, notice pleadings do not require Prosecuting Counsel to match factual allegations to grounds for discipline. Accordingly, where, as here, there exists significant overlap between factual allegations and grounds for discipline contained within the Order to Show Cause, Prosecuting Counsel's matching of factual allegations to grounds for discipline are offered as suggestions, and not as an exhaustive characterization of the evidence to be adduced at a hearing.

3. You were employed as an RN at Royal Rehab and Nursing Facility (Royal) in Braintree, Massachusetts, during December 2019.

4. On December 7, 2019, you were assigned and worked from 7:00 a.m. to 11:00 p.m. (Your Shift) at Royal.

5. During Your Shift you were responsible for the care of Patient A, a [redacted] year old [redacted] speaking male who, among other diagnoses, suffered from [redacted]

6. On December 7, 2019, Patient A had the following physician's order:

   a. "Oxycodone – Schedule II [a Controlled Substance]
   Tablet; 5mg;
   Amount to Administer: 5mg; oral;"

   b. "Every 6 hours – PRN;" and,

   c. "Administer 5 mg/1 tab every 6 hours as needed for moderate to severe pain."

7. On December 7, 2019, you documented the Patient A's pain as zero at 2:00 p.m. and 7:00 p.m.

8. On December 7, 2019, you documented removing three (3) tablets of Oxycodone 5 mg for Patient A at the following times: one at "8A," one at "2P," and one at "8P."

9. On December 7, 2019, you did not document administering any Oxycodone to Patient A in Patient A's Medication Administration Record (MAR).

10. You participated in telephonic interviews with a Board Investigator on June 30, 2020, and August 12, 2020 and during those interviews you made the following statements:

    a. When asked why you did not document the administration of the Oxycodone in Patient A's MAR, you replied: "he got the Oxycodone. You can't take it out without putting it in the MAR;" and "you have a lot of patients and I'm doing things fast. Sometimes something else might occur and you don't get back."

11. On December 7, 2019, at 10:33 p.m. you entered the following in the Resident Progress Notes for Patient A:

a. "A/O, vs 110/70 64,92%ra, 18 bs 151, pt scream and yelling x 1 redirection provided. Poor po intake, house supplements and Po fluids provided by staff with help of [redacted] speaking staff. (sic) hourly rounds maintained for comfort and safety."

12. On December 7, 2019, at 11:14 p.m. you edited the Progress Notes for Patient A citing "more data available" as the reason by adding the following to the Progress Note: "message left for Physician regarding Pt intake."

13. You wrote a statement as part of the facility investigation, dated "12/7/2019," where your stated, among other things, the following:

    a. "I reported my concern to Pt. Daughter, HCP" [that Patient A was not eating the facility's food]; and,

    b. I made several phone calls and left several messages to MD regarding Pt. poor intake."

14. During Your Shift you did not document contacting Patient A's Health Care Proxy (HCP) in Patient A's Resident Progress Notes.

15. During Your Shift you documented only one call to Patient A's doctor, but you did not document making "several calls" and leaving "several messages" for Patient A's doctor as you wrote on your written statement to the facility dated "12/7/2019."

16. During Your Shift Certified Nursing Assistant (CNA) Tatsiana Bazyleva informed you that Patient A was having difficulty breathing, and in response you checked Patient A, and informed CNA Bazyleva words to the effect that it was because "you gave him medicine."

17. You did not document Patient A's difficulty breathing in Patient A's Resident Progress Notes.

18. You did not inform Resident A's doctor of his difficulty breathing.

19. You did not inform Resident A's HCP of his difficulty breathing.

20. During the interviews with the Board Investigator referenced in paragraph 10, the Investigator inquired of your knowledge of Patient A's difficulty breathing, and you replied words to the effect that:

    a. "It was untrue that Patient A had any difficulty breathing during Your Shift;"

    b. "The doctor and family were aware that Patient A was not eating;" and

c. "Patient A's son or someone was there and nothing was wrong with him. He only wouldn't eat."

21. On December 13, 2019, you received a Royal Health Group Corrective Counseling which stated as reasons:

a. "On 12/7/19 you failed to notify Resident's Responsible Person of change in Resident's status;" and,

b. "on 12/07 you recorded a blood glucose level of 151 at 8:47 [p.m.] on 12/7. Assure prism has a test memory capacity with time and date stamp. The Blood Glucose level you recorded, not recorded on Assure prism as recorded memory."

22. As part of the Counseling identified in paragraph 21 you took an Assure Prism Multi Blood Glucose Monitoring System Self-Test.

Legal Basis for Discipline

A. Your conduct as alleged in Paragraphs 2 through 22 above, and any other evidence that may be adduced at hearing, warrants disciplinary action by the Board against your licenses to practice as an RN and LN 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 in Paragraphs 2 through 22 above, and any other evidence that may be adduced at hearing, warrants disciplinary action by the Board against your licenses to practice as an RN and LN pursuant to Board regulation 244 CMR 9.03 (5) for failure to engage in the practice of nursing in accordance with accepted standards of practice.

C. Your conduct as alleged in Paragraphs 2 through 22 above, and any other evidence that may be adduced at hearing, warrants disciplinary action by the Board against your licenses to practice as an RN and LN pursuant to Board regulation 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.

D. Your conduct as alleged in Paragraphs 2 through 22 above, and any other evidence that may be adduced at hearing, warrants disciplinary action by the Board against your licenses to practice as an RN and LN pursuant to Board regulation 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.

E. Your conduct as alleged in Paragraphs 2 through 22 above, and any other evidence that may be adduced at hearing, warrants disciplinary action by the Board against your licenses to practice as an RN and LN pursuant to Board regulation 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.

F. Your conduct as alleged in Paragraphs 2 through 22 above, and any other evidence that may be adduced at hearing, 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).

***

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.

Any and all hearings and/or proceedings associated with this complaint are open to the public unless otherwise ordered.

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.

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

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

Brad Tully
Prosecuting Counsel
Department of Public Health
Office of the General Counsel, 2th Floor
250 Washington Street
Boston, MA 02108

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) 519-7624 to schedule a time that is mutually convenient.

BOARD OF REGISTRATION IN NURSING,

By: _____

Brad Tully
Prosecuting Counsel
Department of Public Health

Date: April 8, 2022

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing Order to Show Cause was served upon the Respondent at her address of record with the Board as follows via First Class and Certified Mail No. (7019 0140 0000 7217 4627) to:

Chantel Perry
122 Wayside Inn Road
Marlborough, MA 01752

Via First Class and Certified Mail No (7019 0700 0000 3087 5609) to:

Chantale Perry
35 O'Donnell Ave.
Shrewsbury, MA 01545

Via First Class Mail to her attorney:

Andra Hutchins
Kerstein, Coren & Lichtenstein, LLP
60 Walnut Street
Wellesley, MA 02481

This 8th day of April, 2022

Brad Tully
Prosecuting Counsel