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

MARY A. BECKMAN
Acting Secretary

MARGRET R. COOKE
Commissioner

Tel: 617-624-6000
www.mass.gov/dph

January .. , 2023

VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED NO. **7020 0090 0000 1273 1929**

Mary E. Skala
61 Meadow Road
East Longmeadow, MA 01028

RE: In the Matter of Mary E. Skala, Docket No. NUR-2019-0269
License No. RN2332l3l

Dear Ms. Skala:

Please find enclosed the **Final Decision and Order** issued by the Board of Registration in Nursing on January 23, 2023, and effective February 6, 2023. This constitutes full and final disposition of the above-referenced complaint, as well as the final agency action of the Board. Your appeal rights are noted on page 8.

Please note that as of the effective date, your license status will change to PROBATION. It will remain in probationary status until the Board notifies you of a change in license status in accordance with the terms of the order.

Please direct all questions, correspondence and documentation relating to probation requirements to the attention of Karen Fishman, Probation Monitor, at the address above. You may also contact Ms. Fishman at (617) 973 – 0951.

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

Sincerely

Heather Cambra BSN, RN, JD on behalf of:

Claire MacDonald, DNP, RN
Executive Director, Board of Registration in Nursing

Encl.

cc: Julie Brady, Esq., Prosecuting Counsel
Karen Gray Carruthers, Esq. Administrative Magistrate
K. Fishman, Probation Coordinator

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION
IN NURSING

In the Matter of
Mary E. Skala
RN License No. 2332131
License Expires 1/19/2024

Docket No. NUR-2019-0269

FINAL DECISION AND ORDER

AFTER SANCTION HEARING AND REMAND

Procedural History

On May 19, 2020, the Board of Registration in Nursing ("the Board") issued an *Order to Show Cause ("OTSC")* to the Respondent, alleging that the Respondent failed to properly document her handling and wastes of controlled substances as well as other safety concerns.

The *OTSC* contains the following alleged grounds for discipline: (A) M.G.L. c. 112, § 61 (deceit, malpractice, gross misconduct in the practice of the profession, or for any offense against the 1aws of the Commonwealth relating thereto) (B) 244 CMR 9.03(5) (for failing to engage in nursing practice in accordance with accepted standards of practice); (C) 244 CMR 9.03(9) (for failing to be responsible and accountable for nursing judgments, actions, and competency; (D) 244 CMR 9.03(35) (for failing to maintain security of controlled substances under responsibility and control); (E) 244 CMR 9.03(38) (for administering any prescription drug or non-prescription drug to any person in the course of nursing practice other than as directed by an authorized prescriber); (F) 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 manner consistent with accepted standards of nursing practice); (G) 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); (H) 244 CMR 9.03(47)

(for engaging in behavior likely to adversely affect public health, safety or welfare); and (I) common law prohibition against engaging in conduct that undermines public confidence in the profession's integrity.

In addition to stating the allegations against Respondent, the *OTSC* notified Respondent that an *Answer to the OTSC* ("*Answer*") was to be submitted within 21 days of receipt of the *OTSC*.[1] The *OTSC* also notified Respondent of the right to request a hearing on the allegations,[2] and that any hearing request ("*Request for Hearing*") was to be submitted within 21 days of receipt of the *OTSC*.[3] 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 *OTSC* is **attached** to this *Final Decision and Order* and is incorporated herein by reference.

On December 7, 2020, Respondent who is pro se (without counsel) filed her *Answer to the OTSC*. On April 13, 2021, Respondent and Prosecuting Counsel jointly filed a "*Stipulation of Facts*" in which the parties agreed that "the Respondent, by her conduct, ... violated each of the laws, regulations, and case law grounds outlined in the *Order to Show Cause*."[4] Given that there are no genuine issues of fact, no adjudicatory hearing is necessary, and the Respondent requested a Hearing on Sanction only. The Board held a Hearing on Sanction on July 13, 2021, before Chief Administrative Magistrate Karen Gray Carruthers ("the Magistrate").[5] On September 21, 2021, the Magistrate submitted her *Tentative Decision After Sanction Hearing*, **attached** hereto and incorporated herein by reference. On February 9, 2022, the Board issued its *Final Decision and Order*, REMANDING the matter to the Magistrate "in order to allow Respondent [time] to provide detailed information about her medical condition from a qualified medical or psychological evaluator."

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[1] In accordance with 801 CMR 1.01(6)(d)(2).
[2] Pursuant to M.G.L. c. 112, § 61.
[3] Respondent was also notified that failure to timely submit a Request for Hearing would constitute a waiver of the right to a hearing.
[4] *See* Tentative Decision, page 6.
[5] Due to social distancing requirements imposed by the COVID pandemic, the hearing was held virtually.

Following the Board's February 9, 2022, *Final Decision and Order*, the Magistrate issued an *Order* on March 15, 2002, giving Respondent until June 1, 2022, "to provide the information sought by the remand. Respondent requested and was granted additional time to obtain an appointment with a provider and submit documentation for Board consideration. The parties jointly completed their submission on November 1, 2022."[6]

Respondent submitted a report of an assessment from Michael Sorrell, M.D. a physician licensed to practice in Massachusetts with a practice in Neurology in Springfield, Massachusetts. In his report, dated September 14, 2022, Dr. Sorrell notes that he examined Respondent, reviewed her medical history and opines that Respondent "has no functional limitations. She needs no other treatments. She is fully able to practice in a sale (sic) and competent manner." On November 22, 2022 Administrative Magistrate Carruthers issued her *Revised Tentative Decision After Sanction Hearing and Remand*. The Board ADOPTS the Magistrate's *Revised Tentative Decision After Sanction Hearing and Remand* as its Final Decision including all findings of fact and rulings of law. The *Revised Tentative Decision* is **attached** hereto and incorporated herein by reference. The Board voted to adopt the within *Decision* at its meeting held on January 11, 2023, by the following vote:

In favor: L. Kelly, DNP, RN, CNP; A. Alley, MSN, RN; K.A. Barnes, JD, RPh; K. Crowley, DNP, RN, CNP; M. Harty, LPN; J. Monagle PhD, RN; D. Nikitas, BSN, RN; V. Percy, MSN, RN; R. Reynolds PhD, RN, MSN; A. Sprague, BS, RN, ASN; L. Wu, MBA, RN. *Opposed*: None; *Abstained*: None; *Recused*: None; *Absent*: L. Keough, PhD, RN, CNP; C. Norris, LPN.

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

[6] See p. 8 of the *Revised Tentative Decision After Sanction Hearing and Remand*.

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). In the instant matter, the Respondent admits that she removed narcotic medications for patients and failed to administer said medications, failed to properly destroy said medications and failed to document appropriately her handling of the medication.

This Board has previously disciplined nurses for engaging in conduct similar to the Respondent. *See,* In the Matter of Dawn Leach, Docket No. NUR- 2019-0071 (Final Decision and Order, December, 2022, wherein the Board ordered Respondent's license be placed on Probation and that she complete specific continuing education because Respondent admitted that she failed to account for certain medications that she withdrew from the facility's medication supply, that she documented the administration of medications before actually removing them from the PYXIS system, and that she failed to write nursing notes on two or more patients in her care who received controlled substances). *See also,* In the Matter In the Matter of Patti Turner, Docket No. NUR-2015-001 (Final Decision & Order, September 25, 2020, wherein the Board ordered that Respondent's license be placed on Probation for six months because she stipulated that she failed to document required information in patients' medical records and that she documented inaccurate information in patients' medical records, in violation of 244 CMR 9.03(5), (15), (31), (38), (39), (44), and (47)). *See also,* In the Matter of John Handren, Docket No. NUR-2011-0265, (Final Decision & Order, July 11, 2014, wherein the Board ordered a Stayed Suspension and Probation for one year with remedial CEUs and monitored practice because Respondent's conduct violated 244 CMR 9.03 (5), (35), (39), (44), (46), and (47)).

Respondent acknowledges that her conduct regarding her handling, administration, and documentation of controlled substances does not meet nursing standards and violates multiple Board regulations and statutes. On the other hand, Respondent denies diversion of controlled substances and denies having a substance use disorder. Her employer (the Complainant) reports that there is no evidence of, or reason to believe that Respondent diverted controlled substances for her own use or another's use. Prosecuting Counsel does not argue that Respondent diverted

controlled substances [redacted]. [redacted] She submitted a recent physician's report that describes no medical condition that impairs her ability to practice nursing in a safe and competent manner.

ORDER

Based on its *Final Decision*, the Board orders that Respondent's license to practice as a Registered Nurse in Massachusetts ("RN"), RN License No. 2332131 be placed on PROBATION for no less than two (2) years (Probationary Period), commencing with the date on which the Board signs this Order (Effective Date). During the Probationary Period, the Respondent shall comply with all of the following requirements to the Board's satisfaction:

1. refrain from the practice of nursing in any of the following employment settings during the Probationary Period:
    i. Settings where structured, consistent on-site supervision is not in place including but not limited to, home care agencies or private home care.
    ii. Travel nurse agencies; or
    iii. Temporary staffing agencies.
2. Comply with all laws and regulations governing the practice of nursing, and not engage in any continued or further conduct such as that set forth in the Order to Show Cause.
3. Notify the Board in writing within ten (10) days of each change in her name and/or address.
4. Timely renew her license to practice nursing.
5. Respond to inquiries from Board staff in a timely manner.
6. Disclose the terms of this Order to the Program Administrator of any Nursing Education Program at which she is enrolled during the Probationary Period.
7. Maintain active employment (Active Practice Requirements) in a position that requires a nursing license, in a facility setting where the Respondent receives consistent, on-site

supervision by a qualified licensed nurse[7] for a minimum average of twenty (20) hours per week throughout the Probationary Period.

8. a qualified licensed nurse is defined as a nurse who 1) possesses a Massachusetts[8] nursing license in good standing or authority to practice under federal law, or both; 2) is employed in a supervisory role; 3) possesses a minimum of one year full-time experience in nursing, or its equivalent, within the last five years; 4) is educationally prepared at or above the level of the Respondent; and 5) has no open complaints with the Board and no open criminal matters.

9. Review this Order with each of her nursing supervisors, and arrange for each nursing supervisor to submit directly to the Board:

    a. a completed and signed "Supervisor Verification Form" (Form 1**)**, provided with this Order, within thirty (30) days of

        (1) the Effective Date *and*

        (2) any subsequent employment commenced during the Probationary Period

    b. *quarterly* written reports[9], using the "Supervision Report Form" (Form 2) provided with this Order attesting to the quality of the Respondent's nursing practice, reliability and attendance and specifically addressing Respondent's documentation practice including any errors and incidents. The Board may take action in the event that any quarterly report reveals a practice issue the Board deems significant.

10. Within 30 days of the Effective Date, notify the Board in writing if the Respondent is not employed in accordance with paragraph f.

11. Complete the Active Practice Requirements within a period up to a maximum of double the length of the Probationary Period.[10]

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[7] The Licensee must receive direct supervision from a qualified licensed nurse who is employed in a supervisory role and is physically located at all times in each facility in which the Licensee practices nursing.
[8] Or a license to practice in the jurisdiction in which the Licensee is employed.
[9] The Licensee is responsible for ensuring that these reports on the required form are received by the Board commencing ninety (90) days after the Effective Date and on the first day of every third month thereafter.
[10] The Probationary Period is defined in Paragraph 1.

12. Notify the Board in writing within seven (7) days of any change in the Respondent's employment status, including each change in Employer, each resignation or termination, and the name, address, and telephone number of each new Employer.
13. Notify the Board in writing within seven (7) days of any complaint filed against her nursing license in any jurisdiction in which she holds such a license.
14. Submit documentation that she has successfully completed the following continuing education[11] within sixty (60) days after the Effective Date:

    i. Six (6) contact hours of continuing education on Medication Administration Standards in Nursing,
    ii. Six (6) contact hours on Documentation Standards in Nursing,
    iii. Three (3) contact hours on Critical Thinking and Clinical Judgment in Nursing, and
    iv. (3) contact hours on Pain Management Standards of Nursing Practice.

The Board voted to adopt the within Final Order at its meeting held on January 11, 2023, by the following vote:

In favor: L. Kelly, DNP, RN, CNP; A. Alley, MSN, RN; K.A. Barnes, JD, RPh; K. Crowley, DNP, RN, CNP; M. Harty, LPN; J. Monagle PhD, RN; D. Nikitas, BSN, RN; V. Percy, MSN, RN; R. Reynolds PhD, RN, MSN; A. Sprague, BS, RN, ASN; L. Wu, MBA, RN. *Opposed*: None; *Abstained*: None; *Recused*: None; *Absent*: L. Keough, PhD, RN, CNP; C. Norris, LPN.

EFFECTIVE DATE OF ORDER

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

[11] These continuing education courses must be *in addition to* any contact hours required for license renewal. They may be taken as home study or as correspondence course, *provided that* they meet the requirements of Board Regulations at 244 CMR 5.00, Continuing Education.

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,

Patricia McNamee

Claire L. MacDonald DNP, RN
Executive Director
Board of Registration in Nursing

Date Issued: January 23, 2023

Notified:

By first-class and certified mail no.
Return Receipt Requested
Mary Skala
[redacted] Meadow Road
East Longmeadow MA 01028

By interoffice mail
Julie Brady, Esq.
Prosecuting Counsel
Department of Public Health
250 Washington Street
Boston, MA 02108

By interoffice mail
Karen Gray Carruthers, Esq.
Administrative Magistrate
Department of Public Health
250 Washington Street
Boston, MA 02108

Commonwealth of Massachusetts
Department of Public Health
Bureau of Health Professions Licensure
Board of Registration in Nursing
239 Causeway Street • Boston, Massachusetts 02114

SUPERVISOR VERIFICATION, AND AGREEMENT TO MONITOR PRACTICE AND PROVIDE PERIODIC REPORTS TO THE BOARD OF REGISTRATION IN NURSING

Name of Nurse on Probation __**Mary Skala**_____

License Type and No. _____Docket No(s). _____

Effective Date of the Probation Agreement or Order: _____

Length of Probation (specified in Agreement or Order): _____

Nurse's Date of Employment: _____Nurse's Job Title:_____

Employer Name and Address: _____

_____

I, _____ (print supervisor's full name) on _____(insert date) reviewed a signed copy of the Probation Agreement (Agreement) or Order between _____ (insert nurse's name) and the Board of Registration in Nursing (Board). I hereby agree that I will monitor and evaluate this nurse's practice as specified in the Agreement or Order, and will provide written reports to the Board on the Supervision Report form provided by the Board at the intervals required by the Agreement or Order.

I also agree to promptly notify the Board's Probation Compliance Officer if the nurse resigns or is terminated from employment.

I further certify that I am a RN / LPN (circle one), have completed at least one (1) year of clinical nursing practice, and that I do not have any open administrative or criminal complaint by any Board of Nursing.

SUPERVISOR'S SIGNATURE_____Date:_____

_____
(Print/Type: Name and Title of Supervisor completing this form)

Supervisor's License Type and No.:_____ Supervisor Phone No.:_____

PLEASE NOTE CAREFULLY: **This completed form must be mailed *with* the supervisor's signed cover letter written on the facility's letterhead directly to: Probation Compliance Officer**
DPH – BHPL, Board of Registration in Nursing
239 Causeway Street, 5th Floor

FORM 1- Manual Version
Final 6/14/07
Revised 8/14/017, 05/09/18
Corrected 9/5/2019

Commonwealth of Massachusetts
Department of Public Health
Bureau of Health Professions Licensure
Board of Registration in Nursing
239 Causeway Street • Boston, Massachusetts 02114

SUPERVISION REPORT FOR NURSES ON PROBATION WITH THE BOARD OF REGISTRATION IN NURSING

(Please review the nurse's Probation Agreement or Order and complete this evaluation of the nurse's practice)

Nurse's Name: _**Mary Skala**_____ Docket No.: _____

License Type and No.: _____Expiration Date_____

Nurse's Job Title: _____

Employer Name and Address: _____

Time period covered by this supervision report: Start Date: _____ to End Date: _____

Rate the following and explain any "Does Not Meet" ratings (use the "Comments" column and if needed the back of this form or include on supervisor's signed cover letter on facility letterhead).

Quality being rated	Does Not Meet	Meets	Comments
Organizes and plans work effectively	☐	☐	
Completes assignments	☐	☐	
Works as a team member	☐	☐	
Communicates effectively	☐	☐	
Seeks guidance and supervision appropriately	☐	☐	
Interacts with patients in a therapeutic manner	☐	☐	
Demonstrates problem solving ability	☐	☐	
Manages stressful situations appropriately	☐	☐	
Makes timely and appropriate nursing assessments	☐	☐	
Makes appropriate nursing interventions	☐	☐	
Delegates nursing care activities appropriately	☐	☐	
Removes, handles, wastes, and accounts for the whereabouts of, medications appropriately	☐	☐	
Documents controlled substances and medication administrations accurately and completely	☐	☐	
Documents nursing care and interventions accurately and completely	☐	☐	
Other practice skill(s) specified by Probation Agreement or Order	☐	☐	

SUPERVISION REPORT FOR NURSES ON PROBATION WITH THE BOARD OF REGISTRATION IN NURSING (continued)

The nurse HAS ☐ HAS NOT ☐ (**please choose one and do not leave any blanks**) worked an average of at least twenty (20) hours per week during the time period covered by this report.

SUPERVISION

How frequently is the nurse supervised?_____

How is supervision provided?_____

Have there been any incidents involving the nurse requiring counseling, conference, oral/written warnings since last report? If yes, please explain and attach copies of all relevant documents.

_____

_____

How often are the nurse's patient records reviewed?_____

Does this nurse have any other nursing practice issues? Explain._____

_____

ADDITIONAL COMMENTS are appreciated

(If needed, please use the back of this form or include on supervisor's signed cover letter on facility letterhead)

****

Please call the Probation Compliance Officer at (617) 973-0863 to discuss any concerns or for clarification regarding the nurse's probation.

SUPERVISOR'S SIGNATURE: _____DATE SIGNED_____

_____

(Print/Type: Name and Title of Supervisor completing this form)

Supervisor's License Type and No.:_____ Supervisor Phone No.:_____

PLEASE NOTE CAREFULLY:

This fully completed form must be mailed *with* the supervisor's signed cover letter written on the facility's letterhead directly to: Probation Compliance Officer

DPH – DBPL, Board of Registration in Nursing
239 Causeway Street, 5th Floor
Boston, MA 02114

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

CHARLES D. BAKER
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MARYLOU SUDDERS
Secretary

MARGRET R. COOKE
Commissioner

Tel: 617-624-6000
www.mass.gov/dph

February 15, 2022

VIA FIRST CLASS & CERTIFIED MAIL NO. 7021 1970 0001 5718 8124, RETURN RECEIPT REQUESTED
Mary E. Skala
61 Meadow Road
East Longmeadow, MA 01028

RE: In the Matter of Mary E. Skala, Docket No. NUR-2019-0269
License No. RN2332131

Dear Ms. Skala:

Please find enclosed the Final Decision and Order After Sanction Hearing issued by the Board of Registration in Nursing on February 15, 2022.

The Board remands the matter to the Magistrate to make further findings.

Sincerely,

Patricia McNamee on behalf of:
Claire L. MacDonald, DNP, RN
Acting Executive Director,
Board of Registration in Nursing

Encl.

cc: Eugene Langner, Esq., Prosecuting Counsel
Karen Gray Carruthers, Esq., Acting Chief Administrative Magistrate

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION
IN NURSING

In the Matter of
Mary E. Skala
RN License No. 2332131
License Expires 1/19/2024

Docket No. NUR- 2019-0269

FINAL DECISION AND ORDER

AFTER SANCTION HEARING

Procedural History

On May 19, 2020, the Board of Registration in Nursing ("the Board") issued an Order to Show Cause ("OTSC") to the Respondent, alleging that the Respondent failed to properly document her handling and wastes of controlled substances as well as other safety concerns.

The OTSC contains the following alleged grounds for discipline: (A) M.G.L. c. 112, § 61 (deceit, malpractice, gross misconduct in the practice of the profession, or for any offense against the laws of the Commonwealth relating thereto) (B) 244 CMR 9.03(5) (failing to engage in nursing practice in accordance with accepted standards of practice); (C) 244 CMR 9.03(9)(for failing to be responsible and accountable for nursing judgments, actions, and competency; (D) 244 CMR 9.03(35) (failing to maintain security of controlled substances under responsibility and control); (E) 244 CMR 9.03(38) (administering any prescription drug or non-prescription drug to any person in the course of nursing practice other than as directed by an authorized prescriber); (F) 244 CMR 9.03(39) (failing to document the handling, administration, and destruction of controlled substances in accordance with all federal and state laws and regulations and in manner consistent with accepted standards of nursing practice); (G) 244 CMR 9.03(44) (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); (H) 244 CMR 9.03(47) (engaging in

behavior likely to adversely affect public health, safety or welfare); and (l) common law prohibition against engaging in conduct that undermines public confidence in the profession's integrity.

In addition to stating the allegations against Respondent, the OTSC notified Respondent that an Answer to the OTSC ("Answer") was to be submitted within 21 days of receipt of the OTSC.[1] The OTSC also notified Respondent of the right to request a hearing on the allegations,[2] and that any hearing request ("Request for Hearing") was to be submitted within 21 days of receipt of the OTSC.[3] 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 OTSC is **attached** to this Final Decision and Order and is incorporated herein by reference.

On December 7, 2020, Respondent who is pro se (without counsel) filed her Answer to the OTSC. On April 13, 2021, Respondent and Prosecuting Counsel jointly filed a "Stipulation of Facts" in which the parties agreed that "the Respondent, by her conduct, ... violated each of the laws, regulations, and case law grounds outlined in the Order to Show Cause."[4] Given that there are no genuine issues of fact, no adjudicatory hearing is necessary, and the Respondent requested a Hearing on Sanction only. The Board held a Hearing on Sanction on July 13, 2021, before Acting Chief Administrative Magistrate Karen Gray Carruthers ("the Magistrate").[5] On September 21, 2021, the Magistrate submitted her Tentative Decision After Sanction Hearing, **attached** hereto and incorporated herein by reference.

DISCUSSION

[1] In accordance with 801 CMR 1.01(6)(d)(2).
[2] Pursuant to M.G.L. c. 112, § 61.
[3] Respondent was also notified that failure to timely submit a Request for Hearing would constitute a waiver of the right to a hearing.
[4] *See* Tentative Decision, page 6.
[5] Due to social distancing requirements imposed by the COVID pandemic, the hearing was held virtually.

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). In the instant matter, the Respondent admits that she removed narcotic medications for patients and failed to administer said medications, failed to properly destroy said medications and failed to document appropriately her handling of the medication.

This Board has previously suspended nurses for engaging in conduct similar to that of the Respondent. Registered Nurses constantly handle and administer controlled substances to the patients with whose care they are entrusted. For a multitude of reasons, the safety and well-being of such patients is at risk when a nurse's capacity to properly handle and administer controlled substances may be compromised by the illicit use of drugs or a medical condition. It is imperative that patients and their families feel assured that they can trust and rely upon the nurses who provide their care to do so responsibly, safely, and competently. *See* In the Matter of Roberta Bolduc, RN-04-284 (December 2006).

Respondent acknowledges that her conduct regarding her handling, administration, and documentation of controlled substances does not meet nursing standards and violates multiple Board regulations and statutes. On the other hand, Respondent denies diversion of controlled substances and denies having a substance use disorder. Her employer (the Complainant) reports that there is no evidence of, or reason to believe that Respondent diverted controlled substances for her own use or another's use. The Petitioner does not argue that Respondent diverted controlled substances [redacted]

[redacted] Therefore, the Board REMANDS this matter back to the Administrative Magistrate in order to allow Respondent to provide detailed information about [redacted]

The Board voted to adopt the within Decision and Order at its meeting held on February 9, 2022, by the following vote:

In favor: A. Alley, RN; K.A. Barnes, JD, RPh; K. Crowley, DNP; D. Drew, MBA; J. Kaneb, MBA; L. Kelly, DNP; L. Keough, CNP; C. LaBelle, RN; D. Nikitas, RN; V. Percy, MSN; E. Pusey-Reid, DNP; A. Sprague, RN; L. Wu, RN. *Opposed*: None; *Abstained*: None; *Recused*: None.

EFFECTIVE DATE OF ORDER

This Final Decision and Order becomes effective upon the tenth (10th) 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,

Patricia McNamee on behalf of

Claire L. MacDonald DNP, RN
Acting Executive Director
Board of Registration in Nursing

Date Issued: February 15, 2022

Notified:

By first-class and certified mail no. 7021 1970 0001 5718 8124, Return Receipt Requested
Mary E. Skala
61 Meadow Road
East Longmeadow MA 01028

By interoffice mail
Eugene Langner, Esq.
Prosecuting Counsel
Department of Public Health
250 Washington Street
Boston, MA 02108

By interoffice mail
Karen Gray Carruthers, Esq.
Acting Chief Administrative Magistrate
Department of Public Health
250 Washington Street *2nd Floor*
Boston, MA 02108

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

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

Tel: 617-624-6000
www.mass.gov/dph

May 19, 2020

By First Class and Certified Mail
No. 7019 0700 0000 3091 1215

Mary Emily Skala
61 Meadow Road
East Longmeadow, MA 01028

RE: In the Matter of Mary Emily Skala, RN License No. 2332131
Board of Registration in Nursing, Docket No. NUR-2019-0269

Dear Ms. Skala:

For the reasons set forth in the attached Order to Show Cause, the Massachusetts Board of Registration in Nursing (Board) within the Department of Public Health, Bureau of Health Professions Licensure (Bureau) is proposing to suspend, revoke or impose other discipline against your license to practice as a Registered Nurse (License # 2332131), relative to the above-listed complaint against your license. The Order to Show Cause and any subsequent hearing are governed by Massachusetts General Laws Chapter 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 matter. 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 nursing in the Commonwealth of Massachusetts, including any right to renew your license.

The request for a hearing and your Answer 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
250 Washington Street, 2nd Floor
Boston, Massachusetts 02108

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

You may contact me at (617) 624-5263 if you have any questions regarding this matter.

Sincerely,

Eugene Langner
Prosecuting Counsel

EL
Encl:
Order to Show Cause
Certificate of Service

cc: Irene Chu, Admin. Assistant

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. ΠΑΡΑΚΑΛΩ ΜΕΤΑΦΡΑΣΤΕ
Questo è un 'avviso importante. Si pregadi farlo tradurre.

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION IN NURSING

Board of Registration in Nursing,
Petitioner,

v.

Mary Emily Skala,
RN License No. RN2332131
License Expires 1/19/22,
Respondent

Docket No. NUR-2019-0269

ORDER TO SHOW CAUSE

Mary Emily Skala, 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) in the Commonwealth of Massachusetts, License No. 2332131, or your right to renew such license, pursuant to Massachusetts General Laws (G. L.) Chapter 112, § 61 and Code of Massachusetts regulations 244 CMR 7.04, based upon the following facts and allegations.

Factual Allegations

1. On or about April 9, 2019, the Board issued a license to you to engage in the practice of nursing, License No. 2332131. Your license is current, and expires on January 19, 2022.

2. Between or about August and September of 2019, while you were employed as an RN at Baystate Medical Center in Springfield, Massachusetts (Baystate), 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 or about August 3, 2019, you removed the following doses of medication for a Baystate patient (Patient 1):

   a. A 2 mg/mL injection of morphine, a Schedule II Controlled Substance, at 9:36 a.m.;

b. A 2 mg/mL injection of lorazepam, a Schedule IV Controlled Substance, at 9:37 a.m.; and
c. A 2 mg/mL injection of morphine at 10:05 a.m.

4. On or about August 3, 2019, Patient 1 had physician's orders for the administration of the following:

a. 2 mg injection of morphine every thirty (30) minutes as needed (PRN) for pain, severe dyspnea and comfort; and
b. 0.5 mg injection of lorazepam every thirty (30) minutes PRN for anxiety.

5. On or about August 3, 2019, you documented administering the following doses of medication to Patient 1:

a. 2 mg of morphine at 9:38 a.m.; and
b. 0.5 mg of lorazepam at 9:38 a.m.

6. At or about 1:53 p.m. on or about August 3, 2019, you documented wasting 1.5 mg of the dose of lorazepam that you had removed for Patient 1 as described in Paragraph 3(b) above.

7. You failed to document the administration, wasting or other disposition of the dose of morphine described in Paragraph 3(c) above.

Patient 2

8. At or about 7:54 a.m. on or about August 7, 2019, you removed three (3) 30 mg tablets of phenobarbital, a Schedule IV Controlled Substance, for a Baystate patient (Patient 2).

9. On or about August 7, 2019, Patient 2 had a physician's order for the administration of 75 mg of phenobarbital two (2) times a day.

10. At or about 7:57 a.m. on or about August 7, 2019, you documented administering 75 mg of phenobarbital to Patient 2.

11. You failed to document the administration, wasting or other disposition of the remaining 15 mg of phenobarbital described in Paragraph 8 above after the administration described in the immediately preceding paragraph.

Patient 3

12. On or about August 18, 2019, you removed the following medication for a Baystate patient (Patient 3):

a. A 2 mg injection of morphine at 9:33 a.m.;

b. A 1 mg tablet of lorazepam at 1:53 p.m.;
c. A 2 mg injection of morphine at 1:53 p.m.;
d. A 2 mg injection of morphine at 5:22 p.m.; and
e. A 2 mg injection of lorazepam at 5:23 p.m.

13. At or about 9:32 a.m. on or about August 18, 2019, you cancelled the removal of a 1 mg tablet of lorazepam for Patient 3.

14. On or about August 18, 2019, Patient 3 had physician's orders for the administration of the following:

a. 1 mg injection of lorazepam every two (2) hours PRN for anxiety/agitation; and
b. 1 mg injection of morphine every two (2) hours PRN for severe pain, dyspnea, and comfort.

15. On or about August 18, 2019, you documented administering the following doses of medication to Patient 3:

a. A 1 mg injection of morphine at 9:35 a.m.;
b. A 1 mg injection of morphine at 1:55 p.m.;
c. A 1 mg injection of morphine at 5:31 p.m.; and
d. A 1 mg injection of lorazepam at 5:31 p.m.

16. On or about August 18, 2019, you documented wasting the following quantities of medication you had removed for Patient 3:

a. A 2 mg injection of lorazepam at 5:26 p.m.;
b. Two (2) 2 mg injections of morphine at 5:27 p.m.; and
c. A 2 mg injection of morphine at 5:28 p.m.

17. You failed to document the administration, wasting or other disposition of the dose of lorazepam described in Paragraph 12(b) above.

Patient 4

18. On or about August 27, 2019, you removed the following 5 mL doses of 2 mg/1 mL oral solution of morphine for a Baystate patient (Patient 4):

a. Two (2) doses at 8:14 a.m.;
b. Two (2) doses at 10:54 a.m.; and
c. Two (2) doses at 2:05 p.m.

19. On or about August 27, 2019, Patient 4 had a physician's order for the administration of 2-4 mg of morphine every three (3) hours PRN for severe pain.

20. On or about August 27, 2019, you documented administering the following doses of morphine oral solution to Patient 4:

    a. 2 mg at 8:16 a.m.; and
    b. 4 mg at 10:56 a.m.

21. You failed to document the administration, wasting or other disposition of the one (1) of the two (2) doses of morphine oral solution you had removed for Patient 4 as described in Paragraph 18(a) above.

22. You failed to document the administration, wasting or other disposition of either of the two (2) doses of morphine oral solution you had removed for Patient 4 as described in Paragraph 18(c) above.

Patient 5

23. At or about 6:51 p.m. on or about August 27, 2019, you removed a 2 mg dose of morphine for a Baystate patient (Patient 5).

24. On or about August 27, 2019, Patient 5 had a physician's order for the administration of 2 mg of morphine every thirty (30) minutes PRN for severe pain, dyspnea and comfort.

25. You failed to document the administration, wasting or other disposition of any of the dose of morphine described in Paragraph 23 above.

Patient 6

26. At or about 8:13 a.m. on or about August 31, 2019, you withdrew a 5 mL dose of 2 mg/1 mL oral solution of morphine for a Baystate patient (Patient 6).

27. At or about 8:30 a.m. on or about September 1, 2019, you withdrew a 5 mL dose of 2 mg/1 mL oral solution of morphine for Patient 6.

28. On or about August 31 and September 1, 2019, Patient 6 had a physician's order for the administration of 1 mg of morphine every four (4) hours PRN for severe pain, dyspnea and comfort.

29. You failed to document the administration, wasting or other disposition of any of either of the doses of morphine described in Paragraphs 26 and 27 above.

Patient 7

30. At or about 1:21 p.m. on or about September 5, 2019, you removed a 5 mg tablet of oxycodone, a Schedule II Controlled Substance, for a Baystate patient (Patient 7).

31. On or about September 5, 2019, Patient 7 had a physician's order for the administration of 2.5 mg of oxycodone every six (6) hours PRN for moderate pain.

32. At or about 1:24 p.m. on or about September 5, 2019, you documented administering 2.5 mg of oxycodone to Patient 7.

33. You failed to document the administration, wasting or other disposition of the remaining 2.5 mg of the dose of oxycodone described in Paragraph 30 after the administration described in the immediately preceding paragraph.

Patient 8

34. On or about September 9, 2019, you removed the following medications for a Baystate patient (Patient 8):

    a. A 2 mg injection of morphine at 10:13 a.m.;
    b. Two (2) 2 mg injections of lorazepam at 10:14 a.m.;
    c. A 2 mg injection of morphine at 2:33 p.m.; and
    d. A 2 mg injection of morphine at 6:33 p.m.

35. On or about September 9, 2019, Patient 8 had physician's orders for the administration of the following:

    a. 1 mg injection of lorazepam every three (3) hours PRN for anxiety; and
    b. 2 mg injection of morphine every four (4) hours PRN for mild pain

36. On or about September 9, 2019, you documented administering the following doses of medication to Patient 8:

    a. 1 mg of lorazepam at 10:16 a.m.;
    b. 2 mg of morphine at 10:17 a.m.;
    c. 2 mg of morphine at 2:35 p.m.; and
    d. 2 mg of morphine at 5:15 p.m.

37. You failed to document the administration, wasting or other disposition of 3 mg of the lorazepam described in Paragraph 34(b) above after the administrations described in the immediately preceding paragraph.

Patient 9

38. On or about September 9, 2019, you removed the following medications for a Baystate patient (Patient 9):

    a. A 0.5 mg tablet of lorazepam at 8:20 a.m.;

b. A 15 mg tablet of morphine at 8:20 a.m.;
c. A 0.5 mg tablet of lorazepam and 10:09 a.m.; and
d. A 15 mg tablet of morphine at 10:10 a.m.

39. On or about September 9, 2019, Patient 9 had physician's orders for the administration of the following:

a. 0.5 mg tablet of lorazepam four (4) times a day PRN for anxiety/agitation; and
b. 15 mg tablet of morphine every four (4) hours PRN for moderate pain.

40. On or about September 9, 2019, you documented administering the following medications to Patient 9:

a. 0.5 mg of lorazepam at 1:23 p.m.; and
b. 15 mg of morphine at 1:23 p.m.

41. You failed to document the administration, wasting or other disposition of the any of either of the doses described in Paragraph 38(a) and (b) above after the administrations described in the immediately preceding paragraph.

Patient 10

42. At or about 8:10 a.m. on or about September 24, 2019, you removed two (2) 15 mg tablets of morphine for a Baystate patient (Patient 10).

43. On or about September 24, 2019, Patient 10 had a physician's order for the administration of one (1) 7.5 mg tablet of morphine daily in the morning.

44. At or about 8:15 a.m. on or about September 24, 2019, you documented administering 7.5 mg of morphine to Patient 10.

45. You failed to document the administration, wasting or other disposition of the remainder of the doses described in Paragraph 42 above after the administrations described in the immediately preceding paragraph.

Legal Basis for Discipline[1]

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

C. Your conduct as alleged above, and any other evidence that may be adduced at hearing, warrant disciplinary action by the Board against your license to practice as an RN pursuant to Board regulation 244 CMR 9.03(9) for failing to be responsible and accountable for your nursing judgments, actions, and competency.

D. Your conduct as alleged above, and any other evidence that may be adduced at hearing, warrant disciplinary action by the Board against your license to practice as an RN pursuant to Board regulation 244 CMR 9.03(35) for failing to maintain the security of controlled substances that were under your responsibility and control.

E. Your conduct as alleged above, and any other evidence that may be adduced at hearing, warrant disciplinary action by the Board against your license to practice as an RN pursuant to Board regulation 244 CMR 9.03(38) for administering any prescription drug or non-prescription drug to any person in the course of nursing practice other than as directed by an authorized prescriber.

F. Your conduct as alleged above, and any other evidence that may be adduced at hearing, warrant disciplinary action by the Board against your license to practice as an RN pursuant to Board regulation 244 CMR 9.03(39) for failing to document the handling, administration, and destruction of controlled substances in

[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," and does not require Prosecuting Counsel to provide a detailed description of evidence he intends 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 is offered as suggestions, and not as an exhaustive characterization of the evidence to be adduced at a hearing.

accordance with all federal and state laws and regulations and in a manner consistent with accepted standards of nursing practice.

G. Your conduct as alleged above, and any other evidence that may be adduced at hearing, warrant disciplinary action by the Board against your license to practice as an RN 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.

H. Your conduct as alleged above, and any other evidence that may be adduced at hearing, warrant disciplinary action by the Board against your license to practice as an RN 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.

I. Your conduct as alleged above, and any other evidence that may be adduced at hearing, also constitute 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 acts to suspend, revoke, or impose other discipline. 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 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. 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 imposed fines.

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 impose fines, 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 the Prosecuting Counsel, at the following address:

Eugene Langner, Esq.
Prosecuting Counsel
Department of Public Health
Office of the General Counsel
250 Washington Street, 2nd floor
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) 524-5263 to schedule a time that is mutually convenient.

Board of Registration in Nursing,
Lorena Silva
Executive Director

By: _____
Eugene Langnier, Esq.
Prosecuting Counsel
Department of Public Health

Date: September 2, 2020

CERTIFICATE OF SERVICE

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

Mary Emily Skala
61 Meadow Road
East Longmeadow, MA 01028

by first class mail, postage prepaid, and by Certified Mail No. 7019 0700 0000 3091 1215

This 29 day of September, 2020.

Eugene Langner
Prosecuting Counsel

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

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

Tel: 617-624-6000
www.mass.gov/dph

May 3, 2021

Jason B. Barshak, Esq.
Chief Administrative Magistrate
Department of Public Health
Office of the General Counsel
250 Washington Street, 2nd Floor
Boston, MA 02108

RE: In the Matter of Mary Emily Skala, RN License No. 2332131
Board of Registration in Nursing, Docket No. NUR-2019-0269

Dear Chief Administrative Magistrate Barshak:

Pursuant to your email of April 30, 2021, enclosed please find a copy of the Order to Show Cause in the above-referenced matter.

Sincerely,

Eugene Langner

Eugene Langner
Prosecuting Counsel

EL

Enclosure

cc: Mary Emily Skala, RN