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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July 14, 2023

Via First Class & Certified Mail No. 7022 2410 0001 6855 4825,
Return Receipt Requested
William D. Saltzman, Esq.
Koufman Law Group, LLC
145 Tremont Street, 4th Floor
Boston, MA 02111

RE: In the Matter of Therese Molloy, Docket No. NUR-2019-0133
License No. RN257345 & LN58831

Dear Counsel:

Please find enclosed the **Final Decision and Order issued by the Board of Registration in Nursing on July 14, 2023.** 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 2.**

You may contact Heather Engman, Esq., Chief Board Counsel at heather.engman@mass.gov with any questions that you may have concerning this matter.

Sincerely,

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

Encl.

cc: Noah Ertel, Esq., Prosecuting Counsel
Jaclyn Gagne, Esq. Chief Administrative Magistrate

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION
IN NURSING

In the Matter of
Respondent Therese Molloy
RN257345
LN58831

Docket No. NUR-2019-0133

FINAL DECISION AND ORDER

Procedural History

On November 24, 2020, the Board of Registration in Nursing ("the Board") issued an *Order to Show Cause* ("OTSC"). On March 29, 2022, the Board issued a Ruling on Motion for Summary Decision. A sanction hearing was held on June 16, 2022.

On December 16, 2022, the Magistrate issued an *Amended Tentative Decision After Sanction Hearing Process ("Tentative Decision")*. The Board 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.

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 Board voted to adopt the within Final Decision at its meeting held on July 12, 2023, by the following vote:

In favor: Anthony Alley; Karen Crowley; Michelle Harty; Anthony B Joseph; Linda Kelly; Lori Keough; Marianne McAuliffe; Janet Monagle; Diane Nikitas; Carolyn Norris; Raquel Reynolds

Opposed: None

Abstained: None

Recused: None

Absent: Kelly Ann Barnes; Virginia Percy; Audra Sprague; Lisa Wu

ORDER

Based on its Final Decision, the Board imposes a **REPRIMAND** on Respondent's nursing licenses, RN257345 and LN58831. The Board notes the facts in this case are not disputed and that Respondent acknowledged the violation and engaged in remediation.

The Board voted to adopt the within Final Order at its meeting held on July 12, 2023, by the following vote:

In favor: Anthony Alley; Karen Crowley; Michelle Harty; Anthony B Joseph; Linda Kelly; Lori Keough; Marianne McAuliffe; Janet Monagle; Diane Nikitas; Carolyn Norris; Raquel Reynolds

Opposed: None

Abstained: None

Recused: None

Absent: Kelly Ann Barnes; Virginia Percy; Audra Sprague; Lisa 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,

Patricia McNamee

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

Date Issued: July 14, 2023

Notified:

By first-class and certified mail no. 7022 2410 0001 6855 4825, Return Receipt Requested
William D. Saltzman, Esq.
Koufman Law Group, LLC
145 Tremont Street, 4th Floor
Boston, MA 02111

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

By interoffice mail
Jaclyn Gange, Esq.
Administrative Magistrate
Department of Public Health
250 Washington Street
Boston, MA 02108

COMMONWEALTH OF MASSACHUSETTS

BOARD OF REGISTRATION IN NURSING

Board of Registration in Nursing v. Therese Molloy RN License No. 257345/exp. 7-16-22 LN License No. 58831/exp. 7-16-05	)	NUR-2019-0133

AMENDED TENTATIVE DECISION AFTER SANCTION HEARING PROCESS

The Order to Show Cause ("OTSC") in this matter was filed on November 24, 2020 [Document A][1] In her Answer, Respondent admitted to the following facts stated in the OTSC:

1. On or about August 7, 2003, the Board issued Respondent a license to engage in the practice of nursing as an RN, License No. 257345. This license expired on July 16, 2022.
2. On or about August 6, 1997, the Board issued Respondent a license to engage in the practice of nursing as an LPN, License No. 58831. This license expired on July16, 2005, and has not been renewed to date. ·
3. On or about May 3, 2019, Respondent was employed and on duty as an RN at Wareham Healthcare in Wareham, Massachusetts (Wareham).
4. On or about May 3, 2019, Respondent dispensed six (6) 25 mg tablets of trazodone, a non-scheduled controlled substance, for a Wareham patient (Patient 1).
5. On or about May 3, 2019, Patient 1 had a physician's order for the administration of 50 mg of trazodone at bedtime for insomnia.
6. Respondent did not document administering the trazodone referenced in Paragraph 4 above in Patient 1's medication administration record.
7. Respondent did not make any nurse's note in connection with the matters referenced in Paragraphs 4 through 6 above.

[1] The following referenced documents are attached to this decision in order to assist the Board.

A. BORN v. Therese Molloy, Docket No. NUR-2019-0133, Order to Show Cause dated November 24, 2020 (OTSC).

B. Board Ruling on Motion for Summary Decision in matter BORN v. Therese Molloy, Docket No. NUR-2019-0133, reissued March 29, 2022 due to grammatical errors in original.

C. Respondent's Memorandum on Disposition.

D. Respondent's Supplemental Memorandum on Disposition. [Information not in evidence redacted.]

E. Prosecution's Memorandum on Disposition.

F. Prosecution's Objections to Respondent's Supplemental Memorandum on Disposition. [Information not in evidence redacted.]

8. Respondent left the trazodone referenced in Paragraph 4 above unattended on Patient l's table.

The Prosecution's Motion for Summary Decision was granted by the Board of Registration in Nursing ("Board") through its Ruling on Motion for Summary Decision issued on March 29, 2022 ("Ruling"). [Document B] The Ruling held that Respondent's conduct warranted disciplinary action by the Board against Respondent's license to practice as an RN and as an LPN, including any right to renew Respondent's licenses pursuant to the following grounds for discipline as stated in the OTSC:

A. G.L. c. 112, § 61, for malpractice, gross misconduct in the practice of the profession, or of any offense against the laws of the Commonwealth relating thereto.

B. Board regulation 244 CMR 9.03(5) for failing to engage in the practice of nursing in accordance with accepted standards of practice.

C. Board regulation 244 CMR 9 .03(9) for failing to be responsible and accountable for your nursing judgments, actions, and competency.

D. Board regulation 244 CMR 9.03(10) for performing acts beyond the scope of nursing practice as defined in M.G.L. c. 112, § SOB and 244 CMR 3.00.

E. [Summary Decision Denied – Board regulation 244 CMR 9.03(35)]

F. 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.

G. 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. [Summary Decision Denied – Board regulation 244 CMR 9.03(47)

A. 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).

I presided over the Sanction Hearing in this matter on June 16, 2022. Prosecuting Counsel Eugene Langer and Respondent's Counsel William Saltzman were both present and presented argument.

Respondent presented two witnesses: (1) Respondent, and (2) nurse Karen Fierimonte. I reviewed and admitted the following three (3) documents as exhibits:

Exhibit 1: Resume of Therese Molloy, R.N.

Exhibit 2: Resume of Karen Fierimonte, R.N.

Exhibit 3: Continuing Education Certificates – Therese Molloy

Prosecuting Counsel presented no witnesses or exhibits.

By order dated June 17, 2022, I granted Respondent's motion allowing both parties to add documents, specifically board decisions, with up to two pages of explanation to their Memorandum on Disposition. Prosecuting Counsel did not elect to file additional documents. Respondent Counsel timely filed

additional documents with explanation in Respondent's Supplemental Memorandum on Disposition.[2] Through administrative error Respondent's Supplemental Memorandum on Disposition and the attached documents were not included in the original Tentative Decision issued in this matter on September 15, 2022. Respondent Counsel brought this error to my attention. The Tentative Decision was withdrawn and is hereby replaced with this Amended Tentative Decision which includes the addition of the following two documents offered by Respondent and entered into evidence over Prosecution's objections

Exhibit 4: BORN Consent Agreement for Reprimand, *Matter of Donna Guerra* (RN-07-04)

Exhibit 5: BORN Consent Agreement for Reprimand, *Matter of Stacy M. Shir*, R.N. (NUR 2012-0059)

Respondent's arguments in favor of Exhibits 4-5 and the Prosecution's objections are noted. Prosecution's objections to three additional documents offered by Respondent were sustained; those documents were not admitted into evidence in this matter.

SUMMARY OF RESPONDENT'S PRESENTATION

Respondent's presentation involved testimony from Respondent, Karen Fierimonte, R.N., and argument from Respondent's Counsel.

The essential facts of this matter are not in dispute. On May 3, 2019, Respondent administered to a patient an amount of trazodone greater than the amount ordered by the physician, which she did not document. [Document A; Document B; Argument of Respondent's Counsel] The Prosecution's Memorandum indicates that Respondent's actions are so similar to those in the two cases cited that she should receive the same sanction, that of indefinite suspension, with conditions on reinstatement. [Document E, pg. 1] Respondent asks that the Board take into account that this case is not as cut and dried as the Prosecution indicates. There is no minimum sanction which the Board is required to impose in this case. A thoughtful comparison of the facts of the cases cited in both Prosecuting Counsel's Memorandum on Disposition, and those cited in Respondent's Memorandum on Disposition, shows that the more appropriate sanction, as supported by applicable Board precedent, is reprimand only. [Argument of Respondent's Counsel]

The Prosecution cites two cases as justifying the requested sanction in this matter: *In the Matter of Debra A. Parr* BORN Document No. NUR-2012-0006 and *In the Matter of Nelena Rae Lowrey*, BORN Document No. NUR-2012-0097. [Document E, pg. 3] The facts set out in both of those cases show more serious lapses in nursing conduct than is present in the instant matter. Specifically, both showed a recklessness which is not present in the instant matter. In *Parr,* the nurse lost track of a patient with hypertension. She therefore failed to administer medication necessary to control blood pressure and failed to alert the physician to these facts. In *Lowrey*, the nurse. administered coumadin twice without a prescriber order, and without implementing the necessary lab work to ensure proper dosage and patient safety. The consequences of giving a blood thinner to someone who doesn't need it can be serious. Respondent Molloy's conduct at issue in this matter does not show the same level of recklessness which

[2] Respondent's Supplemental Memorandum on Disposition was accepted for filing even though it exceeded the two page limitation by one page.

is present in both of the cited cases. Those cases do not show that she merits the same level of sanction. [Argument of Respondent's Counsel]

Respondent's conduct more closely aligns with that shown in *Matter of Donna Guerra* RN-07-04, and *Matter of Stacy M. Shir, R.N.* (Docket No. NUR 2012-0059). Both of those matters were resolved through reprimand only, without suspension. [Exhibits 4 and 5; Document C, pg. 6; Document D, pgs. 1-2; Argument of Respondent's Counsel] Like Respondent, Nurse Shir dispensed extra medication, (prednisone) to a nursing home resident in the absence of a physician's order, and failed to document the administration. [Exhibit 5] Nurse Guerra changed a treatment order without authorization and falsified documentation to show that she had received a telephonic order for the change. [Exhibit 4] Respondent's conduct more closely resembles the facts alleged in these cases, rather than those cited by Prosecuting Counsel. For both of the cited matters, the Board chose to impose a sanction of reprimand only. Therefore, a sanction of reprimand only in this matter would more closely follow Board precedent for similar matters. [Document C, pg. 6; Document D, pgs. 1-2; Argument of Respondent's Counsel]

Respondent also offers the following facts to be considered in mitigation. Respondent has been a nurse since 1997, and a registered nurse since 2003. She has served patients with skill and care in multiple different settings for more than 25 years. She has never before been in trouble with the Board of Registration in Nursing.

The current regrettable actions were taken while under the pressures of working for a chronically understaffed nursing facility that has since gone out of business, Wareham Healthcare (Wareham). [Document C, pg. 3; Respondent Testimony; Nurse Fierimonte Testimony] Wareham had recently purchased the facility from Kindred Healthcare, and in a series of layoffs, Wareham had reduced the staff by at least a third overall, more on particular wards and care areas. [Nurse Fierimonte Testimony]

On May 3, 2019, when the incident in question occurred, Wareham suffered from chronic staffing issues such as a very high staff turnover rate, as well as a high callout rate, where staff would call out sick and be unavailable for work. [Document C, pgs. 2-4; Respondent Testimony; Nurse Fierimonte Testimony] Wareham also lacked an on-site prescriber. Respondent was working a double shift on the day in question, and moreover, was the only RN assigned to Wareham's rehabilitation unit. [Document C, pg. 3; Respondent Testimony; Nurse Fierimonte Testimony] Respondent was working for Wareham through a nursing agency, and was scheduled to work two shifts in the facility, back to back, which was not unusual.

Respondent knew Patient 1 well, having seen her on an almost daily basis for over a year before May 3. Patient 1 was [redacted] years old, and had [redacted]. Respondent also knew Patient 1 to be intelligent, articulate, and competent to participate with her practitioners in making treatment decisions and provide informed consent. [Document C, pg. 4; Respondent's Testimony] On that day, Patient 1 was crying and distraught as she had not slept in 72 hours due to the fact that she has received insufficient sleep medication. In looking at the current order, which was for 50 mg of trazodone, Respondent knew that other practitioners had prescribed up to 200 mg for other patients who had been in her care in the past. Also, experience in working with Patient 1 showed that the facility prescribers always gave Patient 1 what she asked for in the way of medications. Respondent had an entire ward of patients who urgently needed her care, and yet she was time and again in Patient 1's room attempting to calm her. [Document C, pg. 4; Respondent's Testimony] There was no onsite clinician in the facility that day who could adjust Patient 1's medication

order, and Respondent told Patient 1 multiple times that Respondent needed to call the off-site physician in order to get an increase in the medication order. Patient 1 continued to call Respondent to her room when Respondent was attempting to serve other patients on the ward, and continued to cry and plead for additional trazodone. Respondent believed the patient's cries of distress, and thought only to alleviate Patient 1's pain and suffering. [Document C, pgs. 2-4; Respondent's Testimony]

Respondent acknowledges that her actions that day to increase the patient's dose without reaching a prescriber first; then to give Patient 1 the additional trazodone to take as she needed; and finally, failing to document the facts appropriately, all evidence a lapse in judgement on her part, for which she takes responsibility. Respondent was beginning work on her second full shift at Wareham when she learned that the trazodone had been discovered and that Patient 1's possession of the trazodone has been misunderstood. She immediately told the authorities at Wareham, her supervisor Nurse Karen Fierimonte, about what she had done so that Patient 1 would not be blamed.

After Wareham let her go, Respondent immediately found work at Brandon Woods, a stable facility with better staffing and patient care, where she has a regular shift. Her work at Brandon Woods has been exemplary, and she has not repeated any of the errors from Wareham which are the subject of this complaint. She has also taken appropriate steps to strengthen her nursing practice through coursework in proper documentation, as well as legal and ethical issues in nursing. [Document C, pgs. 2-4; Exhibit 3; Respondent's Testimony] Nurse Fierimonte believes that Respondent "is an excellent nurse who made a mistake." [Nurse Fierimonte Testimony] Nurse Fierimonte would hire Respondent again if she had the opportunity to do so. She trusts Respondent's skills and judgement, and believes that she has learned from what occurred at Wareham. [Nurse Fierimonte Testimony]

Respondent is a skilled and compassionate nurse with much to contribute. She's a good nurse who on that day made a bad mistake. This facts of this matter show that the Respondent should not be suspended and then serve a year of probation. A more appropriate sanction would be Reprimand only. Respondent knows what she did wrong; acknowledges her fault; represents that she wouldn't do it again, even if a patient presented as distraught. She has clearly learned her lesson, and there is appropriate Board precedent to support imposition of Reprimand only.

SUMMARY OF THE PROSECUTION'S SANCTION HEARING PRESENTATION

The Prosecution recommends that Respondent's RN license and right to renew, as well as her right to renew her LPN license, be suspended for such time, and subject to such conditions for reinstatement, as may be necessary to protect the public health, safety, and welfare. [Document E, pg. 1] This sanction is appropriate in light of the seriousness of the underlying incident, and is clearly authorized by applicable Board precedent. [Document E, pg. 1-2; Argument of Prosecting Counsel]

The argument presented in Respondent's Memorandum on Disposition and at the sanction hearing in this matter seeks to minimize the seriousness of Respondent's conduct. Respondent gave into the possession of patient with a diagnosis of [redacted] an amount of medication three times that indicated in her physician's order. [Document E, pg. 1-3; Argument and Cross-Examination by Prosecting Counsel] Moreover, after giving Patient 1 200 mg of trazodone, Respondent agrees that she purposefully left Patient 1 alone with those pills and admits that she intended for Patient 1 to take the pills as she wished. [Document E, pages 2-3, Argument and Cross-Examination by Prosecting Counsel] Respondent then compounded her poor judgement by failing to document the incident. She also acknowledges that she

made no attempt whatsoever, either before or after giving Patient 1 the trazodone, to contact the off-site physician to get approval of the increased dosage. Finally, she failed to report the incident until after the medication had been discovered in Patient 1's possession; Patient 1 had lied to staff in an attempt to cover for Respondent; and Patient 1 was forcibly taken to an emergency room, as the staff feared that she had been [redacted] While there was no immediate negative impact on the life and health of Patient 1 due to the incident, [redacted] Respondent cannot claim that this fact relieves her of responsibility for creating such a risk to the health and safety of Patient 1 in the first place. Respondent failed Patient 1 that day, and failed in her duties and obligations as a nurse. Her actions show that she committed acts which undermine public confidence in the integrity of the nursing profession, and merits the requested sanction. The fact that she has continued to work without further incident, and has taken appropriate remedial coursework, might be considered as to the timing of possible reinstatement. It should not prevent the imposition of the requested sanction. [Document E, pg. 1-3; Argument and Cross-Examination by Prosecting Counsel]

PARTIES' POSITIONS AS TO DISPOSITION

Respondent's Position

Respondent asks the Board to impose the lesser sanction of Reprimand only, as authorized by applicable Board precedent presented in Respondent's Memorandum on Disposition and at the sanction hearing, and the facts offered in mitigation in this matter, [Document C, pg. 1; Argument of Respondent's Counsel]

Petitioner's Position

The Prosecution recommends that Respondent's RN license and right to renew, as well as her right to renew her LPN license, be suspended for such time, and subject to such conditions for reinstatement, as may be necessary to protect the public health, safety, and welfare. [Document E, pg. 1]

NOTICE TO PARTIES

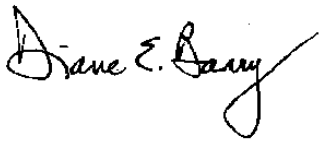
This Tentative Decision has been filed today, with Heather Engman, Chief Board Counsel.

Parties shall file any objections to the Tentative Decision within thirty (30) days of today. Objections shall be filed by mail to Heather Engman, Chief Board Counsel, 250 Washington Street, 2nd Floor, Boston MA 02108. Any objections must also include written arguments in support thereof as the Board will not hold oral arguments on the objections. Parties shall file by mail to Chief Board Counsel Engman at the above address any responses to objections within twenty (20) days of receipt of a copy of the objections.

You should not contact this Hearing Officer regarding this Tentative Decision. If a party has an inquiry regarding the Tentative Decision, that party shall notify Chief Board Counsel Engman by email (heather.engman@mass.gov) and must "cc" the other party in that email. However, if the inquiry contains confidential information, or if the inquiring party does not have an email or does not know the

email address of the other party, then the inquiry shall be made to Chief Board Counsel Engman by mail at the above address with copy of the mailing to the other party.

Any mailing that contains confidential information shall be labelled "Confidential."



Diane E. Barry, Esq.
Hearing Officer
Department of Public Health
Office of the General Counsel
250 Washington Street, 2nd Floor
Boston, MA 02108

Issued and filed: December 16, 2022

Notified: See below

SECURE ELECTRONIC TRANSFER - PROOFPOINT
William D. Saltzman, BBO #439749
ws@kflitigators.com

INTEROFFICE DELIVERY VIA SHARED DRIVE
Patricia Blackburn, Esq.
Heather Engman, Esq.

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION
IN NURSING

Board of Registration in Nursing, Petitioner,	)	
v.	)	Docket No. NUR-2019-0133
Therese A. Molloy, RN License No. RN257345 License Expires 7/16/22 LPN License No. 58831 License Expired 7/16/05, Respondent	)	

ORDER TO SHOW CAUSE

Therese A. Molloy, 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. 257345, or your right to renew such license, and your license to practice as a Licensed Practical Nurse (LPN) in the Commonwealth of Massachusetts, License No. 58831, 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 August 7, 2003, the Board issued a license to you to engage in the practice of nursing as an RN, License No. 257345. Your license is current, and expires on July 16, 2022.

2. On or about August 6, 1997, the Board issued a license to you to engage in the practice of nursing as an LPN, License No. 58831. Your license expired on July 16, 2005, and has not been renewed to date.

3. On or about May 3, 2019, you were employed and on duty as an RN at Wareham Healthcare in Wareham, Massachusetts (Wareham).

4. On or about May 3, 2019, you dispensed six (6) 25 mg tablets of trazodone, a non-scheduled controlled substance, for a Wareham patient (Patient 1).

5. On or about May 3, 2019, Patient 1 had a physician's order for the administration of 50 mg of trazodone at bedtime for insomnia.

6. You did not document administering the trazodone referenced in Paragraph 4 above in Patient 1's medication administration record.

7. You did not make any nurse's note in connection with the matters referenced in Paragraphs 4 through 6 above.

8. You left the trazodone referenced in Paragraph 4 above unattended on Patient 1's table.

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 licenses to practice as an RN and an LPN, including any right to renew your licenses, 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 licenses to practice as an RN and an LPN, including any right to renew your licenses, 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 licenses to practice as an RN and an LPN, including any right to renew your licenses, 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 licenses to practice as an RN and an LPN, including any right to renew your licenses, pursuant to

[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.

Board regulation 244 CMR 9.03(10) for performing acts beyond the scope of nursing practice as defined in M.G.L. c. 112, § 80B and 244 CMR 3.00.

E. Your conduct as alleged above, and any other evidence that may be adduced at hearing, warrant disciplinary action by the Board against your licenses to practice as an RN and an LPN, including any right to renew your licenses, 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.

F. Your conduct as alleged above, and any other evidence that may be adduced at hearing, warrant disciplinary action by the Board against your licenses to practice as an RN and an LPN, including any right to renew your licenses, 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.

G. Your conduct as alleged above, and any other evidence that may be adduced at hearing, warrant disciplinary action by the Board against your licenses to practice as an RN and an LPN, including any right to renew your licenses, 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 licenses to practice as an RN and an LPN, including any right to renew your licenses, 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 Merielles Silva-Herman, MSN-L, MBA, DNP, RN
Executive Director

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

Date: November 4, 2020