STATE OF NEW JERSEY

In the Matter of Quiana Brown
New Jersey Veterans Memorial Home
Vineland, Department of Military and
Veterans Affairs

CSC DKT. NO. 2017-1392
OAL DKT. NO. CSV 17104-16

FINAL ADMINISTRATIVE ACTION OF THE CIVIL SERVICE COMMISSION

ISSUED: MARCH 8, 2019 BW

The appeal of Quiana Brown, Practical Nurse, New Jersey Veterans Memorial Home Vineland, Department of Military and Veterans Affairs, removal effective October 19, 2016, on charges, was heard by Administrative Law Judge Jeffrey R. Wilson, who rendered his initial decision on February 4, 2019. Exceptions were filed on behalf of the appellant and a reply to exceptions was filed on behalf of the appointing authority.

Having considered the record and the Administrative Law Judge's initial decision, and having made an independent evaluation of the record, the Civil Service Commission (Commission), at its meeting of March 6, 2019, accepted and adopted the Findings of Fact and Conclusion as contained in the attached Administrative Law Judge's initial decision.

ORDER

The Civil Service Commission finds that the action of the appointing authority in removing the appellant was justified. The Commission therefore affirms that action and dismisses the appeal of Quiana Brown.

This is the final administrative determination in this matter. Any further review should be pursued in a judicial forum.

DECISION RENDERED BY THE
CIVIL SERVICE COMMISSION ON
THE 6th DAY OF MARCH, 2019

Deirdré L. Webster Cobb

Deirdré L. Webster Cobb
Chairperson
Civil Service Commission

Inquiries
and
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Attachment

State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION
OAL DKT. NO. CSV 17104-16
AGENCY DKT. NO. 2017-1392

IN THE MATTER OF QUIANA BROWN, NEW JERSEY VETERANS MEMORIAL HOME VINELAND, DEPARTMENT OF MILITARY AND VETERANS AFFAIRS.

William A. Nash, Esq., for appellant, Quiana Brown (Nash Law Firm, L.L.C., attorneys)

Jana R. DiCosmo, Deputy Attorney General, for respondent, New Jersey Veterans Memorial Home Vineland, Department of Military and Veterans Affairs (Gurbir S. Grewal, Attorney General of New Jersey, attorney)

Record Closed: December 26, 2018 Decided: February 4, 2019

BEFORE **JEFFREY R. WILSON**, ALJ:

STATEMENT OF THE CASE

The appellant, Quiana Brown, appeals her removal from the New Jersey Veterans Memorial Home Vineland (Veterans Home), effective October 19, 2016, because of record falsification, a medication error and improper documentation.

PROCEDURAL HISTORY

On October 19, 2016, the Veterans Home issued a Final Notice of Disciplinary Action (FDNA) removing the appellant effective that date. She appealed her removal and the matter was transmitted to the Office of Administrative Law, where it was filed on November 10, 2016, as a contested case. N.J.S.A. 52:14B-1 to 15 and N.J.S.A. 52:14F-1 to 13. A hearing was conducted in this matter on September 25, 2017, March 19, 2018, and April 10, 2018. The record closed after the parties submitted written closing briefs.

FACTUAL DISCUSSION AND FINDINGS

Based on the testimony of the witnesses and examination of the documentary evidence, I **FIND** the following **FACTS** are undisputed:

The appellant, Quiana Brown, was hired by the Veterans Home as a per diem Licensed Practical Nurse (LPN), in July 2007. Within a few weeks thereafter, the Veterans Home hired her as a full-time LPN.

On September 12, 2016, the appellant worked the 7:00 a.m. to 3:00 p.m. shift. At 10:31 a.m., Michele Anthony, MD issued Physician's Orders on behalf of resident, "F.P."[1] The Orders included:

> "CEPHALEXIN 500MG CAP (Cephalexin) ONE FIRST DOSE STAT Oral twice daily for 7 days for Wound Infection"
> (J-2.)

The appellant acknowledged receipt of the Physician's Orders by annexing her signature thereto. The appellant then transcribed the Physician's Order for Cephalexin, onto the Medication Administration Record (MAR) (R-12) as follows:

> "9/12/16

[1] For purposes of confidentiality and privacy, the resident will be referred to as F.P. throughout out this Initial Decision.

> Cephalexin 500mg cap First dose stat po[2] twice daily for 7 days for wound infection"
> (R-12.)

Because this medication was ordered to be administered to F.P. STAT[3], then twice a day (BID[4]), the Medication/Treatment Administration Policy #25-1 (J-1) requires that it be administered immediately upon receipt of the Physician's Orders and thereafter at 9:00 a.m. and 9:00 p.m. The appellant made entries and notations on the resident's MAR to reflect the Physician's Orders. (R-12.) On September 12, 2016, the appellant administered the STAT dose to F.P. at 12:00 p.m. (R-12). Deborah Nicolo, LPN, the nurse working the evening shift, administered the next dose at 9:00 p.m. on September 12, 2016. Lynell Rivera, LPN conducted a twenty-four-hour review of F.P.'s Physician's Orders and MAR at 1:00 a.m. on September 13, 2016, (J-2) and noted no problems with either.

On September 13, 2016, Carolyn Gayle, LPN worked the 7:00 a.m. to 3:00 p.m. shift. Gayle administered Cephalexin to F.P. at 9:00 a.m. and again at 12:00 p.m. She documented these medication administrations by placing her initials in the corresponding cells on the MAR. (R-12.) A nurse on the next shift administered the Cephalexin to F.P. at 9:00 p.m. (R-12.) This resulted in F.P. receiving three doses of Cephalexin on September 13, 2016, instead of the prescribed two doses.

The appellant did not work on September 13, 2016. However, upon her return to work on September 14, 2016, she realized that a medication error had occurred because F.P.'s Cephalexin blister packet was missing one pill. (R-11.) The appellant immediately reported the error and was directed to rewrite the Cephalexin order on the MAR. Her superiors alleged that the appellant did not re-write the Cephalexin order as directed and recommended her for discipline.

On September 22, 2016, the respondent issued a Preliminary Notice of Disciplinary Action (PNDA) seeking removal and suspending the appellant pending the

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[2] PO is derived from the Latin phrase "per os" which means by mouth, orally.
[3] STAT is derived from the Latin word 'statim' which means with no delay or immediately.
[4] BID is derived from Latin the Latin phrase "bis in die" which means twice a day.

outcome of the proceedings. (R-1.) On September 26, 2016, amended PNDA was issued to reflect that the suspension pending removal would be without pay. (R-2.)

On October 19, 2016, the respondent issued a Final Notice of Disciplinary Action (FNDA) that alleged the following:

> You improperly incorporated the STAT dose within the order entered attributed to a med error. Specifically, on 9/14/16, you discovered that a medication error had occurred for resident FP (ID#16-0022) when he received an extra dose of an antibiotic. During review of the MAR, it was noted that the nurse had initialed off the 9:00am and 12:00pm dose for 9/13/16. You were directed by the Charge Nurse to rewrite the order on the MAR for clarification and report it to the Nursing Supervisor. When you had reported the error to the Nursing Supervisor the MAR was reviewed and the initial dose from 12:00pm was crossed off with blue ink. This was not on the MAR initially. You were interviewed by the DONS and then shown the proper way to transcribe the order when a STAT dose is ordered and directed to correct the transcription by rewriting the order correctly to avoid any further errors. You did not complete the transcription as directed but further altered the MAR by "X-ing" out the line. The nurse that gave the extra dose was interviewed and reports that she did in fact administer the 12:00pm dose and did not cross out her initials. The only one that had possession of the MAR was you and you intentionally altered the document to make it look as though the resident did not get the dose of medication. The resident needed to get fourteen (14) doses of the antibiotic. As a result of this alteration by you, it was unclear whether the resident actually received the dose or not.
> (R-3.)

The FNDA listed the following sustained charges:

- B-4 – Failure or excessive delay in carrying out an order which would not result in danger to persons or property
- B-6 – Serious mistake due to carelessness but not resulting in danger to persons or property
- C-8 – Intentional misstatement of material fact in connection with work, employment, application,

attendance or in any record, report, investigation or other proceeding

- E-1 – Violation of a rule, regulation, policy, procedure, order, or administrative decision
- 4A:2-2.3(a)(6) – Conduct unbecoming a public employee
- 4A:2-2.3(a)(7) – Neglect of duty
- 4A:2-2.3(a)(12) – Other sufficient cause

(R-3.)

Testimony

Pauline Fearon, Registered Nurse (RN) (Fearon) was the Charge Nurse for the 7:00 a.m. to 3:00 p.m. shift at the Veterans Home on September 14, 2016. On that date, she was approached by the appellant who reported a medication administration error that occurred on September 13, 2016. The appellant showed Fearon the Cephalexin blister pack for F.P. that was missing one dose. Fearon reviewed the MAR with the appellant and informed her that the Cephalexin order was entered incorrectly. Fearon testified that the STAT order should have been entered separately from the BID order in order to avoid confusion. She then told the appellant how the order should have been entered and directed the appellant to rewrite the Cephalexin Order accordingly. Fearon did not show the appellant a written sample of how the MAR should be rewritten nor did she ever follow up to see if the appellant rewrote the order as directed.

While Fearon and the appellant were discussing the situation, the Supervising Nurse, Angela Tirelli, RN (Tirelli) approached. Tirelli was made aware of the situation and the directive from Fearon to the appellant on how to rewrite the Cephalexin order. Tirelli reiterated to the appellant how the order was to be rewritten and then made a copy of the MAR and the Cephalexin blister packet. She also directed the appellant to rewrite the Cephalexin order as instructed

On September 15, 2016, Fearon filed a Facility Reporting Incident & Data Analysis Yield (R-4) that read in pertinent part:

> On 9/14/16 Mrs. Brown showed me the MARS for resident ABT[5]. The stat dose and the regular dose written in same slot appears confusing not clearly understood. She also said she thinks a pill is missing. I told her you can't prove the pills missing from what nurse, so rewrite the order so it can be more clear for the duration of the meds. When Mrs. Tirelli came on the unit she reported it to her. She copied the pages the pill pack and told Mrs. Brown to rewrite the order to make it more clear. There was no X or cross out on the MAR when she showed me.
> (R-4.)

Angela Tirelli, RN, was the Supervisor of Nursing Services and Education at the Veterans Home. She was the appellant's Supervising Nurse in September 2016. On September 14, 2016, the appellant approached Tirelli concerned that the Cephalexin count for resident, F.P., was incorrect because a pill was missing from his blister pack. A review of the resident's MAR revealed that the appellant did not properly enter the medication order on the MAR. Because of this, Carolyn Gayle, LPN, made a medication error on September 13, 2016, by administering an additional dose of the antibiotic to resident, F.P.

Tirelli informed the appellant that the STAT order should have been bifurcated on the MAR and entered separately from the BID order. Tirelli directed the appellant to correct the MAR and rewrite the Cephalexin STAT order and BID order as two separate orders. Although there is no written policy that STAT orders and BID orders must be bifurcated, it is the practice of the Veterans Home nursing staff to do so. The appellant was further directed to return the corrected MAR to Tirelli. As dictated by protocol, Tirelli gathered and generated required documents and made a copy of the incorrect MAR (R-12) and a copy of the Cephalexin blister pack. (R-11.)

Sometime thereafter, the appellant submitted her "corrected" version of the MAR (R-13) to Tirelli. It was noted that the appellant did not bifurcate the Cephalexin and BID orders as instructed. Rather she marked up the original MAR (R-12) using unacceptable markings. Tirelli also noted that an X in blue ink had been placed over the initials C.G.

[5] "ABT" is the acronym for Antibiotic Therapy.

on the "corrected" MAR for 12:00 p.m. on September 13, 2016. This blue ink X was not on the original MAR presented by the appellant when she originally reported the medication error. The "original" MAR (R-12) and the "corrected" MAR (R-13) and all other materials gathered by Tirelli were forwarded to the Director of Nursing Services (DONS), Carmen Ellis-Jackson

On September 14, 2016, Tirelli completed her portion of a Department of Nursing Medication Error Incident Reporting Form (R-8) and indicated that the persons making the error were the appellant, Quiana Brown, LPN and Carolyn Gayle, LPN. Her explanation of the error was reported as "Incorrect transcription of STAT and BID order by Quiana Brown, LPN causing as extra dose of ABT 12noon on 9/13/16." Tirelli reported the resident's then current condition as "No ill effects noted...no complaints of abdominal pain or diarrhea."

On September 22, 2016, Tirelli filed a Facility Reporting Incident & Data Analysis Yield (R-7) that read in pertinent part:

> On the afternoon of 09/14/2016 Ms. Brown approached this writer stating that she felt the antibiotic count for resident (F.P.) was incorrect. She stated one capsule was missing. She showed this writer the corresponding MAR indicating that there was a STAT order followed by a BID for 7 days. The Stat order was started 9/12/2016. After checking the MAR Ms. Brown stated she thought that the antibiotic was also given on 9/13/2016 at 12 noon indicated by the initials C.G. When this writer checked the MAR I in fact saw the initials C.G on the space indicating 12 noon the initials had a blue ink X over them at the time I checked the MAR.
> (R-7.)

Carolyn Gayle, LPN (Gayle) worked the 7:00 a.m. to 3:00 p.m. shift at the Veterans Home on September 13, 2016. On that date she administered two doses of Cephalexin to F.P. One at 9:00 a.m. and the second at 12:00 p.m. She did this based upon her interpretation of the order as written on the MAR by the appellant. On September 15, 2016, Gayle was contacted by the DONS and informed that she made a medication error on September 13, 2016. Gayle acknowledged her medication error.

This was the first time that Gayle had ever made a medication error. She was not disciplined for this however the DONS determined that she had to be retrained.

When Gayle was presented with the "corrected" MAR submitted by the appellant, she testified that she did not place the blue ink X over her initials on the MAR for 12:00 p.m. on September 13, 2016. She further stated that on September 13, 2016, she did not make any entries in blue ink rather on that date she only wrote with black ink.

On September 15, 2016, as directed by the DONS, Gayle completed a Facility Reporting Incident Data & Analysis Yield which read in pertinent part:

> On September 13, 2016, I worked at Independence Hall during the 7:00 AM to 3:00 PM shift. I administered an antibiotic to (FP) at 9:00 AM and 12:00 PM. I did not cross out my initials for the 12:00 PM dose on the Medication Administration Record.
> (J-4.)

Carmen Jackson, RN, DONS, (Jackson/DONS) was the DONS at the Veterans Home in September 2016. On September 14, 2016, Fearon initiated an investigation relative to a reported transcription/medication error that occurred on September 12-13, 2016. On September 14, 2016, Tirelli followed up on the investigation and turned over all relevant materials to Jackson, including the original MAR (R-12) and the "corrected" MAR (R-13) submitted by the appellant. Upon review, Jackson determined that two persons were responsible for the error: Carolyn Gayle, LPN and the appellant, Quiana Brown, LPN. She identified Gayle as the nurse that administered the extra dose of Cephalexin to resident, F.P. and the appellant as the nurse that transcribed the medication that led to the medication error.

On September 14, 2016, Jackson summoned the appellant to her office and pointed out to the appellant why her transcription on the "corrected" MAR was incorrect. Jackson then illustrated on a piece of paper how the MAR should have been rewritten to bifurcate the STAT dose and the BID dose. In addressing the blue ink X over the initials C.G., Jackson reminded the appellant that pursuant to Medication/Treatment Administration Policy #25-1 (J-1), cross outs are not allowed on an MAR. This

transcription error was of great concern to Jackson because the appellant had just received retraining on "Prevention of Medication Errors" on July 22, 2016.

A review of the appellant's Continuing Education Unit (CEU) records revealed that the appellant received 168.1 hours of continuing education training and in-services between July 24, 2007, and September 8, 2016. (R-23.) This included training in Medication Administration Procedures, Physician Order Training and Medication Errors. According to Jackson, the appellant was provided the necessary training to avoid making transcription errors:

> Because the frequency of the medication administration in-services that Ms. Brown has gone through and personally myself, I have in-serviced Ms. Brown on the prevention of medication errors and repetition in itself you have to start to think as a safe and competent nurse what you're doing when you go through it over and over, and I had just recently even before this one conducted in-service training with Ms. Brown on prevention of medication errors.
> (T-2[6]:119 at 25 to 120 at 1 – 8.)

When questioned about the appellant's four CEU's listed for Medication Pass Observation, Jackson indicated:

> There is a lot of medication observations, a lot of medication procedures that would be out of the norm, but it's required, it was required for Ms. Brown because of repetitive errors.
> (T2: 129 at 18 – 21.)

As to the sustained charges listed on the FNDA alleging violations of B-4 (Failure or excessive delay in carrying out an order which would not result in danger to persons or property) and B-6 (Serious mistake due to carelessness but not resulting in danger to persons or property), Jackson testified:

> "Serious mistake due to carelessness but not resulting in danger to persons or property." If in reviewing the whole incident, if Ms. Brown had just been a little bit more cautious

[6] T-2 refers the March 19, 2018, Transcript of Recorded Proceedings

> and careful in transcribing the order and going back and reading it to make sure that it was correct, that it would not have led to the error that occurred. It was a mistake, but it didn't end in danger to the resident.
> (T-2: 141 at 14 – 21.)

Jackson determined that the appellant placed the blue ink X over the initials C.G. on the "corrected" MAR and considered that alteration to be falsification of the MAR in violation of C-8 (Intentional misstatement of material fact in connection with work, employment, application, attendance or in any record, report, investigation or other proceeding).

> Because it was an intentional like cover. We already knew that an error occurred. It was evidenced when Ms. Brown brought it to the charge nurse's attention, but then to intentionally go back and strike out another nurse's signature, or another nurse's initials excuse me, and then make alterations to the document afterward, that wasn't a mistake that was intentional.
> (T-2: 142 at 11 – 18.)

On September 14, 2016, Jackson completed her portion of a Department of Nursing Medication Error Incident Reporting Form (R-8) and indicated:

> "Resident received extra 12 noon dose times 1 on 9/13/16. Stat order was not accurately defined and bracketed off. Nurse administering med also did not read entire order on MAR, resulting in the error. Both nurses identified and error reviewed with them to prevent recurrence. MD notified, no new orders, no adverse reaction," and then there is a check that says "they received an extra dose times one."
> (T-2: 72 at 5 – 12.)

Quiana Brown, LPN, (appellant) worked the 7:00 a.m. to 3:00 p.m. shift on September 12, 2016, at the Veterans Home. That morning, she received Physician's Orders for resident, F.P. that included prescriptions for Mucinex and Cephalexin. The appellant transcribed these orders onto the resident's MAR using black ink. She also entered a "hold order" for the resident's Lasix using blue ink. The appellant denied using blue ink for anything else on September 12, 2016, including the word "twice" in the transcription for the Cephalexin.

The appellant did not work at the Veterans Home on September 13, 2016. She returned to work on September 14, 2016 for the 7:00 a.m. to 3:00 p.m. shift. At approximately 9:00 a.m. she approached resident F.P.'s room with the medication cart. She took the resident's blood pressure and noted that it was a little low. She then began to organize the medications for his morning administration. At that time, the appellant noticed an additional signature on the MAR for a Cephalexin dose administration. She then counted the pills and noticed there was one Cephalexin pill missing from the resident's blister packet. The appellant immediately locked her medication cart and reported to Fearon, the Charge Nurse, with her medication cart and the resident's MAR.

> I told her, I said, you know, I said, "I was giving the medications out." And I said, "it seems like there was an extra signature here." And I said, "it's one pill off." I was like, "do you know why or what happened yesterday?" Like, did a pill drop-off something like that. Like, I didn't know what could have happened.
> (T-3[7]: 68 at 25 to 69 at 1 – 6.)

Fearon then examined the MAR. The appellant could not recall if Fearon made a copy of the MAR. Fearon then returned the appellant to her medication pass. When the appellant completed her med pass, Fearon approached her and directed the appellant to correct the Cephalexin order on the resident's MAR.

> She said, you know, "correct or rewrite the order. But you can't tell this was a med error. We'll wait until Angie come(s) on the unit and will let her know."
> (T-3:71 at 18 to 20.)

The appellant rewrote the Cephalexin order on the MAR by placing an X over the cells for September 14, 15, 16, 17, 18, 2016/12:00 p.m. in blue ink and returned the corrected MAR (R-13) to Fearon. She was adamant that she did not place an X over Gayle's initials in the cell for September 13, 2016/12:00 p.m.

[7] T-3 refers the April 10, 2018, Transcript of Recorded Proceedings

At approximately 12:30 p.m., on September 14, 2016, after the appellant submitted the "corrected" MAR to Fearon, she met with Tirelli, the Supervising Nurse. At that time, the appellant reported the medication error to Tirelli who, in turn, started conducting an investigation. The appellant was directed to complete a Facility Reporting Incident Data & Analysis Yield that read in pertinent part:

> While administering medication on Cart #2, on IH, I observed an additional signature behind an (sic) boxed stat placement on the MAR. I also counted and noted only 8 ABT pills in the cart. I then reported to the nurse.
> (J-3.)

At approximately 2:30 p.m., on September 14, 2016, the DONS summoned the appellant to her office and questioned her as to why she rewrote the MAR as she did. The appellant remained silent because she was confused as to what she had done wrong and was fearful of getting in trouble. It was at that time that the DONS explained that the STAT order and the BID order for the Cephalexin should have been bifurcated and entered as two separate orders. The DONS also showed the appellant the way that the MAR should have been rewritten. Prior to this, the appellant testified that she never received training on how to bifurcate a Physician's Order while employed at the Veterans Home.

The appellant did not have the opportunity to rewrite the MAR as demonstrated by the DONS. Instead, upon returning to work on September 15, 2016, she was reassigned to duties as a Certified Nurse Aide (CNA) and Gayle was reassigned to take over the appellant's med cart assignment.

On September 19, 2016, the appellant was suspended from her employment with the Veterans Home and on September 22, 2016, she was served a PNDA that confirmed her suspension and detailed the disciplinary charges against her seeking removal.

Credibility is best described as that quality of testimony or evidence which makes it worthy of belief. The Supreme Court of New Jersey considered the issue of credibility in In-re Estate of Perrone, 5 N.J. 514 (1950). The Court pronounced:

> Testimony to be believed must not only proceed from the mouth of a credible witness but must be credible in itself. It must be such as the common experience and observation of mankind can approve as probable in the circumstances.
> [5 N.J. at 522.]

In order to assess credibility, the witness' interest in the outcome, motive or bias should be considered. Furthermore, a trier of fact may reject testimony because it is inherently incredible, or because it is inconsistent with other testimony or with common experience, or because it is overborne by other testimony. Congleton v. Pura-Tex Stone Corp., 53 N.J. Super. 282, 287 (App. Div. 1958).

Having considered the testimonial and documentary evidence presented by the respondent, I accept the testimony offered by Pauline Fearon, Angela Tirelli, Carolyn Gayle and Carmen Jackson to be very credible and highly persuasive. Their testimony was free of any histrionics and none of these witnesses exhibited any ulterior motive aside from laying out the facts as they recalled them. None of these witnesses had anything to gain from testifying.

Having considered the testimonial evidence presented by the appellant, her adamance that she did not place the blue ink X over C.G.'s initials in the MAR's cell for September 13, 2016/12:00 p.m. does not comport with a close inspection of her "corrected" MAR. (R-13.) By her own admission, the appellant used blue ink on the resident's MAR on September 12, 2016, and September 14, 2016. All other persons used black ink in those dates. Therefore, I **FIND** as **FACT** that the appellant placed blue ink X's in the cells for September 13,14, 15, 16, 17, 18, 2016/12:00 p.m. on the Cephalexin order of resident's MAR. (R-13.)

LEGAL ANALYSIS AND CONCLUSIONS

The appellant's rights and duties are governed by laws including the Civil Service Act and accompanying regulations. A civil service employee who commits a wrongful act

related to his or her employment may be subject to discipline, and that discipline, depending upon the incident complained of, may include a suspension or removal. N.J.S.A. 11A:1-2, 11A:2-6, 11A:2-20; N.J.A.C. 4A2-2.

The respondent shoulders the burden of establishing the truth of the allegations by preponderance of the credible evidence. Atkinson v. Parsekian, 37 N.J. 143, 149 (1962). Evidence is said to preponderate "if it establishes the reasonable probability of the fact." Jaeger v. Elizabethtown Consol. Gas Co., 124 N.J.L. 420, 423 (Sup. Ct. 1940) (citation omitted). Stated differently, the evidence must "be such as to lead a reasonably cautious mind to a given conclusion." Bornstein v. Metro. Bottling Co., 26 N.J. 263, 275 (1958); see also Loew v. Union Beach, 56 N.J. Super. 93, 104 (App. Div. 1959).

The appellant is charged with violating B-4 (failure or excessive delay in carrying out an order which would not result in danger to persons or property); B-6 (serious mistake due to carelessness but not resulting in danger to persons or property); C-8 (intentional misstatement of material fact in connection with work, employment, application, attendance or in any record, report, investigation or other proceeding); and E-1 (violation of a rule, regulation, policy, procedure, order, or administrative decision).

On September 12, 2016, the appellant transcribed the Physician's Order for Cephalexin to be administered to Veterans Home resident F.P. The medication was to be administered STAT, then BID. The appellant did not bifurcate the STAT order and the BID order on the resident's MAR. On September 13, 2016, Gayle mistranslated the appellant's transcription and administered an extra dose of the medication to F.P. This medication error went unnoticed despite the MAR being reviewed by at least four nurses on subsequent shifts. Fortunately, the resident suffered no ill effects from the additional dose.

The appellant did not work on September 13, 2016. On September 14, 2016, after reviewing signatures on the MAR for resident F.P. and counting his pills, the appellant discovered the medication error relative to the resident's Cephalexin Order and immediately reported it to Pauline Fearon, her Charge Nurse. Fearon directed the appellant to rewrite the medication order on the resident's MAR to bifurcate the STAT

order from the BID order. Fearon did not did not show the appellant a written sample of how the MAR should be rewritten nor did she ever follow up to see if the appellant rewrote the order as directed. The appellant complied and returned the "corrected" MAR (R-13) to Fearon. The appellant did not bifurcate the orders on the "corrected" MAR as directed and she placed blue ink X's over several cells on the MAR including the September 13, 2016/12:00 p.m. cell containing the initials C.G.

Upon questioning, the appellant testified that she was never trained on how to bifurcate orders on a MAR until the DONS demonstrated how to do so after the appellant submitted her "corrected" MAR on September 14, 2016. This appears very unlikely because the Veterans Home provided the appellant training in Medication Administration Procedures, Physician Order Training and Medication Errors on several occasions during her employment. Most recently, she received one hour of training on Prevention of Medication Errors on July 22, 2016, just eight weeks prior to the incident at hand. The appellant was also required to undergo four medication pass observations due to prior errors.

Here the appellant was given an order by her Charge Nurse and Supervising Nurse to rewrite the resident's MAR to bifurcate the STAT order for Cephalexin from the BID order. Although she complied almost immediately, she failed to carry out the order as directed. Such mediation transcription errors are very serious as they could lead to harmful side effects, including death. Luckily, this resident suffered no ill effects.

I **CONCLUDE** that the appellant's conduct did violate B-4 (failure or excessive delay in carrying out an order which would not result in danger to persons or property); B-6 (serious mistake due to carelessness but not resulting in danger to persons or property); and E-1 (violation of a rule, regulation, policy, procedure, order, or administrative decision). I **CONCLUDE** that respondent has met its burden of proof on these charges.

I **CONCLUDE** that the appellant's conduct did not violate C-8 (intentional misstatement of material fact in connection with work, employment, application, attendance or in any record, report, investigation or other proceeding). It must be noted,

and to her benefit, it was the appellant who reported the medication error upon her return to work on September 14, 2016. This medication error went unnoticed despite the MAR being reviewed by at least four nurses on subsequent shifts. Despite being trained on the bifurcation of STAT orders from accompanying orders, the appellant remained oblivious to the fact that it was her transcription that led to the medication error. The actions of the appellant in rewriting the MAR were not an intentional attempt to falsify the record. Rather it was inexcusable carelessness and a violation of her duty of diligence as a nurse. I **CONCLUDE** that respondent has not met its burden of proof on this charge.

The appellant was charged with conduct unbecoming a public employee, N.J.A.C. 4A:2-2.3(a)(6). "Conduct unbecoming a public employee" is an elastic phrase that encompasses conduct that adversely affects the morale or efficiency of a governmental unit or that has a tendency to destroy public respect in the delivery of governmental services. Karins v. City of Atl. City, 152 N.J. 532, 554 (1998); see also In re Emmons, 63 N.J. Super. 136, 140 (App. Div. 1960). It is sufficient that the complained-of conduct and its attending circumstances "be such as to offend publicly accepted standards of decency." Karins, v. City of Atl. City, 152 N.J. at 555 (quoting In re Zeber, 156 A.2d 821, 825 (1959)). Such misconduct need not necessarily "be predicated upon the violation of any particular rule or regulation but may be based merely upon the violation of the implicit standard of good behavior which devolves upon one who stands in the public eye as an upholder of that which is morally and legally correct." Hartmann v. Police Dep't of Ridgewood, 258 N.J. Super. 32, 40 (App. Div. 1992) (quoting Asbury Park v. Dep't of Civil Serv., 17 N.J. 419, 429 (1955)).

A public employee may also be disciplined for "neglect of duty." N.J.A.C. 4A:2-2.3(a)(7). Negligence is a failure to exercise the degree of care in a given circumstance, which a person of ordinary prudence would exercise under similar circumstances. See, e.g., Hempstead v. Rovinson, 1 N.J. 32, 34 (1948). Generally, the term "neglect" connotes a deviation from normal standards of conduct. In re Kerlin, 151 N.J. Super. 179, 186 (App. Div. 1977). "Duty" signifies conformance to "the legal standard of reasonable conduct in the light of the apparent risk." Wytupeck v. Camden, 25 N.J. 450, 461 (1957). Neglect of duty can arise from omission to perform a required duty as well as from misconduct or misdoing. Cf. State v. Dunphy, 19 N.J. 531, 534 (1955). Although the

term "neglect of duty" is not further defined in N.J.A.C. 4A:2-2.3(a)(7), that infraction occurs when an employee has neglected to perform and act as required by his or her job title or was negligent in its discharge. A failure to perform duties required by one's public position is self-evident as a basis for the imposition of a penalty in the absence of good cause for that failure.

I **CONCLUDE** that appellant's behavior did rise to a level of conduct unbecoming a public employee and neglect of duty. The appellant's conduct clearly compromised her ability to be trusted in the context of a facility serving aged and disabled residents. She was grossly lacking in her diligence in her position as an LPN who is entrusted as a caretaker and medical professional. Her conduct serves as a breach of the trust and faith of the public. I **CONCLUDE** that respondent has met its burden of proof on these charges.

The appellant has also been charged with violating N.J.A.C. 4A:2-2.3(a)(12), "Other sufficient cause." Other sufficient cause is an offense for conduct that violates the implicit standard of good behavior that devolves upon one who stands in the public eye as an upholder of that which is morally and legally correct.

I **CONCLUDE** that the respondent has met its burden of proof that appellant violated N.J.A.C. 4A:2-2.3(a)(12), "Other sufficient cause." Her conduct violated the implicit standard of good behavior and demonstrates that she cannot be trusted in a facility serving aged and disabled patients.

PENALTY

Where appropriate, concepts of progressive discipline involving penalties of increasing severity are used in imposing a penalty in disciplining a civil servant. The penalty should be reasonable and relative to the charge. W. New York v. Bock, 38 N.J. 500, 523-24 (1962).

In this matter, the appellant was employed at the Veterans Home for a period of approximately nine years. She was a seasoned LPN. The appellant was trained and in-serviced numerous times on Medication Administration Procedures, Physician Order

Training and Medication Errors. She was also required to undergo retraining and medication pass observations due to prior errors.

The appellant's disciplinary record (R-18) and Last Chance Agreement (R-19) were sealed at the hearing and not unsealed until after this ALJ made his findings and conclusions as to the charges alleged. The appellant's disciplinary record reflects eleven prior incidents of discipline, resulting in counseling, written warning, official reprimand or suspension. One of the prior disciplinary actions sought a "resignation not in good standing" and was settled for an eighty-five-day suspension. Two of the prior disciplinary actions sought removal. The first was settled for a six-day suspension. The second removal action resulted in the last Chance Agreement entered on June 15, 2016.

The Last Chance Agreement encompassed violations of N.J.A.C. 4A:2-2.3(a)(7), Neglect of Duty, N.J.A.C. 4A:2-2.3(a)(12)[8], Other Sufficient Cause and a fourth violation of B-6, serious mistake due to carelessness but not resulting in danger to persons or property. Pursuant to the terms of the Agreement, in lieu of removal, the appellant would be suspended for thirty-days and required to undergo retraining. It was further agreed that any subsequent incidents of this nature, for three years from June 15, 2016, would result in the removal from State service.

The appellant's conduct in this matter was so careless and irresponsible as to justify her removal. Her conduct raises even more concern taking into consideration her prior disciplinary record and Last Chance Agreement. Where the charged dereliction is an act which, in view of the duties and obligations of the position, substantially disadvantages the public to be served, good cause exists for removal. Golaine v. Cardinale, 142 N.J. Super. 385, aff'd, 163 N.J. Super. 453 (App. Div. 1978). In this case appellant was obligated to provide the utmost of diligence in providing care to the residents. Her removal is the appropriate penalty in light of the public interest in the well-being of the Veteran Home's residents and the interest in maintaining public confidence in the Department of Military and Veterans Affairs. Therefore, I **CONCLUDE** that

[8] Incorrectly listed in the Last Chance Agreement as N.J.A.C. 4A:2-2.3(a)(11)

appellant's removal from her position as an LPN at the Veterans Home effective, October 19, 2016, must be affirmed.

ORDER

It is hereby **ORDERED** that the appellant's removal from the New Jersey Veterans Memorial Home Vineland, effective October 19, 2016, is hereby **AFFIRMED**. The appellant's appeal is hereby **DISMISSED**.

I hereby **FILE** my initial decision with the **CIVIL SERVICE COMMISSION** for consideration.

This recommended decision may be adopted, modified or rejected by the **CIVIL SERVICE COMMISSION**, which by law is authorized to make a final decision in this matter. If the Civil Service Commission does not adopt, modify or reject this decision within forty-five days and unless such time limit is otherwise extended, this recommended decision shall become a final decision in accordance with N.J.S.A. 52:14B-10.

Within thirteen days from the date on which this recommended decision was mailed to the parties, any party may file written exceptions with the **DIRECTOR, DIVISION OF APPEALS AND REGULATORY AFFAIRS, UNIT H, CIVIL SERVICE COMMISSION, 44 South Clinton Avenue, PO Box 312, Trenton, New Jersey 08625-0312**, marked "Attention: Exceptions." A copy of any exceptions must be sent to the judge and to the other parties.

2-4-19
DATE

JEFFREY R. WILSON, ALJ

Date Received at Agency: February 4, 2019

Date Mailed to Parties: February 4, 2019 (Sent Via Email)

dm

WITNESSES

For Appellant:

Quiana Brown

For Respondent:

Pauline Fearon, RN
Angela Tirelli, RN
Carolyn Gayle, LPN
Carmen Jackson, RN, DON

EXHIBITS

Joint Exhibits:

J-1 Medication/Treatment Administration Policy #25-1
J-2 Physician's Orders, dated September 12, 2016
J-3 Facility Reporting Incident Data & Analysis Yield / Quiana Brown, dated September 14, 2016
J-4 Facility Reporting Incident Data & Analysis Yield / Carolyn Gayle, dated September 15, 2016

For Appellant:

None

For Respondent:

R-1 Preliminary Notice of Disciplinary Action, dated September 22, 2016
R-2 Amended Preliminary Notice of Disciplinary Action, dated September 26, 2016

R-3 Final Notice of Disciplinary Action, dated October 19, 2016

R-4 Facility Reporting Incident Data & Analysis Yield / Pauline Fearon, dated September 15, 2016

R-5 Entered into evidence as Exhibit J-3

R-6 Entered into evidence as Exhibit J-4

R-7 Facility Reporting Incident Data & Analysis Yield / Angela Tirelli, dated September 22, 2016

R-8 Medication Error Incident Reporting Form

R-9 Request for Corrective/Disciplinary Action

R-10 Entered into evidence as Exhibit J-2

R-11 Copy of Medication Blister Pack and Labels

R-12 Medication Record, dated September 1, 2016, to September 30, 2016

R-13 "Corrected" Medication Record, dated September 1, 2016, to September 30, 2016 (Color Copied)

R-14 Sample Medication Record, dated September 1, 2016, to September 30, 2016 (With Notation)

R-15 Sample Medication Record, dated September 1, 2016, to September 30, 2016 (With Notation)

R-16 Medication Pass Protocol Sheets, dated July 16, 2013, October 22, 2013, February 20, 2014, March 7, 2014, July 1, 2014 and August 14, 2015

R-17 Continuing Education Unit Transcript

R-18 Employee Disciplinary Action Report as of November 29, 2016 (UNSEALED January 24, 2019)

R-19 Disciplinary Action Appeal Settlement Agreement, dated June 15, 2016 (UNSEALED January 24, 2019)

R-20 Entered into evidence as Exhibit J-1

R-21 Facility Policy Concerning Employee Conduct Receipt, dated October 23, 2013

R-22 Employee Code of Conduct / Policy #43-5.1

R-23 Continuing Education Unit Transcript