STATE OF NEW JERSEY

In the Matter of Phyllis Davis Ancora Psychiatric Hospital Department of Health CSC DKT. NO. 2015-1704 OAL DKT. NO. CSV 17154-14	:	**FINAL ADMINISTRATIVE ACTION OF THE CIVIL SERVICE COMMISSION**

ISSUED: February 27, 2020 BW

The appeal of Phyllis Davis, Human Services Assistant, Ancora Psychiatric Hospital, Department of Health, removal effective November 21, 2013, on charges, was heard by Administrative Law Judge Susan L. Olgiati, who rendered her initial decision on January 30, 2020. 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 February 26, 2020, 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 Phyllis Davis.

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 26TH DAY OF FEBRUARY, 2020

Deirdré L. Webster Cobb

Deirdré L. Webster Cobb
Chairperson
Civil Service Commission

Inquiries
and
Correspondence

Christopher S. Myers
Director
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Civil Service Commission
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Attachment

State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION

OAL DKT. NO. CSV 17154-14

AGENCY DKT. NO. 2015-1704

IN THE MATTER OF PHYLLIS DAVIS, DEPARTMENT OF HUMAN SERVICES, ANCORA PSYCHIATRIC HOSPITAL.

William A. Nash, Esq., for appellant Phyllis Davis (Law Offices of William Nash, attorneys)

Elizabeth Davies, Deputy Attorney General, for respondent Ancora Psychiatric Hospital (Gurbir S. Grewal, Attorney General of New Jersey, attorney)

Record Closed: October 30, 2019 Decided: January 30, 2020

BEFORE **SUSAN L. OLGIATI**, ALJ:

STATEMENT OF THE CASE

Appellant, Phyllis Davis, appeals the action of the respondent, Department of Human Services, Ancora Psychiatric Hospital (Ancora), removing her from her position as a human services assistant based on disciplinary charges arising out of appellant's interaction with a patient on October 31, 2013. Appellant denies the charges and argues that her actions were appropriate and in defense of another.

PROCEDURAL HISTORY

By Preliminary Notice of Disciplinary Action dated January 28, 2014, appellant was advised of charges against her relating to an October 31, 2013, incident involving patient T.M., and of her proposed removal. A departmental hearing was held on October 7, 2014. Thereafter, on or about November 14, 2014, appellant was served with a Final Notice of Disciplinary Action (FNDA) removing her from her position effective November 21, 2013. The FNDA contained the following charges: conduct unbecoming a public employee in violation of N.J.A.C. 4A:2-2.3(a)(6); neglect of duty in violation of N.J.A.C. 4A:2-2.3(a)(7); other sufficient cause pursuant to N.J.A.C. 4A:2-2.3(a)(12); neglect of duty, loafing, idleness, or willful failure to devote attention to tasks which could result in danger to persons or property in violation of the New Jersey Department of Human Services Disciplinary Action Program, Administrative Order (A.O.) 4:08, B-2.1; physical or mental abuse of a patient, client, resident, or employee, in violation of A.O. 4:08, C-3.1; inappropriate physical contact or mistreatment of a patient, client, resident, or employee, in violation of A.O. 4:08, C-5.1; and violation of a rule, regulation, policy, procedure, order, or administrative decision, in violation of A.O. 4:08, E-1.2.

Appellant timely filed a notice of appeal, and on December 19, 2014, the matter was transmitted to the Office of Administrative Law for a hearing as a contested case. N.J.S.A. 52:14-1 to -15 and N.J.S.A. 52: 14F-1 to -13.

Due to litigation/court proceedings related to the October 31, 2013, incident, this matter was subject to several Orders of Inactivity spanning April 20, 2015, through June 2018. The matter was reassigned to the undersigned in June 2018. The due-process hearing in this matter was held on March 5, 2019, March 8, 2019, and June 20, 2019. The record remained open for the parties to obtain a transcript of the proceedings and to submit written summations. The record closed on September 17, 2019. The matter was reopened on October 24, 2019, to clarify certain items in the record. The record re-closed on October 30, 2019, following receipt of requested clarification. Thereafter, the undersigned requested and received additional time to complete the Initial Decision. By way of an Order of Extension, the time to file the Initial Decision was extended until January 30, 2020.

FACTUAL DISCUSSION AND FINDINGS

Testimony

The following is a summary of the relevant and material testimony given at hearing.

For respondent:

Elisa Bouisseau is a quality assurance specialist at Ancora. She has held this position since 2014. Bouisseau previously worked as a charge nurse at Ancora and was working as a charge nurse in October 2013.

Bouisseau began her testimony by viewing the surveillance video (Camera 11) of the October 31, 2013, incident. (R-17).[1] Bouisseau testified that appellant's conduct seen in the video was inappropriate because she pushed patient T.M. multiple times. Appellant also walked away from the patient and did not attempt to help her up off of the floor. T.M. was on one-to-one observation, which required staff to be within three arm's lengths of her. Appellant did not properly monitor T.M. on one-to-one and did not maintain constant visual contact. While T.M.'s behavior was very intrusive, appellant should have attempted to engage her and encourage her to interact. Appellant should have used more physical means such as dancing or walking to redirect T.M.

Bouisseau was familiar with T.M. She would get into others' personal space, "drape" her body over others, and pinch. T1:34:11. However, Bouisseau never saw T.M. "really hurt anyone," as she was not very strong. T1:34:16 to 35:1. T.M.'s behavior could cause others to react and result in T.M. getting hurt.

Appellant's actions in pushing T.M. constituted abuse and inappropriate physical contact. Her actions also constituted neglect because she pushed T.M. to the floor and walked away. Appellant should have put down the cup she had in her hand throughout the incident and attempted to engage the patient. Staff are not supposed to eat or drink

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[1] The relevant portion of the video played at hearing begins at approximately 11:43:30 and runs through approximately 11:55:15.

in the presence of patients. Additionally, appellant did not report T.M's fall. As a result, T.M. was not immediately assessed for injury.

Bouisseau testified that Ancora has aggressive patients. Staff are expected to model appropriate behavior even if a patient is being assaultive. If staff has a problem with a patient on one-to-one monitoring, they should notify the charge nurse so she can determine if medication is needed or if the psychiatrist should be contacted. Bouisseau testified that pushing is not condoned. Instead of pushing T.M., appellant should have taken the patient out of the area or to the nurse's station to notify Bouisseau (the charge nurse) of T.M.s behavior.

On cross-examination, Bouisseau explained that she often relieved staff assigned to T.M. and was familiar with her behavior. She did not agree with the characterization that T.M. "threw" her body on others. Bouisseau acknowledged various entries in the Team Notes for T.M. (P-1) where her behavior was described as assaultive to staff or it was noted that T.M. was pinching, hair pulling, hitting, and/or pushing. Bouisseau acknowledged that this was not safe behavior. She also acknowledged that it was difficult at times to redirect T.M. and that "Therapeutic Options" did not always work on her.

Bouisseau agreed that the surveillance video of the incident did not show the entire dayroom. She acknowledged that T.M.'s touching of the other patient, as seen in the video, appeared to be unwelcomed. Bouisseau did not agree that T.M'.s behavior towards Davis was assaultive. Rather, she testified that T.M. was intrusive and that she was leaning into appellant's personal space. Based on her review of the video, Bouisseau could not tell whether T.M. had tripped (over the other patient's feet). No falls were reported to Bouisseau on October 31, 2013. The Unusual Incident Report that was prepared in this matter was prepared by the second-shift charge nurse (on the following day). (P-2.) That report indicated no injuries to T.M.

Bouisseau explained that, typically, if one-to-one monitoring was not effective, restraints would be used for a brief period of time.

She further acknowledged that on October 30, 2013, the day before the incident, T.M. had an altercation with one of her peers. T.M. had been grabbing and pushing and caused another patient to hit her head.

Michael Voll is the director of nursing at Ancora. He has held this position since April 2018. Prior to this, Voll held various nursing positions at Ancora. Voll testified that staff are required to conduct themselves in a caring, kind, and professional manner. They are expected to build therapeutic relationships with the clients/patients. Failure to do so can result in loss of patient trust and can affect patient care.

Voll testified that he viewed the surveillance video of the October 31, 2013, incident in preparation of the hearing. Appellant's actions seen in the video were inconsistent with the special-observation, or one-to-one, policy. Specifically, Davis turned her back on T.M., was not within the required arm's lengths of her, and walked away from her. Additionally, appellant's action in holding a cup while monitoring T.M. was in violation of the Environmental Monitoring policy. Staff are not permitted to eat or drink in the unit. The policy is designed to ensure that patients do not take food items that are inconsistent with their diet. Food could also be a source of agitation for patients who are not permitted to have certain food. Allowing staff to eat or drink in front of patients could break down rapport with the clients and could negatively impact their treatment.

Appellant's actions in pushing T.M. several times into a chair and pushing her onto the floor violated Ancora policy. Staff are required to report allegations of abuse. Staff receive annual/ongoing training regarding abuse. Pushing is an example of physical abuse. No injury is required for a finding of physical abuse to be established. Appellant's actions constitute abuse because she pushed T.M. several times. The pushing in this instance was not supportive. Appellant's actions also constitute neglect. As the incident was not reported, proper medical care was not provided to T.M. When a patient falls to the floor, staff are required to report the incident and notify the charge nurse. Pursuant to the fall-management policy, patients are required to be assessed by a registered nurse (RN) following a fall. This policy applies regardless of whether the patient fell as a result of tripping or being pushed. Appellant violated this policy because she did not notify the RN of T.M.'s fall.

The policy on ethical interactions is designed to ensure that patients are treated in the best possible manner. Appellant's behavior in pushing T.M. was not ethical. Appellant's actions towards T.M. also constitute abuse and neglect.

On cross-examination, Voll acknowledged that the video of the incident does not capture T.M.'s feet or the feet of the patient seated next to her.

Voll acknowledged that the Environmental Monitoring policy directs staff to refrain from eating and drinking in patient-care areas. The policy does not provide that staff "shall" or "must" refrain from such conduct. A typical discipline for a first offense of this policy is counseling.

Kathleen Engstrom is a program specialist IV at Ancora. Prior to this position, she served as director of staff development and training, and worked as a charge nurse. She has been employed at Ancora for a total of thirty-two years.

Engstrom is familiar with the policy regarding reporting abuse and neglect. Staff receive initial training on the policy and receive annual updates. Staff take a course on ethical staff/patient interactions. In that course, staff learn appropriate interactions between them and the patients. Pushing is an example of inappropriate physical contact.

In accordance with the fall-management policy, staff are required to notify a charge nurse when a patient falls so the patient can be assessed.

During the Therapeutic Options review course, staff are taught how to de-escalate situations. They are also taught hands-on techniques regarding how to deal with aggressive and assaultive behavior. Staff are taught to put distance between themselves and the patient and to give the patient time, and to allow for redirection. Pushing is not taught as part of Therapeutic Options. The Therapeutic Options program consists of two days of training. Staff members receive annual refresher training on Therapeutic Options.

Engstrom believes that appellant was properly trained on how to handle difficult patients. This topic would have been covered in the Therapeutic Options training.

Appellant also received crisis-management training which dealt with aggressive behavior, verbal de-escalation, and giving patients "space and time." T2:15:7–9. Staff are trained to offer options and set limits. If verbal de-escalation does not work, staff are taught therapeutic, hands-on techniques such as escorting the patient out of the area. Training includes role play in how to respond if the patient is aggressive or if a situation escalates. The role play training is designed to be as realistic as possible.

On cross-examination, Engstrom explained that she taught several of the training classes that appellant received. Appellant also received training on the Patient Services Compliance Unit (PSCU) module, which addresses pushing.

Engstrom was unaware whether T.M.'s treatment team had requested additional training on how to handle her.

For appellant:

Tiffany McClinton[2] is employed as a human services technician (HST) at Ancora. She has worked there since 2001. McClinton worked with T.M. for approximately a few months to a year. As an HST, McClinton was part of T.M's treatment team. She testified that T.M. appeared sweet and meek, but pulled hair and lunged at people, and was always aggressive. T.M. would stand and lean forward into others. T.M. was like a "Roomba"[3]; she didn't realize that something was in her way, she would turn around and "come right back." T2:87:21–24.

Staff were discouraged from calling a "code" on T.M. because she was "high profile." T2:69:3. T.M.'s parents were very involved in her care. Even though T.M. was extremely assaultive, her parents discouraged the use of medication on her.

T.M. was not easily redirected. She would focus on what she wanted to do. She was very repetitive in her actions. She would come into people's personal space. She was placed on one-to-one observation for a long time.

[2] Formerly known as Tiffany "Smith."
[3] A reference to a robotic vacuum.

The treatment team was not provided with instruction on how to handle T.M. McClinton did not receive training on the things T.M. was doing. McClinton sent two emails to employee relations asking for assistance on how to deal with T.M.

One-to-one observation was not effective on T.M. Staff tried to come up with creative solutions for dealing with her. T.M was placed in a seclusion room, which removed her from the other patients but allowed her to move about. McClinton did not recall T.M. being restrained while on the first shift, which was typically staffed by more experienced individuals. There was no treatment plan for T.M.

McClinton later acknowledged that it did not take much force to redirect T.M. Staff only had to put a hand out and she would sit back down. T2:88:16–19. T.M. was "easily moved around." T2:89:16. Staff would sometimes dance or do other playful things to redirect T.M. They would try to make a game out it. T.M. did not have a very steady gait. It didn't require the use of all one's force to push her off. McClinton explained, however, that when T.M. was in an aggressive cycle, a gentle touch would not work, and you would have to touch T.M. more aggressively.

If a patient fell without injury, an Unusual Incident Report would not be filed, but staff would report the fall to the charge nurse. When McClinton cared for T.M., a fall did not always lead to an Unusual Incident Report being filed.

Tamia Caviness is an HST, and she has been at Ancora since 2000. She testified that T.M. was assaultive to staff, other patients, and her family. She rated T.M. a "ten"(the highest) on a scale of one to ten in difficulty to deal with. T.M. would lunge, pull hair, scratch, hit, and slap. She would fixate on a target. Redirection would work only for a few seconds.

Staff raised questions regarding how to deal with T.M., but did not receive answers. T.M.'s family was very involved in her care, and this was not helpful.

Staff would "tap out" to give each other a break when dealing with T.M. If T.M. tried to throw herself on Caviness she would hold her hand up and brace herself so T.M.

would not fall on her. T.M. fell often. When she fell, Caviness would report it to the nurse but would not complete an Unusual Incident Report.

Caviness described a "code blue" as an incident when a patient is acting out. Staff were not permitted to call code blues on T.M. because there "would be a code every hour on her." T2:181:2.

On cross-examination, Caviness confirmed that someone on staff is supposed to check on a patient after they fall. She acknowledged that minimal force was needed to redirect T.M.

Natasha Almon is an HST, and she has worked at Ancora for twenty years. She testified that she worked with T.M. for a couple of months.

T.M. was placed in one-to-one monitoring for safety reasons and because of her behavior. T.M. hit, attacked, and pulled on people. She would "flop" and throw herself on others. T2:209:3–5. Almon did not recall T.M. hurting anyone. T2:204:21. Almon did not have to use physical force to redirect T.M. If T.M. did not to respond to Almon's attempts at redirection, Almon would call a nurse or someone from the team. Almon did not participate in T.M.'s treatment meetings.

On cross- examination, Almon acknowledged that she did not witness the incident between petitioner and T.M. She confirmed that she never had to use physical force with T.M.

April White is a human services assistant (HSA). She has worked at Ancora for fifteen years. White described T.M.'s behavior as "intrusive." T3:8:11. She testified that T.M. was placed on "precautions" the majority of the time. T3:8:12–13. T.M. was assaultive to staff and patients. She would pull hair and put her full weight on others. White would "always" see T.M. fall or throw herself on the floor. T3:10:2–4. Incident reports were not always prepared when T.M. fell, because she often threw herself on the floor.

Training was not provided on how to deal with T.M. The Therapeutic Options training did not work on T.M. Nothing worked for her. The staff begged management for help and they "laughed" in response. Staff received no assistance from management. T3:12:2–6.

T.M. targeted White. On a daily basis, T.M. would pull her hair, and chase her and try to come at her. T3:12:24–25 to 13:1–2. T.M. was always aggressive to her, would fall on her or put her weight on her. T3:13:6–8. White would try to redirect her when this happened and T.M. would then try to target other people.

White was working on the date of the incident. Davis was acting as T.M.'s one-to-one. T.M. tried "to come at" White "as usual." T3:14:23. Davis redirected T.M. to sit down and not attack people. T3:15:5–6. White thinks that Davis may have touched T.M. on her shoulder. T3:15:9.

On cross-examination, White testified that she received training and knew how to handle difficult patients. She also testified that she did not see T.M. fall as a result of someone touching her.

Estella Ramble is a registered nurse and a charge nurse at Ancora. She has worked there since 2007. She described T.M.'s typical behavior as lying on others. She testified that T.M. also pinched and grabbed staff. Her behavior was assaultive. Ramble heard the term "flopper" used to describe T.M. She would lay herself down in a "flaccid behavior." T3:22:12–15. Management did nothing to control T.M.'s behavior. Due to her illness, Therapeutic Options training did not work on T.M. No training was provided by Ancora on how to deal with T.M. There was no treatment plan for her.

Unusual Incident Reports were not always done on T.M . An incident report would not be prepared if T.M. deliberately put herself on the floor. However, if the fall was not intentional or if T.M. sustained an injury, a report would be done. Ramble has seen T.M. trip and fall on another patient.

T.M. required redirection because she was constantly pushing herself onto the staff. T3:25:20–22. Staff would have to physically redirect T.M. They would have to "touch her a little bit" to redirect her. T3:25:25.

Ramble described Davis as hard-working. She reported for work on time and followed Ancora policy. She was a good employee.

On cross-examination, Ramble testified that she did not witness the October 31, 2013, incident.

She confirmed that if a patient fell she would assess the patient and notify the medical doctor, even if the patient did not appear to be injured and an incident report had not been prepared. T3:30:25–31:1.

Sandra Dean is a nursing supervisor, and she has worked at Ancora since 2013. She testified that she is familiar with T.M.'s behavior. Her behavior was "very unusual for a psychiatric hospital." T3:34:20. She would run around, and scream without rationale. It was intermittent and bizarre behavior. T3:34:25. She would hit people and flop on the floor. There was no treatment plan for T.M.'s behavior. Therapeutic Options did not work for her. Staff would try to control her behavior. Occasionally, they would have to touch T.M. to sit her down and to direct her to a certain task, or to do something that would not be injurious to T.M. or others. T3:38:4–9.

T.M. was one of their most challenging patients. A special chair (a geri chair) had to be brought in to help control her outbursts. Staff was assigned to T.M. at all times.

Dean is also familiar with appellant. She described Davis as very good at engaging with patients. She would follow directions without "pushback." When she learned that Davis was being removed from her position, Dean told her boss, "how dare you," because staff had not been provided with training on how to deal with T.M. T3:39:8–13. In response, Dean's supervisor told her that if she had seen the video she would understand. T3:3916–17. Dean acknowledged that she did not see the video of the incident, but did not believe that Davis would intentionally harm anyone.

On cross-examination, Dean acknowledged that Ancora staff receive annual training and are able to handle their jobs. She acknowledged that staff are required to treat even "very difficult patients" with respect. T3:50:12–18.

Dean acknowledged that she did not witness the October 31, 2013, interaction between appellant and T.M.

Dean never saw T.M. fall as a result of physical redirection by staff, nor had she seen T.M. trip on another patient.

Mark Woods is a training assistant who specializes in crisis management and intervention. He has worked at Ancora for thirty-six years. He testified that his supervisor requested that he work with T.M. to see if there were anything that would help with her behavior. He had been told that T.M. was aggressive and would not stay in one place. Woods was able to place T.M. in a physical hold for a short period of time. He was able to do this because he was experienced. Woods was not successful in dealing with T.M.

Staff receives Therapeutic Options training once at orientation, and receives annual refreshers. Therapeutic Options is one of the trainings that Woods teaches. The purpose of the training is to intervene with clients and to prevent them from becoming violent. If the patient becomes violent, staff are trained how to respond. "One-to-one" monitoring is a form of special observation. It is designed to prevent certain behaviors from occurring.

Every patient at Ancora should have a treatment plan. If something is not working, the treatment plan should be revisited.

Upon review of the video of the October 31 incident, Dean testified that he saw "nothing that's not consistent" with Davis' training. T3:69:9–10. She redirected T.M. to try to prevent aggression towards other patients. He believes that Davis was attempting to do her duty. Woods testified that barriers between a staff member and patients are not permitted. However, the barrier used by Davis during the incident appeared to be working.

On cross-examination, Woods acknowledged that he is currently facing disciplinary charges seeking his removal due to an alleged violation of the State policy against discrimination. Woods testified that the charges against him are false.

Woods did not agree that appellant's actions towards T.M. were forceful. Nor could he say whether appellant was an appropriate distance from T.M., because the distance for one-to-one observation varies.

Phyllis Davis was hired as an human services assistant at Ancora in 2004. She testified that her initial training lasted approximately one month and consisted mainly of reading and taking tests. She also received some hands-on training. Thereafter, she received annual training, which consisted of fast-paced rotation through different stations and dealing with different topics. Davis believes that more intensive training is needed.

At the time of the incident, T.M. had only been on Cedar Hall for a few months. Davis worked with T.M. on a nearly daily basis. T.M. was not always assigned to Davis, but she and the other staff were familiar with her. There was no treatment plan for T.M. She was unlike any other patient at Ancora. Nothing staff tried worked with T.M. It was "every man for himself." T3:90:3. Staff would have to come up with their own ways of dealing with T.M. They asked management for help in dealing with her. Staff were not permitted to call codes when T.M. was acting up. They were not allowed to put her in restraints. T.M.'s parents were very vocal regarding her treatment. The team's hands were "tied." T3:91:6–6. T.M.'s mother voiced her opinion to the staff and suggested that their days were "numbered," and that they would be replaced. T3:91:21–25 to 92:1–2.

On the date of the incident, T.M. had originally been assigned to another employee, Ms. Cadet, for one-to-one observation. Cadet was an older woman who had recently had knee surgery. T.M. was attacking Cadet, so Davis volunteered to work with T.M. on that date. Davis took T.M. to her commitment hearing, which was held in another building on the Ancora campus. While at the hearing, T.M. attacked her mother. She pulled her mother's hair. Davis had to stop T.M. from doing this. Once the court hearing was finished, Davis took T.M. to the dayroom.

Davis described T.M.'s typical behavior as focusing in on one person or staff member. She was always trying to attack someone. Sometimes redirection would work for a little while, and then T.M. would return to her behavior. April White was one of the persons whom T.M. would often try to attack. She would fixate on White and "come at her." T3:99:10–11.

New measures were always being tried with T.M. She was placed on one-to-one or two-to-one special observation almost daily.

The video of the October 31, 2013, incident does not show the right side of the dayroom, where White was seated at a table doing the dayroom census. T.M. tried to attack White.

Davis reviewed the video of the incident at the hearing and explained that T.M. tried to lean on her with her full body weight, so Davis put her arm up. Davis had a cup of ice in her hand throughout the incident because she is severely anemic and was trying to stay hydrated. She did not want to put the cup down because she did not want the patient to get it and choke on the ice. Davis explained that she was redirecting T.M. from "attacking April, because like I said, you can't hear sound in the video, but the whole time she's yelling, 'I'm going to get April [White].'" T3:105:19–22. Nor does the video capture Davis trying to talk to T.M. throughout the entire incident to assure her that White is minding her business and not going to harm her. T3:105:22–25.

When Davis directed T.M. to the row of chairs, T.M. attempted to grab the hair of another patient. Thereafter, Davis tried to direct T.M. to another seat. T.M. again attempted to put her full weight on Davis. T.M. was heavy; Davis did not want T.M. to fall on her, so Davis put her forearm out and tried to guide T.M. to a seat. T.M. then tripped on the feet of the other patient. Davis left T.M. on the ground because in her experience when you would lean down to help her, T.M. would pull your hair or spit on you. T3:110:2–5. T.M. was still fixated on White. Davis saw that T.M. was fine. Davis retreated because she did not want to give T.M. a reason to attack her. T3:110:11–12.

Davis then walked over to where her clipboard was so she could complete her paperwork. T.M. was still yelling the whole time. Davis used a chair as a barrier with T.M. because she continued to fixate on White. The chair was used as a cushion so T.M. would not flop onto Davis.

There were other instances when they had created a barrier, or locked T.M. in a conference room. This is what they had been told by the nurses to do. Davis thought that she was allowed to use a barricade to prevent an attack on White. T3:113:20–22.

Davis did not complete an Unusual Incident Report regarding T.M.'s fall because "this happens every day, all day." "T.M. is always tripping, falling, flopping." T3:109:17–19.

Davis denied pushing T.M. into the chair. She explained, "I say I did not push her because I'm trying to avoid a situation." T3:117:19–20. Rather than having T.M. fall on Davis or on the floor, she redirected T.M. to the chair. The chairs are really old and are sunk down in the middle.

Davis continued to keep the cup in her hand and eat the ice because she was trying to act normal and not further agitate T.M. T3:123:16–25 to 124:1–4. She did not want to put the cup down because White was seated on the other side of the table. The tables where White was seated were wide.[4] Davis moved T.M. back "out of her face" because T.M. had a tendency to spit. T.M. tried to get around the chair barricade to get at White.

Following her interaction with T.M., another staff member, Mr. Turberville, walked onto the ward. He took T.M. by her hands and turned it into a dance. He tried redirecting her by dancing. T3:131:22–24. As he was dancing with her, T.M. attempted to grab at another patient. Turberville redirected T.M. into the corner.

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[4] Davis estimated the width of the table at which White was seated by comparing it to the ceiling titles in the OAL courtroom, which measure 2 x 4 feet. Davis testified that the width of the table was two and one half that of the ceiling tiles.

Davis acknowledged that T.M. never tried to attack her. "I don't know what it was. She never really tried to attack me so that's why I volunteered to take her from Ms. Cadet earlier and I took her to court. You even see her coming past me. She's not coming to me. She's going—she's trying to get to April." T3:142:14–20.

Davis testified that she loved her job at Ancora. She tried to make the patients' experience pleasant. She liked to make them look and smell nice.

Credibility

For testimony to be believed, it must not only come from the mouth of a credible witness, but it also has to be credible in itself. It must elicit evidence that is from such common experience and observation that it can be approved as proper under the circumstances. See Spagnuolo v. Bonnet, 16 N.J. 546 (1954); Gallo v. Gallo, 66 N.J. Super. 1 (App. Div. 1961). A credibility determination requires an overall assessment of the witness' story in light of its rationality or internal consistency and the manner in which it "hangs together" with the other evidence. Carbo v. United States, 314 F.2d 718, 749 (9th Cir. 1963). Also, "'[t]he interest, motive, bias, or prejudice of a witness may affect his credibility and justify the [trier of fact], whose province it is to pass upon the credibility of an interested witness, in disbelieving his testimony.'" State v. Salimone, 19 N.J. Super. 600, 608 (App. Div.), certif. denied, 10 N.J. 316 (1952) (citation omitted).

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).

As to the credibility of respondent's witnesses, I accept the testimony of Elisa Bouisseau as credible. Her testimony regarding the type of conduct expected of Ancora staff members, even when dealing with difficult patients, was rational and reasonable. Similarly, her assessment that appellant's actions, and inactions, towards T.M. constituted abuse and neglect was straightforward and reasonable. I also find her characterization of T.M.'s typical behavior as "intrusive" rather than "assaultive" to be

credible. This characterization was based upon Bouisseau's own experience with, and observations of, T.M., including that she was not very strong and that she never saw T.M. hurt anyone. This testimony is supported by that of Natasha Almon who similarly testified that she did not recall T.M. hurting anyone. For these reasons, and despite appellant's arguments to the contrary, I accept Bouisseau's testimony as well-informed and reliable.

I accept the testimony of Michael Voll as credible. His testimony regarding Ancora's policies and practices was straightforward and reasonable. Further, his assessment that appellant's actions violated these policies and practices was reasonable and rational.

I also accept the testimony of Kathleen Engstrom as credible. Her testimony regarding the training received by appellant was supported by the documentary evidence in the record. Similarly, her opinion that appellant was properly trained to perform her job duties, including handling difficult patients, was reasonable and supported by the documentary evidence.

Next, I assess the credibility of appellant's witnesses. I accept as credible the testimony of witnesses McClinton, Caviness, Almon, Ramble, and Dean, characterizing T.M.'s behavior as aggressive, assaultive, and extremely difficult. This characterization is based upon their experience with, and observations of, T.M. and is therefore reasonable. I also accept as credible their testimony that Unusual Incident Reports were not always completed on occasions when T.M. fell, but that in such instances the charge nurse should/would be notified. I also accept as credible the testimony of these witnesses that while T.M. was difficult to redirect, it did not take much physical force to do so. However, as none of these individuals witnessed the October 31 incident, their testimony lends no weight to the determination of whether appellant engaged in the conduct alleged.

As to April White, I accept as credible her testimony that she was a frequent target of T.M. and that on October 31, 2013, T.M. tried to "come at" her as usual. However, White's testimony describing appellant's actions as redirecting T.M. to sit down to avoid an attack, and touching T.M. on the shoulder, is incomplete at best. This testimony is inconsistent with the surveillance video that clearly shows appellant engaging in other

acts such as pushing T.M. several times, down and over the arm of a chair, and pushing her backwards and causing T.M. to fall onto to the floor. Thus, it would appear that White did not fully witness the entirety of the incident or is attempting to minimize appellant's actions. For these reasons, I find this portion of White's testimony unreliable and not credible.

As to Mark Woods, I accept as credible his testimony regarding his efforts to work with T.M. and his inability to find a solution to her behavioral issues. However, based on a review of the video, his opinion that appellant's actions towards T.M. were not inconsistent with her training is not reasonable. Moreover, as this testimony conflicts with that of Engstrom and her conclusion that appellant's acts were violative of her training and various Ancora policies and procedures, I accept Woods' testimony as less credible than Engstrom's. Finally, as Woods is currently facing disciplinary action by respondent, it appears that his testimony is biased and/or motivated by other factors.

Finally, as to appellant, I do not accept her testimony regarding her actions towards T.M., or her attempts to justify same, as credible. Appellant contends that she acted to prevent an attack on White. In support of this contention, appellant claims that throughout the incident, T.M. repeatedly yelled that she was going to "get" White. This testimony is unsupported by any other evidence in the record, including the testimony of White, the intended target of the alleged "attack" and the only individual called to testify who witnessed the October 31 incident. While White confirmed that T.M. tried to "come at" her as usual, she provided no details regarding T.M.'s actions. Moreover, White gave no testimony regarding any statements made by T.M., let alone that T.M. yelled repeated threats to "get her." It belies reason that if T.M. had yelled repeated threats at her, White would fail to testify to same.

Further, even if appellant believed that T.M. was targeting and threatening White, a review of the video and appellant's testimony confirms that there was no imminent ability for T.M. to "get" White or to act in her usual manner of chasing, hair pulling, falling, or putting her weight on White. Throughout the incident, White was seated behind a table on the right side of the dayroom, which was out of view of the surveillance camera. During most of the incident, T.M. was located several, if not more, feet away from White. On the

occasions when T.M. approached the area where White was located, she was separated from White by the "wide" table, as described by appellant, at which White was seated. Finally, there was nothing preventing White from getting up and leaving the table if necessary to avoid an "attack" upon her. Thus, appellant's testimony does not "hang together" or ring true.

Appellant's additional claims that T.M. fell as a result of tripping on the feet of another patient are equally lacking in credibility. As an initial matter, there is no evidence in the record to support this claim, as neither T.M.'s feet nor the feet of the patient seated next to her are captured on the surveillance video. Moreover, this claim completely ignores the fact that appellant pushed T.M. backwards several feet towards the area where the other patient was seated. As appellant was pushing T.M. backwards she fell to the floor. Thus, but for appellant pushing T.M., she would not have fallen.

Appellant further claims that she left T.M. on the ground and did not attempt to assist her because, in her experience, this was when T.M. would attempt to pull hair or spit. This claim is also not credible, as it is internally inconsistent with appellant's testimony that she was not a target of T.M.'s attacks. In fact, this was one of the reasons appellant gave as to why she volunteered to serve as T.M.'s one-to-one on the date of the incident.

Finally, appellant's testimony that she kept the cup in her hand and drank/ate from it throughout the incident because she is severely anemic and needed to stay hydrated and because she was trying to act normal and not agitate T.M., is not credible. There is no evidence in the record to support appellant's testimony regarding her claimed medical condition. Moreover, the suggestion that the cup in appellant's hand was a signal to T.M. that everything was normal (a point also argued by petitioner's counsel) simply makes no sense.

Thus, for the reasons set forth above, I do not accept appellant's testimony as credible.

The Video

Having had an opportunity to review the DVD of the surveillance video of the October 31, 2013, incident (R-17) during and after the hearing, at both regular and slow speeds, I **FIND** the following as **FACT**:

The relevant portion of the video, captured by camera eleven, begins at approximately 11:48:30. Appellant and T.M. appear on the right side of the screen. Using her right arm, appellant moves T.M. backwards several feet to the left side of the dayroom and directs her to a chair. Appellant stands in front of T.M. holding a cup in her left hand while T.M. is seated. As T.M. begins to get up, appellant pushes T.M. several times back into her chair. Appellant then walks away towards the right side of the dayroom. T.M. gets up and walks over to a row of seats in another area of the dayroom and sits next to another patient. T.M. begins touching the other patient. Her actions appear unwelcomed and bothersome to the other patient. At approximately 11:49:45 appellant approaches T.M., cup in hand, and directs her to another chair and walks away from T.M. towards the right side of the room. T.M. gets up and moves towards appellant.

At approximately 11:50:09 appellant begins to push T.M., with her extended right arm, backwards to the area where she had been seated (near the other patient). As she is being pushed backwards T.M. falls to the floor. While T.M. is on the floor, appellant turns and walks away towards the right side of the dayroom. Appellant takes a drink from her cup. At approximately 11:50:40, appellant walks back towards T.M. as she is getting herself up from the floor. Appellant gets a chair and places it at the end of the row of seats where T.M. was located. The chair is between T.M. and appellant. T.M. begins to move around the left side of the chair and appellant turns and walks away from her towards the tables on the right side of the room. T.M. then walks towards appellant.

At approximately 11:52:12, using her right arm, appellant pushes T.M. backwards to the chairs and then over the arm of the chair. T.M. lands sideways in the chair with her legs hanging over the arm. Appellant walks back towards the tables on the right side of the room. T.M. again begins to follow appellant. At approximately 11:52:48, appellant pushes T.M. backwards over the right arm of the chair and into the seat for a second time.

At approximately 11:53:29 appellant moves T.M. back to the chairs and pushes her over the arm of the chair for a third time. Thereafter, T.M. reaches toward appellant. Appellant gets a chair and places it between herself and T.M. Appellant repositions the chair several times to keep T.M. behind it. At approximately 11:54:39, another staff member enters the dayroom and T.M. turns towards him. He takes T.M. by the hands and begins to dance with her. At approximately 11:55:34, T.M., followed by appellant, walk towards the front of the dayroom and out of view of the camera.

Additional Findings of Fact

After having an opportunity to consider the testimony, observe the demeanor of the witnesses and assess their credibility, and review the documentary evidence, I **FIND** the following **ADDITONAL FACTS.**

Appellant was properly trained to perform her job duties as a human services assistant, including how to handle difficult patients.

T.M. was a very difficult patient. Her behavior was intrusive, aggressive, and at times, assaultive.

On the date of the October 31, 2013, incident, appellant volunteered to serve as T.M.'s "one-to-one." Appellant escorted T.M. from her court hearing and then brought her to the dayroom.

At no time during the incident did appellant notify the charge nurse of T.M.'s behavior or otherwise seek assistance.

Appellant did not complete an Unusual Incident Report documenting T.M.'s fall, nor did she report the fall to the charge nurse or other medical professional so that T.M. could be assessed for injury.

LEGAL ANALYSIS AND CONCLUSIONS

Appellant's rights and duties are governed by the Civil Service Act and accompanying regulations. A civil service employee who commits a wrongful act related to his or her employment, or provides other just cause, may be subject to major discipline. N.J.S.A. 11A:2-6 through 2-20; N.J.A.C. 4A:2-2.2, through 2.3. Major discipline includes removal, or fine, or suspension for more than five working days. N.J.A.C. 4A:2-2.2. Employees may be disciplined for insubordination, neglect of duty, conduct unbecoming a public employee, failure or inability to perform duties, and other sufficient cause, among other things. N.J.A.C. 4A:2-2.3.

The appointing authority has the burden of establishing the truth of the allegations by a 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). The evidence must "be such as to lead a reasonably cautious mind to the 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).

Conduct Unbecoming a Public Employee

The appellant is charged with "conduct unbecoming a public employee" in violation of 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, 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)).

Here, the surveillance video of the October 31, 2013, incident clearly shows appellant pushing T.M. several times back and into a chair in which she was seated. The video also shows appellant pushing T.M. several times over the arm of another chair and causing her to fall sideways into the seat with her legs over the chair arm. The video further shows appellant pushing T.M. backwards and causing her to fall onto the ground. After T.M. fell to the ground, appellant left her there. Without making any attempt to assist T.M., appellant then walked away from her. Throughout the incident, appellant continues to hold a cup in her hand and drink and/or eat from it. Additionally, appellant did not prepare a report of T.M.'s fall and did not otherwise advise the charge nurse or any other medical professional of the fall so that T.M. could be assessed for injuries. These actions and inactions of appellant towards T.M. are contrary to and offend publicly accepted standards of decency and good behavior.

Appellant's argument that T.M. was a difficult patient who displayed intrusive, aggressive, or even assaultive behavior does not in any way justify her actions. Similarly, appellant's claims that there was no treatment plan for T.M. and that in her opinion T.M.'s family was "heavily involved" in her treatment in no way justifies her actions. Ancora is a psychiatric hospital that cares for patients with mental-health issues. Regardless of T.M.'s behavior, she, along with all other patients, is entitled to be treated with dignity and respect, and to be free from abuse, neglect, or other mistreatment.

Accordingly, I **CONCLUDE** that the respondent has proven by a preponderance of the credible evidence that appellant's conduct towards patient T.M. constitutes conduct unbecoming a public employee in violation of N.J.A.C. 4A:2-2.3(a)(6).

Neglect of Duty

Appellant is also charged with neglect of duty, in violation of N.J.A.C. 4A:2-2.3(a)(7). "Neglect of duty" has been interpreted to mean that an employee "neglected to perform an act required by his or her job title or was negligent in its discharge." In re

Glenn, CSV 5072-07, Initial Decision (February 5, 2009), adopted, Civil Serv. Comm'n (March 27, 2009), http://njlaw.rutgers.edu/collections/oal/. The term "neglect" means a deviation from the normal standards of conduct. In re Kerlin, 151 N.J. Super. 179, 186 (App. Div. 1977). "Duty" means conformance to "the legal standard of reasonable conduct in the light of the apparent risk." Wytupeck v. Camden, 25 N.J. 450, 461 (1957) (citation omitted). Neglect of duty can arise from omitting to perform a required duty as well as from misconduct or misdoing. State v. Dunphy, 19 N.J. 531, 534 (1955). Neglect of duty does not require an intentional or willful act; however, there must be some evidence that the employee somehow breached a duty owed to the performance of the job. 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.

Here, appellant also failed to take appropriate action required of her position. After T.M. fell to the ground, appellant left her there and did nothing to assist her. Further, contrary to appellant's testimony, she made no attempt to approach T.M. to ensure that she was not injured. Rather, appellant turned her back and walked away from T.M., leaving her on the ground for several seconds while she attempted to get up on her own. Appellant did not complete an Unusual Incident Report documenting T.M.'s fall and did not notify the charge nurse or any other medical professional of the fall. In failing to notify anyone of T.M.'s fall, appellant prevented her from timely receiving medical assessment or assistance. These actions and inactions by appellant demonstrate a failure to perform her job duties. Finally, by continuing to hold the cup in her hand and drinking/eating from it throughout the incident, including at times when she was physically redirecting T.M., appellant demonstrate a failure to devote proper attention to her tasks.

Accordingly, I **CONCLUDE** that the respondent has proven by a preponderance of the credible evidence that appellant's conduct constitutes neglect of duty in violation of N.J.A.C. 4A:2-2.3(a)(7).

Other Sufficient Cause

Appellant is also charged with other sufficient cause in violation of N.J.A.C. 4A:2-2.3(a)(12). Other sufficient cause is an offense for conduct that violates the implicit

standards of good behavior that devolves upon one who stands in the public eye as an upholder of that which is morally and legally correct. In re MacDonald, Mercer Cty. Corr. Ctr., CSR 9803-13, Initial Decision (May 19, 2014), adopted, Civ. Serv. Comm'n (September 3, 2014), https://njlaw.rutgers.edu/collections/oal/.

Having concluded that appellant's actions constitute conduct unbecoming and neglect of duty, it is clear that her actions also constitute other sufficient cause. However, in addition to the above-referenced charges, appellant is also charged with violating provisions of the Department of Human Services Disciplinary Action Program, Administrative Order (A.O.) 4:08. Specifically, she is charged with violating sections: B-2.1, Neglect of duty, loafing, idleness or willful failure to devote attention to tasks which could result in danger to persons or property; C-3.1, Physical or mental abuse of a patient, resident or employee; C-5.1, Inappropriate physical contact or mistreatment of a patient, client, resident, or employee; and E-1.2, Violation of a rule, regulation, policy, procedure, order, or administrative decision.

Neglect of duty

Having concluded that appellant's actions constitute neglect of duty in violation of N.J.A.C. 4A:2-2.3(a)(7), I further **CONCLUDE** that her actions also constitute neglect of duty or willful failure to devote attention to tasks which could result in danger to persons or property, in violation of A.O. 4:08, B-2.1.

Physical or mental abuse of a patient

Administrative Order 4:08, Supplement 1, defines physical abuse as:

> A physical act directed at a service recipient by a DHS employee of a type that could tend to cause pain, injury, anguish, and/or suffering. Such acts include, but are not limited to, the service recipient being kicked, pinched, bitten, punched, slapped, hit, pushed, dragged, and/or struck with a thrown or held object.
>
> [R-3.]

Here, the surveillance video confirms that appellant pushed T.M. multiple times during the October 31 incident. Thus, for the reasons set forth above, I further **CONCLUDE** that appellant's actions also constitute physical abuse of a patient in violation of A.O. 4:08, C-1.3.

Inappropriate physical contact or mistreatment of a patient, client, resident, or employee

Having concluded that appellant's actions constitute physical abuse in violation of A.O. 4:08, C-1.3, I further **CONCLUDE** that her actions also constitute inappropriate physical contact or mistreatment in violation of A.O. 4:08, C-5.1.

Violation of a rule, regulation, policy procedure, order, or administrative decision

The FNDA provides in the incidents giving rise to the charges (the specifications) that appellant's actions constitute abuse and mistreatment and are in violation of Executive Policy Reporting and Investigating Allegations of Patient Abuse (R-13), Unusual Incidents (R-14), Ethical Interactions (R-15), Special Observations (J-2), and Environmental Monitoring (R-12).

For the reasons set forth above and having concluded that appellant's actions constitute conduct unbecoming, neglect of duty, and other sufficient cause, it is clear that her actions also violate Ancora policy and procedures concerning Unusual Incidents, Ethical Interactions, and Special Observations. However, the remaining two policies appear inapplicable in this instance. While appellant's actions clearly meet the definitions of abuse and neglect pursuant to the Executive Policy for Reporting and Investigating Allegations of Patient Abuse, it appears the purpose of this policy is to advise employees of their obligation to report abuse and neglect and to develop procedures for investigating reports of same. Respondent does not adequately address the issue of appellant's failure to report her own actions other than Engstrom's testimony that staff is required to report abuse. Thus, respondent has not sufficiently proved this aspect of the charge and/or it is inapplicable in this situation. Similarly, the Environmental Monitoring policy is a nursing-staff policy, the purpose of which appears to be the overall organization and cleanliness of the ward, thus it too appears inapplicable in this instance. The policy provides at

procedure #17 that the dayroom and dining areas are to remain clear of unused food and accumulated trash. In keeping with this objective, the policy provides that employees are to "refrain" from eating or consuming beverages in these areas. A reasonable interpretation of the policy is that it directs employees to avoid eating and drinking in the dayroom, rather than prohibits them from doing so. Thus, respondent has not proved this aspect of the charge and/or it is inapplicable in this instance.

As I have determined that appellant's conduct violated three of the five policies referenced in the specifications, I **CONCLUDE** that her actions also constitute a violation of a rule, regulation, policy, or procedure in violation of A.O. 4:08, E-1.2

Accordingly, I **CONCLUDE** that the respondent has proven by a preponderance of the credible evidence that appellant's conduct as set forth above constitutes other sufficient cause in violation of N.J.A.C. 4A:2-2.3(a)(12).

PENALTY

A civil service employee who commits a wrongful act related to his or her duties may be subject to major discipline. N.J.S.A. 11A:1-2(b), 11A:2-6, 11A:2-20; N.J.A.C. 4A:2-2.2, -2.3(a). This requires a de novo review of appellant's disciplinary action. In determining the appropriateness of a penalty, several factors must be considered, including the nature of the employee's offense, the concept of progressive discipline, and the employee's prior record. George v. N. Princeton Developmental Ctr., 96 N.J.A.R.2d (CSV) 463. Pursuant to West New York v. Bock, 38 N.J. 500, 523–24 (1962), concepts of progressive discipline involving penalties of increasing severity are used where appropriate. See also In re Parlo, 192 N.J. Super. 247 (App. Div. 1983).

However, "[p]rogressive discipline is not a necessary consideration when reviewing an agency head's choice of penalty when the misconduct is severe, when it is unbecoming to the employee's position or renders the employee unsuitable for continuation in the position . . . ." In re Herrmann, 192 N.J. 19, 33 (2007).

In an attempt to mitigate her conduct, appellant claims, among other things that, she acted to prevent an attack on another, additional training was needed, there was no treatment plan for T.M., and that management provided no assistance in dealing with T.M. For the reasons set forth herein, these claims are unpersuasive and do not warrant any mitigation of penalty.

Appellant's disciplinary history reflects only one prior discipline, a six-day suspension (a major discipline) in 2010. This discipline was based on appellant's conduct in leaving an assigned work area without permission and creating a danger to persons or property in violation of A.O. 4:08, A-12.1 (R-2.) Despite appellant's limited disciplinary history, the seriousness of the current charges warrants imposition of the penalty of removal. Ancora is a psychiatric hospital responsible for the care and treatment of mentally ill patients. As a human services assistant, appellant was required to treat all patients with dignity and respect and was prohibited from engaging in acts of abuse, neglect, or other mistreatment. Appellant's actions fell far short of her responsibilities and publicly accepted standards of decency. Thus, the penalty of removal, which is consistent with the table of offenses outlined in the Department of Human Services, Disciplinary Action Program, is warranted.

Accordingly, I **CONCLUDE** that removal is the appropriate penalty and should be affirmed.

ORDER

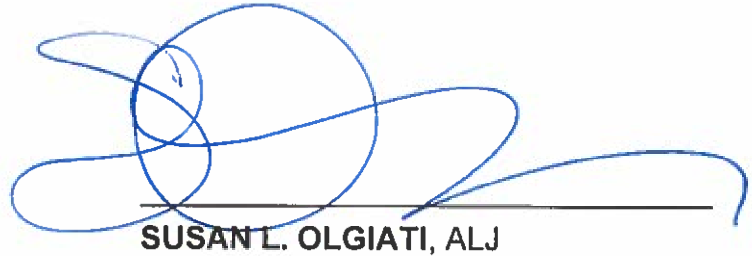
I hereby **ORDER** that the charges against appellant are **SUSTAINED**. I further **ORDER** that respondent's action removing appellant from her position of employment is **AFFIRMED** and appellant's appeal is hereby **DISMISSED**.

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.



January 30, 2020
DATE

SUSAN L. OLGIATI, ALJ

Date Received at Agency: 1-30-20

Date Mailed to Parties: 1-30-20

SLO

APPENDIX

LIST OF WITNESSES

For respondent:

Elisa Bouisseau

Michael Voll

Kathleen Engstrom

For appellant:

Tiffany McClinton

Tamia Caviness

Natasha Almon

April White

Estella Ramble

Sandra Dean

Mark Woods

Phyllis Davis

LIST OF EXHIBITS

Joint

J-1 Nursing Staff Assignment Sheet, October 31, 13 (formerly R-5)

J-2 Special Observation Policy (formerly R-11)

For respondent:

R-1 FNDA, November 14, 2014

R-2 Davis Disciplinary Action Appeal Settlement Agreement

R-3 DHS Disciplinary Action Program

R-4 Not admitted

R-5 Not admitted

R-6 Employee Interview, Bouisseau

R-7 Special Observation Monitoring Sheet

R-8 Not admitted

R-9 Employee Training History, Davis

R-10 Not admitted

R-11 Not admitted

R-12 Environmental Monitoring --Nursing Policy and Procedure

R-13 Reporting and Investigating Allegations of Patient Abuse and Professional Misconduct—Executive Policy and Procedure

R-14 Unusual Incidents–Reporting, Investigation and Follow-up

R-15 Ethical Interactions Patients & Staff Policy

R-16 Fall Management Policy

R-17 DVD of October 31, 2013 incident

For appellant:

P-1 Team Notes re: T.M., October 1, 2013-November 19, 2013

P-2 Unusual Incident Report Form No. 104, dated November 1, 2013

P-3 Treatment Plan for T.M., April 29, 2015