State of New Jersey

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FINAL DECISION
OAL DKT. NO. HSL 12401-13

AGENCY DKT. NO. DRA #13-018

C.N.,

Petitioner,

v.

Department of Human Services

Respondent.

A. INTRODUCTION

On August 15, 2013, the Department of Human Services (DHS) notified C.N. that her name would be placed on the Central Registry of Offenders against Individuals with Developmental Disabilities as a result of a substantiated act of neglect against a Division of Developmental Disabilities (DDD) service recipient. On August 29, 2013, the matter was received by the Office of Administrative Law as a contested case. A hearing was held on December 2, 2014. The record was closed upon receipt of written closing arguments on January 8, 2015. The Initial Decision was issued on February 23, 2015. Numerous extensions were necessitated due to long delays in obtaining the transcripts of the hearing so that exceptions and replies could be filed by the parties in response to the initial decision.

B. THE INITIAL DECISION

The Initial Decision was based upon the testimony of five witnesses; the Petitioner, herself, and four for the Respondent. The witnesses were examined by Erick Lucadamo, Deputy Attorney

General (DAG), for the Respondent, Michael L. Testa, Esquire (Esq.), for the petitioner, and the Administrative Law Judge (ALJ), Bruce M. Gorman.

The Department alleged that C.N. should be placed on the Central Registry due to neglect; citing that C.N. was a licensed Registered Nurse whose job was to allot and dispense medications to individuals with developmental disabilities who live in a group home, according to physicians' prescriptions. C.N. simultaneously administered multiple medications that were to be administered at three different and separate times to a vulnerable individual. The medications were all administered at dinner (approximately 5:00pm), rather than as prescribed, at 4:00pm, 8:00pm, and at bedtime. The medications given have serious or potentially serious side effects. C.N. failed to offer any medical assistance upon learning that the service recipient was experiencing physical distress symptoms. C.N. attempted to deter emergency medical personnel from taking the service recipient to the hospital for these symptoms. C.N. did not advise the emergency medical personnel that the medical records being sent along with the service recipient to the emergency room were not accurate. Further, C.N. falsely documented the administration of the medications in the Medication Administration Record (MAR) and misrepresented that she had medically assessed the individual.

The ALJ did not present a structured list of facts that he found to be true. The findings centered on whether or not two pills were given to the service recipient; "one pill in applesauce and a second in pudding." The initial decision found that there was not enough evidence to conclude a pill was served in applesauce. The ALJ found that the service recipient suffered no harm and that if a second pill had been administered, there was no showing of the service recipient's having been placed in harm's way. The ALJ concluded that there was no damage from an over-issuance of medication. The ALJ ordered the reversal and dismissal of the Department's actions.

C. EXCEPTIONS

Exceptions to the Initial Decision were received. The DAG, representing DHS, argued that the initial decision was faulty because the initial decision erred in reasoning that the actual presence of harm is a necessary element to placing a caretaker on the Central Registry. The exceptions argued that courts have found failure to maintain true patient records is reckless endangerment of patients

The Respondent's response argued that the initial decision should be upheld. The Respondent argued that the Department failed to show that C.N. falsified medical records, administered afternoon medications and evening records together, C.N. was not responsive in aiding the service recipient, and did not update the responding Emergency Medical Technicians (EMTs) to the actual medications ingested.

D. FINAL DECISION

The Initial Decision must be rejected and modified due an error of law. The error of law mandates the reconsideration of the entire record of testimony recorded in the transcripts, evidential documents, and exceptions. The Initial Decision does not properly apply the correct law – the Central Registry of Offenders against Individuals with Developmental Disabilities (N.J.S.A. 30:6D-73 et seq. and its attendant regulations N.J.A.C. 10:44D). The DHS review of the entire record reveals baffling conclusions based on evidence that was inconsequential to the placement of C.N. on the Central Registry. The Initial Decision in this case is arbitrary and capricious and must be rejected and modified.

The only question to be decided at the hearing was whether or not the Respondent, C.N., had been correctly placed on the Central Registry of Offenders against Individuals with Developmental Disabilities. Although the initial decision cites the correct statutes and regulations (N.J.S.A. 30:6D-73 et seq. and N.J.A.C. 10:44D), the application is faulty. The initial decision ignores that the weight of the evidence at trial proves the reasons the Department initially cited for substantiating neglect, improperly examines the level of neglect, and dismisses the Legislature's definition of neglect by seeming to require an actual physical harm – when only the potential for harm is necessary.

DHS substantiated neglect of a service recipient by C.N. following investigations by the agency that administers the service recipient's group home and the Department's Office of Investigations (OI). By a preponderance of the evidence, the investigations showed that C.N. had neglected the service recipient; as defined by the Legislature at N.J.S.A. 30:6D-74.

> '"Neglect" shall consist of any of the following acts by a caregiver on an individual with a developmental disability: willfully failing to provide proper and sufficient food, clothing, maintenance, medical care, or a clean and proper home; or failure to do or permit to be done any act necessary for the well-being of an individual with a developmental disability.'

C.N. willfully failed to provide proper and sufficient medical care to an individual with a developmental disability and failed in her duty to provide proper medication.

C.N.'s testimony at the hearing was that "she prepared the medication in advance by taking the pills out of the blister packs and marking the medication book" (ID. page 11). Preparing medicines more than an hour before they are administered is against the Elwyn Medical Administration Policy (ID, page 8 and Respondent's Exhibit 7). The pills to be administered at 8:00pm had already been removed from their packaging and marked as having been given to the service recipient during dinner time. The service recipient was taken by ambulance to the hospital at 6:30pm.

The initial decision documented that at least some of the pills were given to the service recipient in chocolate pudding (Testimony of Cruz ID, page 3, Tomko ID page 5, and C.N. ID, page11). All of the medications listed for the service recipient are listed to be given "by mouth" (Respondent's Exhibit 2). Further, the Elwyn Medical Administration Policy (ID, page 8 and Respondent's Exhibit 7, page 5) states, "Tablets may **not** be crushed into and/or given with applesauce or pudding **without** a written authorization from the physician **only**" (Boldface type

is in the original). The medication administration records for the service recipient specify "by mouth" and do not mention a physician's authorization for an alternate administration.

After dinner, the service recipient was showered, put in her bed clothes and began watching television. At approximately 6:00pm the service recipient leaned forward in her chair and became unresponsive (Cruz ID, page5). Tomko also testified that the service recipient "was not acting right. She was lethargic" (Transcript, page 57). According to Tomko; she, Cruz, and a third staff member, found the service recipient to be in an altered state (ID, page5). Tomko testified that Cruz tried to locate the petitioner to attend to the service recipient, but was unable to do so; Cruz called 911. When the EMTs arrived, at approximately 6:30pm, and began to load the service recipient onto a stretcher, C.N. came into the room. C.N. did not assist the EMTs or confer with them, despite being a Registered Nurse assigned to care for the individual. The EMTs were given the service recipient's medical records and C.N. never stated to the EMTs that the record of the medicines administered was not accurate. The importance of those medical records was noted during the testimony of Veronica Trio, EMT, when she stated that in reading the records on the way to the hospital, she noticed that the medications seemed to have been administered early (Transcript, page 76). Tomko stated that C.N. never provided any treatment to the service recipient at the time she was with the EMTs (Transcript, page 60).

DHS correctly and by a preponderance of the evidence, substantiated that C.N. was neglectful when she consciously failed to provide proper and sufficient medical care to an individual with a developmental disability. C.N. failed in her duty to provide proper medical care to the service recipient. C.N. did not administer medications properly.

The ALJ did not issue a conclusion on what medications the service recipient did or did not receive, only that there was no pill in an apple sauce serving. The log filled out and initialed by C.N. is completely false. The log shows that all medications were administered at the prescribed times. The service recipient could not have been dosed and the drugs should not have even been removed from their packaging as the log purports to show, because the service recipient was on her way to the emergency room at 6:30pm (or earlier).

C.N. failed in an ordinary level of care as described in the Elwyn Medical Administration Policy in how and when she administered medications. When the service recipient became unresponsive, Cruz had to get two other staff members to help her place the service recipient into a bed. Unable to find the petitioner, Cruz called 911. C.N. appeared in the room as EMTs were placing the service recipient on a stretcher and gathering the medication log for the trip to the emergency room of the hospital. C.N. did not tend to the service recipient, did not speak to the EMTs, and did not mention that the medication log was falsely filled in. C.N. neglected the service recipient by withholding proper medical care for her, as described at N.J.S.A. 30:6D-74.

DHS correctly and by a preponderance of the evidence, determined that C.N.'s neglect of an individual with developmental disabilities was reckless or grossly negligent, as defined by N.J.A.C. 10: 44D-4.1(c):

(c) In the case of a substantiated incident of neglect, it shall be determined if the caregiver acted with gross negligence, recklessness or evidenced a pattern of behavior that caused harm to an individual with a developmental disability or placed that individual in harm's way.
1. Acting with gross negligence is a conscious, voluntary act or omission in reckless disregard of a duty and of the consequences to another party.
2. Acting with recklessness is the creation of a substantial and unjustifiable risk of harm to others by a conscious disregard for that risk.
3. A pattern of behavior is a repeated set of similar wrongful acts.

C.N.'s actions, as described at the hearing, displayed a total disregard for the medical well-being of the service recipient. As a licensed Registered Nurse, C.N. was the one person on the shift allowed to administer medications to the extremely medically involved residents of the group home. She completely ignored the minimum level of care for preparing, timing, and administering drugs as described in the Elwyn Medical Administration Policy.

C.N.'s own testimony recounts her recklessness with drugs from the beginning of the shift until the service recipient is taken to the hospital. The first pill C.N. tried to administer was spit out. C.N. never changed the log to reflect that it was not ingested. She administered another pill at some later time that was not recorded in the log. The pill was placed in chocolate pudding – a technique that was not approved. C.N. removed pills from their packaging well ahead of the time that they should have been. C.N. testified that this was to make her duties easier, even though it is against Elwyn's policy. C.N. testified that this practice of setting out medications ahead of time was a normal practice of hers. When C.N. was brought to the room where the service recipient had become unresponsive or lethargic to such an extent that 911 had been called, she did not even attempt to assist the EMTs on the scene. C.N. did not confer with the EMTs and did not ever mention to anyone, before the hearing, that the drug administration log was false, but that she thought she could correct it in a few days. C.N. states that she threw away pills that were not administered, but did not ever document their disposal. Pills were administered by C.N. in chocolate pudding, as acknowledged by the testimony of all three staff members, none of the administered pills were properly recorded or documented; even after the hearing, there was no conclusion or finding of what pills were actually ingested.

The Elwyn Medical Administration Policy sets the minimum level of care that should be expected from someone administering drugs to medically fragile individuals. C.N.'s removing of medications from their packaging and setting them aside for dispensing later creates a whole host of unnecessary dangers – contamination, being given to the wrong client, misidentification of similar looking pills, as well as removal by staff or residents that might be intentional or inadvertent. A Registered Nurse should be aware of these dangers and by ignoring the dangers, C.N.'s actions are reckless. Not properly documenting the actual administration of the drugs creates a wholly unacceptable level of risk to the person served.

The medically involved residents are on a myriad of medications. The service recipient affected in this case was on a total of ten different medications. By not administering these doses at the proper, prescribed times, there is the threat of creating hazardously high or low amounts in the blood stream or inter-actions between drugs that should not be taken together. The service

recipient was unnecessarily exposed to danger when C.N. allowed the EMTs to take the victim to the hospital without correcting the log as to what drugs were actually in the patient's system or even advising or consulting with the EMTs as the resident was taken out on a stretcher. C.N. is not an ordinary staff member; she is a Registered Nurse. She was hired because of her training and licensure. She was the only person in the residence who was allowed to administer medications. Her actions display a wanton disregard for even minimal standards of patient safety. She ignored the unnecessary risks that she imposed on the residents. Her actions display a careless indifference to her duty to provide competent medical care. C.N. acted in a wonton, reckless, and grossly negligent manner. She was correctly placed on the Central Registry.

The initial decision incorrectly attempts to find a meaning for harm in N.J.A.C. 10: 44D-4.1(c) (quoted above), by stating "courts typically consider whether someone has suffered harm they consider the physical trauma that is sustained." The harm contemplated in that citation is neglect of an individual with developmental disabilities. It is the neglect defined by the Legislature at N.J.S.A. 30:6D-74 (quoted above). As shown above, C.N. neglected the service recipient by failing to provide proper medical care which C.N. had a duty to provide. The physical trauma type of harm is found in the Legislature's definition of physical abuse –

> '"Physical abuse" means a physical act directed at an individual with a developmental disability by a caregiver of a type that causes one or more of the following: pain, injury, anguish, or suffering" (N.J.S.A. 30:6D-74).

C.N. was not substantiated with having committed abuse, but with neglect. Further, the three cases cited in the initial decision (In re Manla, 2014 N.J. Super. Unpub. LEXIS 957, 4 (App. Div. 2014), Easely v. Woodbine Developmental Agency, 1998 N.J. AGEN LEXIS 41,7 (1998), and In the Matter of Daniel Wilkinson, Ancora Psychiatric Hospital, 2011 N.J. CDC Lexis 1365, 54 (2011)), are sounded in acts of physical abuse rather than of neglect. C.N. was substantiated for medically neglecting a person served and the level of the neglect met the prescribed degree of wanton, grossly negligent, and reckless behavior. The harm sounds in negligence – the potential for risk which a prudent person would seek to avoid – not in physical trauma.

The case that is most on point to show that the courts consider the deliberate falsification of medical records as reckless and grossly negligent, was suggested by the Respondent in the exceptions filed. The quote below shows that such an act is a breach of duty sufficient to uphold the revocation of a doctor's license.

> "We are persuaded that a physician's duty to a patient cannot but encompass his affirmative obligation to maintain the integrity, accuracy, truth and reliability of the patient's medical record. His obligation in this regard is no less compelling than his duties respecting diagnosis and treatment of the patient since the medical community must, of necessity, be able to rely on those records in the continuing and future care of that patient. Obviously, the rendering of that care is prejudiced by anything in those records which is false, misleading or inaccurate. We hold, therefore, that a deliberate falsification by a physician of his patient's medical record, particularly when the reason therefor is to

protect his own interests at the expense of his patient's, must be regarded as gross malpractice endangering the health or life of his patient." (In re Jascalevich, 182 N.J. Super. 455, 471-472 (App.Div. 1982))

The response of the Petitioner to the Respondent's exceptions is insufficient to overcome a correct application of the proper legal standards that would require an affirmation of the initial decision. The falsification of medical records, improperly preparing medications in advance, failure to document dosages and times is, in fact and at law, negligent. The wanton disregard for any proper documentation and the emphasis on ease of administration over patient safety is reckless. The hearing failed to show when or what drugs were administered by C.N. due to the careless disregard that C.N. paid to the integrity of the medical records. The allegation that C.N. was not available when the service recipient became unresponsive is not a part of the consideration of this Final Agency Decision' and is inconsequential in the determination of C.N.'s reckless medical neglect of the service recipient, manifested by her other actions. As argued above, C.N.'s failure to inform the EMTs about the resident's actual drug intake was, in fact, negligent. The hearing has brought forth a preponderance of evidence that, when applied to the correct legal definitions, demonstrate that C.N. was wantonly negligent in her failure to provide the medical attention it was her duty to provide in order to protect an individual from the potential of danger.

STATEMENT OF APPLICABLE LAW

The Legislature, for the purpose of the Central Registry, defined neglect as, "any of the following acts by a caregiver on an individual with a developmental disability: willfully failing to provide proper and sufficient food, clothing, maintenance, medical care, or a clean and proper home; or failure to do or permit to be done any act necessary for the well-being of an individual with a developmental disability" (N.J.S.A. 30:6D-74). Neglect allegations are investigated by an organization that reports outside of the Developmental Center –the Office of Investigations – in order to avoid conflicts. If the investigation finds, by a preponderance of the evidence, that neglect is substantiated; the case is reviewed for the presence of "gross negligence, recklessness, or a pattern of behavior that causes or potentially causes harm to an individual with a developmental disability." N.J.S.A. 30:6D-77 b.2. If the investigating unit believes that one of those elements is present, the case is forwarded to a designee of the Commissioner. The Commissioner's designee will review the case de novo to confirm or deny that there is preponderance of evidence to verify that an act of neglect occurred that involved recklessness, gross negligence, or as part of a pattern of behavior. If the Commissioner's designee confirms such a level of neglect, a notice of intent to place the offender on the Central Registry is sent to the offender, as well as a notice of appeal rights.

FINDINGS AND CONCLUSIONS OF LAW

I find from the evidence, testimony, and comments of the ALJ in the initial decision that by a preponderance of the evidence, C.N. was negligent. C.N. willfully failed to provide proper and

sufficient medical care to an individual with a developmental disability and failed in her duty to provide proper medication. C.N.'s acts were correctly substantiated as neglect under definitions contained in the Central Registry of Offenders against Individuals with Developmental Disabilities.

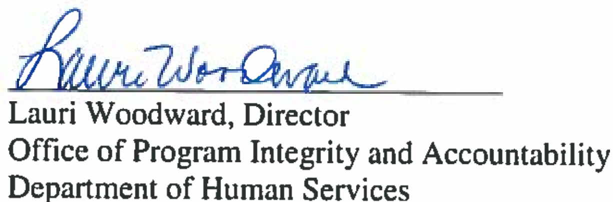
I find that in the evidence and testimony presented at the hearing and in the exceptions, there is a reasonable determination, by a preponderance of the evidence, that C.N. acted recklessly, grossly negligently, and wantonly as defined in the Central Registry regulations. She egregiously disregarded the minimal level of care that it was her duty to provide.

I therefore find and conclude that C.N. was properly placed on the Central Registry of Offenders against Individuals with Developmental Disabilities.

Careful consideration was given to the entirety of the Initial Decision of the Administrative Law Judge, as well as the entire record of testimony, evidential documents, the exceptions, and the petitioner's response. Because the ALJ had the opportunity to listen to the testimony and observe the demeanor of the witnesses, his findings concerning credibility were given proper deference. Because the initial decision contained errors of applicable law, the entire record was given a greater scrutiny. Upon review, several conclusions and determinations were found to lack a showing of support or reliability in proper application of the suitable law. The recommended decision of the ALJ is hereby **REJECTED and MODIFIED** by the Office of Program Integrity and Accountability.

I find that C.N. was grossly negligent in her provision of care to an individual with developmental disabilities. I further find that C.N. was properly placed on the Central Registry of Offenders against Individuals with Developmental Disabilities. Therefore, pursuant to N.J.A.C 1:1-18.6(b), it is the Final Decision of the Department of Human Services that C.N. shall be placed on the Central Registry of Offenders against Individuals with Developmental Disabilities.

Date: 11/20/15



Lauri Woodward, Director
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