State of New Jersey

CHRIS CHRISTIE
GOVERNOR

KIM GUADAGNO
LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
PO BOX 700
TRENTON, NJ 08625-0700

CAROLE JOHNSON
COMMISSIONER

REVISED FINAL DECISION
PURSUANT TO REMAND OF
SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-1841-15T2

C.N.,
Petitioner-Appellant
v.
Department of Human Services
Respondent-Respondent

A. INTRODUCTION

On August 15, 2013, the Department of Human Services 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. C.N. appealed the placement determination to the Department of Human Services (DHS), and the Department transmitted the matter to the Office of Administrative Law on August 29, 2013. The matter was received by the Office of Administrative Law and 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. A final agency decision was issued by the Department of Human Services (Department) on November 20, 2015. The final decision of the Department to place C.N. on the Central Registry was appealed to the Superior Court of New Jersey, Appellate Division. The court issued a reversal and remanded the matter back to the Department to make specific findings of fact and conclusions of law, supported by the record. Specifically, the Department must determine whether C.N. acted with gross negligence or recklessness under N.J.A.C. 10:44D-4.1 and whether the record supports a finding that her actions actually caused harm or created a potential for harm.

B. THE INITIAL DECISION

The Initial Decision was based upon the testimony of five witnesses; the Petitioner, herself, and four witnesses for the Respondent. The witnesses were examined by Erick Lucadamo, DAG, for the respondent, Michael L. Testa, Esq., for the petitioner, and the Administrative Law Judge (ALJ), Bruce M. Gorman. The transcript of the hearing on December 2, 2014, the discovery

material introduced at that trial, and the subsequent submissions of the parties to the ALJ are the basis for this Decision on remand.

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 lived in a group home, according to physicians' prescriptions. The medications that were to be precisely dispensed have serious or potentially serious side effects. Upon learning that her patient was experiencing physical distress symptoms, C.N. failed to offer any medical assistance. C.N. attempted to dissuade the staff of the home from having emergency medical personnel take the service recipient to the hospital for symptoms they had observed. 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 mentioned evidence as to how and whether pills were given to the service recipient. The initial decision found that there was conflicting evidence and did not issue a concrete finding of when any of the prescribed pills were actually ingested by the service recipient. The ALJ found that there was "no showing that S.K. suffered any harm 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 Deputy Attorney General (DAG), representing the Department of Human Services, 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 a reckless endangerment of patients; not alerting the Emergency Medical Technicians to the true dosages actually administered to C.N. was not only medically negligent, but reckless.

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 and evening medications together, that C.N. was not responsive in aiding the service recipient and that C.N. did not update the responding EMTs to the actual medications ingested.

D. ORIGINAL FINAL AGENCY DECISION

The original Final Agency Decision issued by DHS, in November 2015, argued that the Initial Decision improperly compared the evidence against the statutory and regulatory definitions of neglect (N.J.S.A. 30:6D-73 et seq. and N.J.A.C. 10:44D) to determine that neglect of an individual with developmental disabilities had been substantiated. Further, the Initial Decision had not used those definitions to properly examine the actual level of neglect. The Initial Decision seemed to require an actual showing of physical harm, rather than the statute's potential to cause harm. The original Final Agency Decision found that C.N. was grossly negligent in her provision of medical care to an individual with developmental disabilities and that C.N. was properly placed on the Central Registry of Offenders against Individuals with Developmental Disabilities.

E. APPELLATE DIVISION DECISION

The Appellate Division reversed and remanded the original Final Agency of the Department in an unpublished decision issued January 9, 2018. The court remanded the case for further proceedings stating that the Department failed to sufficiently explain its findings and, therefore, had acted arbitrarily and capriciously. The court asked that the Department make specific findings of fact and conclusions of law supported by the evidence in the record. Specifically, the court asked for a determination that C.N. had acted with gross negligence or recklessness and whether there was support in the record to show S.K. was actually harmed or placed in harm's way.

F. FINAL DECISION ON REMAND

The Initial Decision must be rejected and modified due to 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 Department of Human Services' review of the entire record reveals 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 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.

Placement of caregivers on the Central Registry should follow the Legislature's two-step protocol, by examining each step in order and determining the facts at each juncture and whether an appropriate conclusion has been reached by the requisite preponderance of the evidence standard. The first issue to be determined was whether C.N. had committed an act of neglect against an individual with developmental disabilities under her care; the incident must be investigated and substantiated by the Office of Investigation. The second issue was whether the act met the statutory and regulatory criteria for placement on the Central Registry, which, in the case of neglect, consists of "in the case of a substantiated incident of neglect, the caregiver shall have acted with gross negligence, recklessness, or in a pattern of behavior that causes or potentially causes harm to an individual with a developmental disability."[1]

ANALYSIS OF THE TESTIMONY AND EVIDENCE

Initial Decision did not render a structured finding of facts in the body of the text. The ALJ gave credit to C.N.'s testimony and noted that Tomko's testimony was reliable, even though there were points on which C.N.'s and Tomko's testimonies were in conflict. The Department has, therefore, relied primarily upon C.N.'s and Tomko's testimony in this current decision.

[1] N.J.S.A. 30:6D-77b(2)

The D'Ippolito group home is "more like a nursing home" with sixteen clients who are "mostly wheelchair bound, bedridden[2]." There is a nurse assigned to the cottage at all times due to the intense medical involvement of its residents. In addition to the group home counselors, who are responsible for the feeding, bathing, moving, and clothing of clients, there is a licensed nurse scheduled during every shift at the residence – 24 hours a day. The nurse is the only person permitted to administer medications in the D'Ippolito group home[3].

C.N. is a licensed Registered Nurse. She was the nurse on duty at the time of the incident in question. As the one person responsible for the medications in the group home, her testimony concerning its administration was studied particularly carefully for this review. C.N.'s medical training and credentials were introduced and detailed by her attorney.

Upon being sworn in, C.N.'s attorney established C.N.'s credentials as a nurse. C.N. received a Bachelor of Science in business management from New Jersey City University in Jersey City. She attended Seton Hall University and received a BSN degree in 2004. C.N. passed her licensing exam and began working as a Registered Nurse in 2004. She worked at a number of hospitals and went into psychiatric nursing working with developmentally disabled individuals at Ancora Psychiatric Hospital, Vineland Developmental Center, and Elwyn (operator of the D'Ippolito group home).[4] C.N. had worked in the D'Ippolito group home occasionally and was familiar with its staff and clients. She was familiar with S.K.'s previous hospitalization.[5] C.N. was instructed to pay extra attention to S.K. because she was a "very big fall risk."[6]

C.N. acknowledged having been advised, at the beginning of her shift, about the medical histories of S.K.'s earlier admissions to the hospital. S.K. was admitted to the hospital on October 15, 2012 suffering from ambulatory dysfunction that was attributed to sub-therapeutic Dilantin levels. At the hospital, her Dilantin dose was increased and she was discharged on October 18, 2012. In addition, on October 19, S.K had been sent to the hospital because she had fallen in the bathroom and required stitches to her head.

Upon coming to work on October 20, C.N. was struck by the sight of S.K. sitting slumped in a wheelchair – "Slumped over and quiet, not the way she usually sits."[7] C.N. consulted with the outgoing nurse and learned that the day before S.K. had fallen in the bathroom, been taken to the hospital, and received stitches to her head before being returned to the residence. The outgoing nurse showed C.N. the statement from the hospital[8]. The outgoing nurse told C.N. that S.K. had slept all through the previous shift and had been put in a wheelchair because her gait was unsteady; S.K. was weak and lethargic.

Recognizing S.K.'s special condition, C.N. testified that she took S.K. to the nurses' station/ medication room and examined her physically. C.N. gave S.K. her 4:00 medication – one, 100 mg pill of Dilantin. S.K. spit the pill onto the floor. C.N. picked up the pill and threw it in the garbage.[9] C.N. did not remove another pill from the blister pack. C.N. made no attempt to re-

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[2] Cruz 10:15-17
[3] Ibid. 11:22-13:17.
[4] C.N. T145:10-149:13
[5] Ibid. 153:15- 154:14
[6] Ibid. 161:25 -162:2
[7] Ibid. 155:9-157:15
[8] Ibid. 164:9-15
[9] Ibid. 168:1-21

administer the prescribed dosage, nor did she correct the MAR or the blister pack to document the missed dosage. In fact, C.N. recorded on the MAR. that she successfully administered the 4:00 p.m. dosage.[10] C.N. stated that she then moved S.K.'s wheelchair out of the nurses' station to a point where she could be monitored visually. C.N. went on to administer medications to the other 15 residents of the house.

"During dinner around five, 5:30,"[11] C.N. testified that she noticed that S.K. was not eating and that was unusual for S.K. C.N. tried to feed S.K. – despite the fact that S.K. normally feeds herself and there was a counselor assigned to feed S.K. S.K. refused to eat. C.N. then stated that because S.K. was not eating, she "ran to the refrigerator in the kitchen…there wasn't any food in there. So I ran to the other kitchen" and grabbed three puddings – chocolate and tapioca. C.N. then ran back to the dining room and gave S.K. a tapioca pudding telling the counselor to make sure that S.K. eats it, "her medication depends on it." C.N. testified that there was no medication in the tapioca pudding and that she meant, by that statement, that S.K. should not take medication on an empty stomach.[12] C.N. testified that she then "ran out to" take care of another resident whose gait was unsteady.

C.N. stated that after dinner, she asked that S.K. be left with her so that she could keep an eye on her, rather than being put in bed. Between 6:00 and 6:10, C.N. testified "she hasn't taken her 4:00 Dilantin and I know she's the seizure – seizure patient and she needs – she fell yesterday – the day before and she hasn't taken her Dilantin, the 4:00."[13] C.N. asked S.K. how she was; S.K. replied, "Hurt, hurt, hurt, Mommy. Hot, hot, hot." C.N. then "ran and got the other pudding" and put a Dilantin and a Tylenol in the pudding. C.N. states that she "gave" the pudding to S.K. and "ran" off to tend to another patient on "the other side" who was screaming.[14] There is no testimony that S.K. actually ingested the pills and it was C.N.[15] who testified that S.K. was not eating her dinner. C.N. stated that after tending to the screaming patient, she then went to the bathroom. There, she was later found by Tomko. C.N. says that from the bathroom, she then ran to S.K.'s bedroom.

At this point, where C.N. runs off leaving a pudding with drugs in it with S.K. to tend to a screaming client and go to the bathroom, C.N.'s testimony directly contradicts the testimony of three other witnesses: Cruz, Tomko, and Trio. C.N. said that she found S.K. alone in her bedroom and did a series of medical evaluations of S.K. C.N. said that she was present when the EMTs came into the bedroom, gave a report of S.K.'s vital signs to the EMTs (who responded, "You were right"), and that she helped load S.K. onto the stretcher.[16] Both Cruz and Tomko testified that C.N. did not appear in the bedroom until after the EMTs had entered. Trio, one of the EMTs, did not recall C.N., a person identifying herself as a nurse, or anyone else having offered any vital signs or medical readings to the EMTs. Cruz, Tomko, and Trio did not recall C.N. saying anything to the EMTs, only comments directed to the staff counselors about not needing 911, dehydration, or questioning why 911 had been called.

Linnerys Cruz, one of the group home counselors, testified that after dinner, she took S.K. from the dining room, gave her a shower, and dressed her in pajamas, and observed her in the living

[10] Ibid. 193:22-194:6
[11] Ibid. 171:3-7
[12] Ibid. 171:19-174:17
[13] Ibid. p. 176:10-176:14
[14] Ibid. 176:21-177:4
[15] Ibid. 171:22
[16] Ibid. 179:3-181:25

room watching TV. At around 6:00 pm, S.K. told Cruz, "It hurts;" at which time S.K. "just leaned forward in the chair and she stopped being responsive to us."[17] Cruz called out for C.N., the nurse on duty, and other staff tried to locate the nurse. Unable to locate the nurse and S.K. still unresponsive, Cruz "ran to the closest phone and called 911"[18]. Three of the staff then took S.K. to her bedroom and put on her pants and shoes for a trip to the hospital. Cruz testified that the EMTs arrived in S.K.'s bedroom, and had placed her on a stretcher, at the time that C.N. first appeared. C.N. said to Cruz, "She was fine. Why did you call 911?" Cruz did not see C.N. speak to the EMTs or provide any medical treatment to S.K.[19] Cruz accompanied S.K. in the ambulance to the hospital, after retrieving the MAR book from the nurses' office.[20]

Joyce Tomko, another group home counselor on duty at the time of the incident, testified that counselors do not administer medications to the residents of D'Ippolito (there is either an RN or an LPN present full time to administer medications). Tomko testified that after dinner service, "S.K. became very tired, kind of like not responding to any of us, not wanting to move or do anything."[21] Tomko testified to being called over to observe S.K. "because she was not – S.K. was not acting right."[22] Tomko assisted in placing S.K. onto her bed so that her clothes could be changed. Tomko stated that Cruz "wanted to call 911, because she (S.K.) was not acting right. She was lethargic."[23] Tomko left the bedroom to locate C.N. and found her in the bathroom of the locker room, as the EMTs were headed to S.K.'s bedroom (according to Tomko, at about 5:45 to 6:00pm). Tomko watched as the EMTs "did her (S.K.'s) vitals and loaded her up on the stretcher and took her to the hospital."[24] Tomko did not see C.N. provide any medical treatment to S.K. at that time; she only recalled C.N. commenting that S.K. might be dehydrated.[25]

Veronica Trio testified that she was one of the responding Emergency Medical Technicians to respond to the D'Ippolito group home (at "around six, maybe a little after"). Trio testified that she had been called "for a patient who was possibly unresponsive[26]," the staff having found the patient "unresponsive to them more than normal.[27]" The staff could not locate the nurse and had called 911. Trio found S.K. to be conscious – responding with "What," when Trio called her name – "but she was lethargic.[28]" S.K.'s vitals were taken, she was given oxygen, and she was taken to the hospital. In the ambulance, Trio reviewed the MAR book and it appeared that the 8:00 p.m. medications and the bedtime medications had already been initialed as having been administered.[29] The ALJ inquired of Trio why S.K. had been taken to the hospital since her vitals were within normal ranges. Trio, who had worked at D'Ippolito prior to becoming an EMT and was familiar with its population, responded "Because the staff said that she was not her normal self, she appeared lethargic to me and I thought she should be checked out to make sure everything was okay."[30]

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[17] Cruz 19:8-21:17
[18] Ibid. 20:7
[19] Ibid. 23:16-25:18
[20] Ibid. 25:18-26:20
[21] Tomko T56:18-20
[22] Ibid. 57:2-7
[23] Ibid. 57:8-20
[24] Ibid. 59:9-60:18
[25] Ibid. 60:19-22
[26] Trio T73:15-16
[27] Ibid. 73:16-18
[28] Ibid. 73:21-23
[29] Ibid. 76:12-77:15
[30] Ibid. 92:2-7

At the hospital, an attending physician described S.K.'s October 20, 2012 admission to the hospital: "the day prior to admission, all the patient wanted to do was sleep but the ambulance was called when she became 'unresponsive' according to the nurse at the group home."[31] "Ultimately the patient's mental status changes were attributed to her medications which were adjusted."[32] Exhibit P-3 shows 500 mg of Dilantin-Phenytoin being administered to S.K. at 9:33 p.m., on October 20, 2012. These Exhibits were introduced into the official record of the hearing, and cited in the Initial Decision.

C.N. was asked to explain the admissions records of S.K.'s hospital stay beginning on October 20, in laymen's terms. In describing "suffering from ambulatory dysfunction," C.N. stated, "...Her gait was weak and she was weak and lethargic ... that means her balance are not right (sic), because at any time she will fall or she's—a little confused."[33] Explaining a sub-therapeutic Dilantin level, C.N. explained, "That's happened with Dilantin. When Dilantin level is low and patient tend to be confused. They have so – so many kind of problems and being that she has schizophrenia and depressed and dementia, mental retardation and she has osteoporosis and kyphosis is because her bones are like – brittle."[34] C.N. explained osteoporosis as the bones being soft, sometimes it is an inherited condition and sometimes it is brought on by the medications taken for other issues such as mental retardation (sic) and seizures – "because of so many medications they are taking."[35] C.N. explained kyphosis in laymen's term as hunchback, which can make one prone to fall by losing one's balance and falling.

C.N. described Dilantin as an anti-seizure medication. She noted that S.K. had a lot of seizure medication, but Dilantin was the main one.[36] When asked to explain the Dilantin given to S.K. upon admission to the hospital at 9:33 p.m. on October 20, 2012, C.N. explained that the dosage of 500 milligrams was five times greater than the usual, single dosage given several times a day in the group home. Also, the hospital administered the drug intravenously rather than orally in order to get into S.K.'s system more rapidly[37].

During her testimony, C.N. stressed the importance of Dilantin to S.K. C.N. stated, "Because Dilantin is the main medication that she needs, because when Dilantin level goes down it can cause so many problems for her. So that's why I was particular for her to get her Dilantin level – Dilantin – if you see on the report in the hospital you will see as she came in when – when they did their – their - the blood test and everything, toxicology, they saw that the – it was so low. That's why they have to give the I.V. quick."[38]

FINDINGS FROM THE RECORD

The ALJ wrote in the Initial Decision that, "There is no proof by a preponderance of the evidence that S.K. was given two pills.[39]" The ALJ further added, "There is no proof of any kind that if, in fact, S.K. was given two pills, that the two pills could have placed S.K. in harm's way." The record is replete with evidence and repeated testimony about the harmful effects to S.K. when she does not get her proper dosage of Dilantin. C.N., a licensed Registered Nurse,

[31] Exhibit P-2, p 1
[32] Exhibit P-2, p 2
[33] C.N. T158:1-6
[34] Ibid. 158:16-23
[35] Ibid 159:18-24
[36] Ibid. 160:9-21
[37] Ibid. 162:11-163:17
[38] Ibid. 185:16-24
[39] Initial Decision pp.15-16

discussed the importance of Dilantin to S.K. The Initial Decision focused on the possibility of an overdose of Dilantin and overlooked that the substantiation of neglect was based upon improper administration of medication. The evidence indicates that a reckless disregard for proper administration procedures led to an under dosage of medication, aggravated by improper medical records. The petitioner asked that hospital records be introduced concerning S.K.'s treatment for sub-therapeutic drug levels and had C.N. explain their meaning. Those exhibits were made part of the record by the ALJ. C.N. called Dilantin "the main medication she needs." C.N. cited lethargy, unsteady gait, and confusion as symptoms of insufficient Dilantin, which could lead to an increased risk of falling. The risk of S.K. falling would be exacerbated by brittle bones caused by other medications prescribed to S.K. C.N. testified that Dilantin is needed to prevent the risk of "major seizure."[40]

On October 20, 2012, C.N. met with the outgoing nurse before going on with her duties and reviewed S.K.'s recent hospital stays – October 15, 2012 until October 18, 2012, where S.K. in the week prior to admission "had been less responsive and increasingly unsteady in her gait and more and more confused"[41] was treated by having her seizure medication levels adjusted. C.N. knew that on October 19, 2012, S.K. had fallen in the bathroom and required stitches to her head. C.N. was familiar with S.K. from earlier shifts and immediately found her lethargy remarkable. As soon as C.N. entered the residence, C.N. resolved to make S.K. her "main person" throughout the shift, keeping her close to the nurses' station while she prepared and gave out medications.

C.N. popped all of S.K.'s medications, for 4:00 p.m., 8:00 p.m., and bedtime, out of their blister packs and initialed the MAR book as though they had been administered at their prescribed times. Removing medicines from their blister packs can only be done 30 minutes before or 30 minutes after the prescribed administration time (a one-hour window)[42]. As her "main person," C.N. chose S.K. as her first patient of the day and gave S.K. a Dilantin pill. S.K. spit the pill onto the floor. C.N. picked up the pill and put it in the garbage. While in the nurses' station, with all of the medications and records at her fingertips, C.N. failed to pop out another Dilantin pill and administer it to S.K. to maintain her prescribed dosage level. C.N. failed to mark the blister pack to account for the wasted pill and failed to edit the MAR book to document that the Dilantin had not been given at the prescribed time. Instead, C.N. moved S.K.'s wheelchair out of the nurses' station to a spot where she could be seen and proceeded to administer medications to the other 15 residents.

During dinner service, C.N. looked in on S.K. and noticed that she was not eating, which was very atypical for S.K. C.N. ran from one kitchen to another and grabbed up three puddings. She ran back and gave a tapioca pudding to the counselor to give to S.K., saying it is important for her medication – meaning, but not articulated to the counselor, that S.K. needs to eat before C.N. can give her medicine. C.N. ran off to tend to another individual, who was walking unsteadily. When C.N. returned, she put a Dilantin pill and a Tylenol in a chocolate pudding and "gave" it to C.N. (Medications are not to be mixed with foods without directions to do so from the prescribing physician; there were no such directions for S.K.).[43] Afterwards, C.N. ran off to another service recipient who was screaming. C.N. then went to the bathroom. There was no evidence that S.K. ingested the pudding or either of the pills C.N. left.

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[40] C.N. T185:16-186:13

[41] Exhibit P-2

[42] R-7 Elwyn N.J. Policy/Procedure Manual, Medication Procedure

[43] R-7 Elwyn N.J. Policy/Procedure Manual, Medication Procedure

S.K. was taken to her room and was changed into her pajamas, then moved to another room to watch TV. A group home counselor noticed that S.K. was slumping over in her wheelchair. S.K. was unresponsive to the counselor. The counselor called out for C.N. and when C.N. did not respond, asked other counselors to look for C.N. When C.N. could not be found, 911 was called to summon the EMT squad. S.K. was taken to her bedroom and had shoes and a pair of pants put on, in preparation for a trip to the hospital. Three witnesses testified that C.N. appeared in S.K.'s bedroom at the time the EMTs were placing S.K. onto a stretcher, to transport her to the hospital, at approximately 6:30 p.m. None of the three witnesses saw C.N. interact with the EMTs or S.K. C.N. did not give any medical information about S.K. to the EMTs. Whenever C.N. realized that the MAR book had been sent to the hospital with S.K., she did not mention any discrepancies to the EMTs, nor did she phone the hospital to inform them that all of the medication dosage information was inaccurate. S.K. had never received her 4:00 p.m. Dilantin pill, and there was no way to know if she had ingested any pudding, Tylenol, or Dilantin.

At the hospital, S.K. was tested and diagnosed with a deficiency of Dilantin in her system. At 8:30 p.m., S.K. was hooked up to an IV tube and was administered five times the dosage of the 4:00 p.m. pill, which was never administered - to bring her Dilantin levels back to normal.

ANALYSIS

The Office of Investigation correctly substantiated that C.N. had, by a preponderance of the evidence neglected S.K. C.N. failed to properly provide even a minimal level of medical treatment. C.N. never administered the prescribed 4:00 p.m. Dilantin dosage in a timely manner. The statute for the Central Registry provides that 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.[44]" C.N. willfully failed to provide proper and sufficient medical care to S.K., an individual with a developmental disability under her, sole, medical care. C.N. was versed, at the beginning of her shift of S.K.'s more fragile than usual condition.[45] C.N. was aware of the extreme importance of S.K.'s medications.[46] C.N.'s sole job on the shift was to properly administer medications and to record the dosing.[47] C.N. did not administer drugs to S.K. at the proper time, or at the proper dosage, in the approved method.[48] C.N. willfully failed to provide proper and sufficient medical care to S.K. The substantiation of medical neglect of S.K by C.N. is justified by a preponderance of the evidence. The first prong of the Central Registry analysis is met.

To be placed on the Central Registry for neglect, C.N.'s behavior must be shown to constitute gross negligence, recklessness, or part of a pattern of behavior that caused harm or placed an individual with developmental disabilities in harm's way.

The Elwyn Medication Manual contains descriptions of basic medical procedures to be followed by caregivers without specialized medical training or licensure who work in group homes with residents who have very few medical complications. The D'Ippolito group home houses extremely medically involved individuals. In recognition of that population, management

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[44] N.J.S.A. 30:6D-74 Definitions
[45] C.N. T164:9-15
[46] Ibid. 185:16-24
[47] Cruz T11:22-13:17
[48] Passim

schedules a licensed nurse during all 24 hours of the day to administer medications and tend to the medical needs of those residents – in addition to the group home counselors who bathe, feed, clothe, and transport the residents. The Medication Manual spells out the base line procedures that laymen should follow. The manual mandates that medications be prepared and administered 30 minutes before or after the prescribed dosage time. The MAR book is to be filled in and initialed when the medication is actually ingested. Medications are not to be placed in food without a physician's order to do so. C.N. is not a lay person. She is a licensed Registered Nurse. She was hired because of that professional status and was scheduled on that particular shift to perform in that professional capacity. C.N.'s failure to prepare the medications in a timely manner, faithfully document the dosages, as well as her placement of medications in food without a physician's order is grossly negligent. C.N. was hired to perform at a higher level of competence than the people the Medication Manual was written for, yet she failed in the first hour of her shift to meet its minimal standards in these three basic fields. Her failure to meet the very basic minimums, as described in the manual, represented gross negligence.

C.N. testified to having been familiar with S.K. from having worked with her before. As soon as she entered the home, C.N. says that she recognized how lethargic S.K. appeared; she was slumped in her wheelchair, unlike her earlier self. C.N. testified that she consulted with the outgoing nurse and was made aware that a week earlier S.K. had been admitted to the hospital because of being less responsive and having an unsteady gait. At the hospital, S.K. had her seizure medication levels adjusted to a point where she was more responsive and was discharged back to the home. The outgoing nurse informed C.N. that S.K. had fallen the day before and was taken to the hospital to get stitches in her head. C.N. testified to the court that low levels of Dilantin cause an unsteady gait, lethargy, weakness, confusion, and an unsure balance. C.N. testified that Dilantin was the main and most important medicine that S.K. was taking. She took it upon herself to make S.K. her "main person."

C.N. began her shift by examining S.K. and then preparing her medications. The one pill that was prescribed for S.K. at 4:00 p.m. was a 100 mg pill of Dilantin. Sitting at the medical cart, with the all of the medications, C.N. gave the pill to S.K. and S.K. spit it on the floor. C.N. then put the pill in the garbage. Rather than take another pill out of the blister pack, document the unused pill, and give S.K. her proper dose of Dilantin within the prescribed time, C.N. moved S.K. out of the nurses' station (albeit within eyesight) and proceeded to medicate the other 15 residents. Sometime during the dinner service, C.N. decided to give S.K. Dilantin. She removed the 8:00 p.m. pill from the cart and mixed it with pudding and a Tylenol. C.N. then gave the pudding to S.K., who she had previously noticed was not eating. C.N. immediately left to tend to another resident without ever knowing if the Dilantin was ingested.

Recklessness is defined as the creation of an unjustifiable risk of harm to others and a conscious disregard or indifference to that risk. C.N. was well aware of the risk that a low Dilantin level would present to S.K. C.N. very explicitly defined the risks presented by low Dilantin levels to the court. C.N. had been put on notice that only a few days prior, S.K. had been hospitalized to get her medications levels normalized and that only the day before, S.K. had fallen. C.N. was aware of the unjustified risk of not giving S.K. her prescribed dosage of Dilantin. C.N. consciously chose to ignore that risk by failing to administer another pill from its holder and administer it while S.K. was seated at her cart. She continued to ignore that risk of S.K.'s low Dilantin level through dinner, when, finally, she may or may not have administered the 8:00 p.m. pill (popped out of its pack and initialed as administered, at 4:00 p.m.). C.N.'s choice to ignore the risk of a low Dilantin level was reckless. That risk became manifest a few hours later, when S.K. found herself receiving a large IV Dilantin dosage in the hospital.

LEGAL PRECEDENT

A New Jersey Supreme Court case (G.S. v. Department of Human Services, 157 N.J. 161) is illustrative of a caretaker's responsibility for administering medications in matters of neglect. A caretaker who was solely responsible for the administering of medication to children was given a bottle of medicine by another employee. When the time came to administer the medication, the caretaker was confused about the dosage. Without attempting to obtain clarification from the child's mother, the caretaker simply assumed that the entire bottle was a single dose and administered the entire bottle.

The Supreme Court reversed an appellate decision and ruled that the caretaker was guilty of neglect by administering an overdose of medication because she willfully and recklessly administered medication in contradiction to the facility's medication manual - without making any attempt to determine the correct dosage. The neglect standard in the statute required a finding of willful and wanton conduct, with reckless disregard for the consequences. The fact that there was no permanent injury was held irrelevant to the findings in the case. The decision did not cite any expert medical testimony, stating that, "Intelligent adults understand the grave dangers associated with prescription medication."[49] The Supreme Court ruled that the caretaker acted with reckless disregard for the probable consequences of her actions. By taking no action to clarify the dosage, the caretaker failed to exercise even a minimum degree of care toward the child. Those facts were sufficient to hold her liable for neglect under the Child Abuse Registry (CAR) statute N.J.S.A. 9:6-8.21(c)(4)(b) – a statute upon which the Central Registry was based.

In the CAR case, the medication procedure, as spelled out in the facility's medication manual, was that prior to the administration of the medication, the caretaker was to "check the bottle for the correct child's name, correct medication, correct dosage, correct time, and correct method." The caretaker did not attempt to obtain clarification from the child's mother or from any other source about the dosage that she administered. The caretaker in this case was not a medically trained professional.

In this Central Registry case, C.N. ignored the Elwyn Medication Manual's guidelines and failed to properly administer the prescribed dosages of Dilantin to S.K.; popping out dosages before their prescribed times, not re-administering a spit out pill, and placing medications in food without a doctor's order, as well as leaving that food with a patient who was refusing to eat.

In the CAR case, the Supreme Court concluded that there was sufficient evidence to support a finding of neglect. The caretaker's conduct indisputably demonstrated a failure to exercise a minimum degree of care. She did nothing to ensure that she was administering the correct dosage. The court also found that conduct rose to the level of wanton or willful neglect. Intelligent adults understand the grave dangers associated with prescription medication. As a medication administrator, the caretaker should have been particularly sensitive to the consequences that could result from over-medication. Even though she did not intend harm to befall the patient, she disregarded the substantial probability that harm would result from her actions.

Comparing the actions of C.N. to the Supreme Court case, C.N. also acted wantonly, recklessly, and with gross negligence. C.N. recounted to the court the extra care that should have been afforded S.K., due to her observations of S.K.'s listlessness and slumping in the wheelchair. C.N.

[49] 157 N.J. 161, at 183

recounted to the court that she was aware that S.K. had a very recent hospital stay to correct her seizure medicine level. C.N. recounted that a low level of Dilantin would cause confusion, lethargy, and an unsteady gait. The consequence of this low level of Dilantin would be an increased risk of falling. The consequence of S.K. falling was even greater than that to another person because of the other medications that she took that made her bones more brittle. C.N. was a trained and licensed Registered Nurse her medical testimony was cogent and much more detailed than that in the CAR case. C.N.'s testimony showed that she was professionally adept and knowledgeable about the medications. She testified about the drugs, their side effects, the harm of not giving them, as well as the symptoms indicating that Dilantin levels were insufficient. C.N. was aware of the dangers of not giving S.K. her prescribed dosage of Dilantin at the prescribed time in the prescribed manner. C.N. testified extensively to the importance of S.K. receiving proper doses of medicines, and particularly of Dilantin. C.N. failed to use even a minimal level of care to ensure that S.K. received her prescribed dosages of Dilantin. At 4:00 p.m., when S.K. was given a dose of Dilantin, S.K. spit out the pill. C.N. threw out that pill and did not attempt to re-administer the dosage or to properly document the thrown away pill and the failure to administer the medicine, despite having the patient, medicines, and books at her fingertips, and, while within the window of time prescribed. C.N. waited until dinner, well after the time window the first dosage was due, and may or may not have impermissibly given a dose of Dilantin to S.K. by putting it in food and leaving it with her, when she was not eating. S.K. wound up in the hospital with an IV application of Dilantin to bring her level of the drug back to normal a few hours later. The New Jersey Supreme Court found that a person administering drugs to a vulnerable individual without the minimal amount of care (as described in a medication manual) and who is aware of the dangers is demonstrating conduct that "clearly rises to the level of wanton or willful."[50]

> "As a medication administrator, G.S. should have been particularly sensitive to the dire consequences that could result from over-medicating a child. Even though she did not intend harm to befall [the child], she utterly disregarded the substantial probability that harm would result from her actions... [Despite there being no lasting harm to the child], G.S. acted with careless disregard for the consequences of her actions."[51]

C.N. failed to provide a minimal level of medical care (as described in the manual) and by those standards set out by the Supreme Court so disregarded the substantial probability of resultant harm, that C.N. was reckless and grossly negligent.

FINDINGS AND CONCLUSIONS OF LAW

After a careful re-examination of the entire record generated during the hearing at the Office of Administrative Law – its initial decision, transcripts, exhibits, and exceptions – **I FIND**, by a preponderance of the evidence that the Office of Investigation properly substantiated medical neglect on the part of C.N. C.N. willfully failed to provide proper and sufficient medical care to an individual with a developmental disability, as defined by N.J.A.C. 10:44D.

I FURTHER FIND, by a preponderance of the evidence, that C.N. recognized the dangers of improper dosage levels of drugs to S.K. C.N., as a licensed Registered Nurse, was the only person permitted to administer drugs to the very medically involved individuals residing in the D'Ippolito residence. C.N.'s failure to exercise a minimum of care to provide proper medical

[50] 157 N.J. 161, at p 183
[51] Ibid.

dosage in a timely manner, combined with her recognition of the dangers associated with that failure, represents gross negligence and reckless behavior, as defined by N.J.A.C. 10:44D. C.N.'s gross negligence was evident when she acted or failed to act properly to administer drugs to S.K., in a reckless disregard of her duty to administer prescription drugs on time and in the proper amount. C.N. acted recklessly by creating an unjustifiable risk of harm to S.K., of which she was consciously aware, when she ignored the prescribed dosages and times. By acting with gross negligence and recklessness, C.N. was properly placed on the Central Registry of Offenders against Individuals with Developmental Disabilities.

This decision is based upon a careful consideration of the Initial Decision and a review of all of the evidence, testimony, and exhibits; deference was given to the ALJ's having the opportunity to hear testimony and observe witnesses' demeanor to evaluate credibility. Although C.N. had the only motivation at the hearing to dissemble, the ALJ appeared to credit C.N.'s testimony. C.N.'s description of the events was used to create the timeline of events and the details of the administration of medical assistance to S.K. The variation in the Department's analysis was to the timeline, which was considered reasonable because three other witnesses presented directly opposing testimony as to what transpired in S.K.'s bedroom, during the medical intervention with the EMTs. The Initial Decision lacked a showing of support for its conclusions by an improper application of the law. There was no two-step analysis of whether or not there was a substantiation of neglect by the investigating unit and no analysis of the substantiated neglect to determine whether or not it rose to the level required for placement on the Central Registry, as defined at N.J.A.C. 10:44D. Therefore, the recommended decision of the ALJ is hereby **REJECTED and MODIFIED** by the Office of Program Integrity and Accountability. **IT IS THE FINAL DECISION OF THE DEPARTMENT OF HUMAN SERVICES THAT,** C.N. was properly substantiated for the medical neglect of S.K. and that C.N. was grossly negligent and reckless in her provision of medical care to an individual with developmental disabilities. C.N. **IS THEREFORE ORDERED** to be placed on the Central Registry of Offenders against Individuals with Developmental Disabilities.

Date: 5/29/18

Lauri Woodward

Lauri Woodward, Director
Office of Program Integrity and Accountability
Department of Human Services