SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-1841-15T2

C.N.,

Petitioner-Appellant,

v.

NEW JERSEY DEPARTMENT OF HUMAN SERVICES,

Respondent-Respondent.

Submitted November 8, 2017 – Decided January 9, 2018

Before Judges Hoffman and Gilson.

On appeal from the Department of Human Services, Docket No. 13-018.

Testa, Heck, Scrocca & Testa, PA, attorneys for appellant (Michael L. Testa, of counsel and on the brief; Anthony M. Imbesi, on the brief).

Christopher S. Porrino, Attorney General, attorney for respondent (Melissa H. Raksa, Assistant Attorney General, of counsel; Mark D. McNally, Deputy Attorney General, on the brief).

PER CURIAM

Petitioner C.N.[1] appeals from a November 20, 2015 final agency decision of the Department of Human Services, Office of Program Integrity and Accountability (Department), placing her on the Central Registry of Offenders against Individuals with Developmental Disabilities (Central Registry). We reverse and remand for further proceedings because in rejecting and modifying the initial decision of the Administrative Law Judge (ALJ), the Department did not sufficiently explain its findings and, thus, acted arbitrarily and capriciously.

I.

In 2009, petitioner was hired by Elwyn New Jersey (Elwyn) as a per diem Registered Nurse. Elwyn operates group homes for individuals with developmental disabilities. S.K., who has a developmental disability, was a resident at an Elwyn group home. S.K. was prescribed Dilantin to treat her seizure disorder, and received three 100-milligram doses per day, at 8:00 a.m., 4:00 p.m., and 8:00 p.m. or bedtime. S.K. also received a variety of medications for other health conditions. It was petitioner's responsibility to prepare and administer S.K.'s medications.

This appeal arises out of an incident on October 20, 2012, which resulted in S.K.'s hospitalization. Prior to being taken

[1] To protect the identity of the individuals, we refer to them by their initials. R. 1:38-3(f)(8).

to the hospital, two counselors observed that S.K. was unresponsive and in need of medical attention. After unsuccessfully attempting to locate petitioner, who was S.K.'s nurse, they called 911. S.K.'s Medication Administration Report (MAR) was given to responding EMTs and the hospital physicians. The MAR reflected that petitioner had dispensed S.K.'s 8:00 p.m. dose of Dilantin at 6:00 p.m., and had prematurely marked S.K.'s other 8:00 p.m. medications as having been administered.

Elwyn conducted an internal investigation and found that petitioner neglected S.K. by improperly administering her medications and failing to properly document the administration of those medications. On August 15, 2013, the Department substantiated the finding of neglect, and sent petitioner a letter stating its intent to place her on the Central Registry. Petitioner contested the Department's decision and requested a hearing in the Office of Administrative Law (OAL).

An ALJ conducted a hearing on December 2, 2014. The Department presented four witnesses: L.C. and J.T., two of petitioner's co-workers; V.T., one of the responding EMTs on October 20, 2012; and S.R., an internal investigator at Elwyn. The petitioner testified on her own behalf. The Department did not present medical testimony regarding any harm or risk of harm to S.K. that was allegedly caused by petitioner's actions.

The testimony and evidence established that on October 20, 2012, at approximately 4:00 p.m., petitioner attempted to administer S.K.'s afternoon dose of Dilantin. S.K. refused to ingest the pill and spit it out. Petitioner marked the medication package "wasted" to reflect that S.K. did not ingest her 4:00 p.m. dose, but failed to mark "wasted" on S.K.'s MAR.

Around 5:15 p.m., S.K. was brought to the dining room for dinner. L.C. testified that petitioner came into the dining room with the medication cart and administered two doses of medicine to S.K.: one in applesauce, and one in chocolate pudding. J.T., however, testified that petitioner only brought S.K. one chocolate pudding, and that she did not have the medication cart in the dining room. J.T. stated that petitioner told her to make sure S.K. ate the pudding because her medication was in it. Based upon the inconsistencies of the testimony, the ALJ found that L.C.'s testimony was "difficult to credit."

Contrary to L.C.'s and J.T.'s testimony, petitioner testified that during dinner service, she handed a chocolate pudding to a counselor and said, "please make sure [S.K.] eats this pudding, because her medication depends on it." According to petitioner, she said that because S.K. did not eat dinner, and could not take her Dilantin on an empty stomach.

Around 6:00 p.m., petitioner became concerned that S.K. still had not received her 4:00 p.m. dose of Dilantin. Petitioner was particularly concerned because S.K. had been hospitalized five days earlier for "ambulatory dysfunction" caused by "sub-therapeutic Dilantin" levels. Dilantin was S.K.'s most important medication, and S.K. was at risk of having a seizure if her Dilantin levels dropped. Thus, petitioner provided S.K. with a dose of Dilantin, which she placed in chocolate pudding. The Dilantin that petitioner administered at 6:00 p.m. was taken from S.K.'s 8:00 p.m. medications. Accordingly, petitioner marked off the 8:00 p.m. Dilantin on S.K.'s MAR.

Petitioner stated that she administered S.K.'s Dilantin at 6:00 p.m. because that particular medication should be given as soon as possible after a missed dose. She further explained that when medication is taken out of the cart and its packaging, she is required to mark it on the MAR. It was petitioner's practice to record personal notes regarding whether or not the client ingested the medication, and transfer those notes to the MAR at the end of her shift.

After giving S.K. her Dilantin, petitioner felt ill and went to the employee restroom. Moments after petitioner left, L.C. testified that S.K. became unresponsive. L.C. and other counselors attempted to locate petitioner, but could not immediately find

her. L.C. then called 911. In the meantime, J.T. was able to find petitioner in the employee restroom.

Petitioner arrived at S.K.'s room around the same time as EMTs. Petitioner did not assist the EMTs because she believed it was Elwyn policy not to interfere unless she was asked to help. The EMTs confirmed that S.K.'s vitals were normal, and noted that S.K. was responsive, but lethargic. When the EMTs took S.K. to the hospital, they took her MAR so that physicians could review her medical history and medications.

Petitioner had also prepared S.K.'s other medications early that day. She typically administered S.K.'s evening medications first because S.K. was one of her "critical patients." Petitioner stated that she punched all of S.K.'s 8:00 p.m. medications from the packaging, and put them into cups. The cups were then stored in S.K.'s designated drawer in the medication cart. Petitioner maintained that she intended to correct the MAR at the end of her shift based upon her personal notes, but never had the opportunity to do so because the MAR was taken to the hospital with S.K. Petitioner conceded that she did not inform the EMTs about the premature entries marked on the MAR. In that regard, she testified that everything happened quickly.

The ALJ filed his initial decision on February 23, 2015, finding that the Department failed to prove that petitioner acted

with gross negligence, recklessness, or a pattern of behavior that caused or potentially could have caused harm to S.K. The ALJ dismissed the charges against petitioner and ordered that she be removed from the Central Registry. The Department filed exceptions, arguing that the ALJ erred in reasoning that proof of actual harm was necessary to place a caretaker on the Central Registry.

On November 20, 2015, the Director of the Department's Office of Program Integrity and Accountability (Director) filed a final decision. The Director rejected and modified the ALJ's initial decision, finding that petitioner acted with gross negligence and recklessness, and therefore neglected S.K. as defined in N.J.A.C. 10:44D-4.1(c).

In her final decision, the Director found that "[t]he falsification of medical records, improperly preparing medications in advance, [and petitioner's] failure to document dosages and times is, in fact and in law, negligent." She also found that petitioner's "failure to inform EMTs about [S.K.'s] actual drug intake was . . . negligent." In reaching these conclusions, the Director noted that petitioner's conduct was in violation of Elwyn's procedures. She did not, however, explain how petitioner's violations of Elwyn procedures amounted to gross negligence or recklessness, as required under N.J.A.C. 10:44D-4.1(c).

Ultimately, the Director concluded that petitioner was properly placed on the Central Registry. Petitioner now appeals from the Department's final decision.

II.

On appeal, petitioner contends that (1) the final decision was arbitrary and capricious because it applied a negligence standard instead of gross negligence or recklessness as required under N.J.A.C. 10:44D-4.1(c); and (2) the final decision was not supported by credible evidence in the record. Petitioner also asks us to consider the record anew, and exercise our fact-finding authority to determine whether her actions rose to the level of gross negligence or recklessness.

The record is inadequate to allow us to exercise our original fact-finding authority. Having considered petitioner's arguments in light of the record, however, we reverse the Department's November 20, 2015 final decision and remand for further consideration.

Our review of an agency's final decision is limited. Clowes v. Terminix Int'l, Inc., 109 N.J. 575, 587 (1988). "An administrative agency's final quasi-judicial decision will be sustained unless there is a clear showing that it is arbitrary, capricious, or unreasonable, or that it lacks fair support in the record." In re Herrmann, 192 N.J. 19, 27-28 (2007). Nonetheless,

appellate review of an agency decision calls for careful and principled consideration of the agency record and its findings. Clowes, 109 N.J. at 587.

While an agency final decision may reject and modify an ALJ's initial decision, the authority to do so is not without limit. Specifically, N.J.A.C. 1:1-18.6 provides:

> The agency head may reject or modify conclusions of law, interpretations of agency policy, or findings of fact . . . but shall clearly state the reasons for so doing. The order or final decision rejecting or modifying the initial decision shall state in clear and sufficient detail the nature of the rejection or modification, the reasons for it, [and] the specific evidence at hearing and interpretation of law upon which it is based . . . .
>
> [N.J.A.C. 1:1-18.6(b).]

Relevant here are regulations codified at N.J.A.C. 10:44D-1.1 to -7.2, which establish the Central Registry. Caregivers placed on the Central Registry are prohibited from working with developmentally disabled individuals. N.J.S.A. 30:6D-73(d). A caregiver can only be placed on the Central Registry if he or she 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." N.J.A.C. 10:44D-4.1(c). Gross negligence is a conscious, voluntary act or omission in reckless disregard of a duty and of the consequences

to another party. N.J.A.C. 10:44D-4.1(c)(1). Recklessness is the creation of a substantial and unjustifiable risk of harm to others by a conscious disregard of that risk. N.J.A.C. 10:44D-4.1(c)(2).

Petitioner argues that in the final decision, the Director incorrectly applied a negligence standard, instead of applying the appropriate standard of gross negligence or recklessness. Having reviewed the Department's final decision, including the Director's conclusions, we cannot determine that the Director applied the correct legal standard because she did not identify the specific evidence and standard for her decision.

In her final decision, the Director used the terms negligence, gross negligence, and recklessness interchangeably, and failed to explain how petitioner's conduct satisfied the statutory definition of each. For example, the Director stated, "[Petitioner] was not substantiated with having committed abuse, but with neglect . . . [t]he harm sounds in negligence — the potential for risk which a prudent person would seek to avoid — not in physical trauma." The Director then stated, "The falsification of medical records, improperly preparing medications in advance, failure to document dosages and times is, in fact and in law, negligent." Moreover, the Director found "from the evidence, testimony, and comments of the ALJ in the initial decision . . . [that petitioner] was negligent." In contrast, the

Director did at times state that petitioner "acted recklessly, grossly negligently, and wantonly . . . ." She did not, however, explain how petitioner's actions amounted to recklessness or gross negligence.

In addition, the Director refers to risks of harm to S.K. that were not supported by evidence in the record. Specifically, the Director found that (1) petitioner created a risk of dangerously high or low amounts of Dilantin in S.K.'s blood stream by failing to administer the drug at the proper time; (2) by preparing S.K.'s medications prematurely, petitioner created the risk of contamination, giving the medications to the wrong client, or misidentifying similar looking pills; and (3) petitioner exposed S.K. to danger when she prematurely marked medications on S.K.'s MAR, and allowed EMTs to take her to the hospital without correcting the MAR. The Director did not identify the evidence she relied on in making those findings. More critically, those findings do not appear to be based on evidence in the record.

There was no medical testimony to establish that petitioner's decision to give S.K. her Dilantin at 6:00 p.m., after the missed 4:00 p.m. dose, was potentially dangerous. The only testimony regarding Dilantin came from petitioner, who stated that it was appropriate to administer Dilantin as soon as possible after a missed dose.

There was also no medical testimony to support a finding that petitioner's premature preparation of S.K.'s other medications created a risk of harm. Petitioner testified that she prepared the medications early and placed them in S.K.'s designated drawer in the medication cart. Thus, it is unclear how the early preparation of S.K.'s medication created a risk of harm to S.K.

Finally, there was no medical testimony to establish that petitioner's early completion of the MAR created a risk of harm to S.K. given the medications she was taking. Indeed, the ALJ expressly found that there was no evidence presented of any actual or potential harm to S.K.

Determinations that are "predicated on unsupported findings [are] the essence of arbitrary and capricious action." See In re Certificate of Need of the Visiting Nurse Ass'n of Sussex Cty., 302 N.J. Super. 85, 95 (App. Div. 1997). Accordingly, we reverse the November 20, 2015 final decision, and remand the matter to the Department for further consideration.

On remand, the Department must make specific findings of fact and conclusions of law supported by evidence in the record. Specifically, the Department must determine whether petitioner (1) acted with gross negligence or recklessness as defined in N.J.A.C. 10:44D-4.1(c); and if so, (2) whether the evidence in the

record supports a finding that her actions actually harmed S.K. or placed S.K. in harm's way.

Reversed and remanded. We do not retain jurisdiction.