A-13

STATE OF NEW JERSEY

In the Matter of Lulu Umih
Hudson County, Department of Corrections

CSC DKT. NO. 2016-1389
OAL DKT. NO. CSV 01774-16

FINAL ADMINISTRATIVE ACTION
OF THE
CIVIL SERVICE COMMISSION

ISSUED: NOVEMBER 15, 2016 BW

The appeal of Lulu Umih, Supervisor of Nurses, Hudson County, Department of Corrections, removal effective August 24, 2015, on charges, was heard by Administrative Law Judge Thomas R. Betancourt, who rendered his initial decision on July 12, 2016. 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, at its meeting on November 10, 2016, 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 Lulu Umih.

Re: Lulu Umih

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
NOVEMBER 10, 2016

Robert M. Czech

Robert M. Czech
Chairperson
Civil Service Commission

Inquiries
and
Correspondence

Nicholas F. Angiulo
Assistant Director
Division of Appeals and Regulatory Affairs
Civil Service Commission
Unit H
P. O. Box 312
Trenton, New Jersey 08625-0312

Attachment

State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION
OAL DKT. NO. CSV 01774-16
AGENCY DKT. NO. CSC 2016-1389

LULU UMIH,
Appellant,
v.
HUDSON COUNTY DEPARTMENT OF CORRECTIONS,
Respondent.

William P. Hannan, Esq., for appellant (Oxfeld Cohen, attorneys)

John A. Smith, II, Esq., Assistant County Counsel, for respondent (Donato J. Battista, County Counsel)

Record Closed: June 10, 2016 Decided: July 12, 2016

BEFORE **THOMAS R. BETANCOURT**, ALJ:

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

Appellant, Lulu Umih, appeals a Final Notice of Disciplinary Action, dated January 5, 2016, imposing a penalty of removal, effective August 24, 2015, for Incompetency, inefficiency or failure to perform duties; neglect of duty; and, other

sufficient cause, as set forth in the Final Notice of Disciplinary Action dated January 6, 2016.

The Civil Service Commission transmitted this matter to the Office of Administrative Law (OAL), where it was filed on January 28, 2016, as a contested case. N.J.S.A. 52:14B-1 to -15; N.J.S.A. 52:14F-1 to -13.

A hearing was held on May 24, 2016. The record was kept open until June 10, 2016, to permit the parties to file post-hearing submissions, at which time the record was closed.

ISSUES

Whether there is sufficient credible evidence to sustain the charges set forth in the Final Notice of Disciplinary Action; and, if sustained, whether a penalty of removal is warranted.

STIPULATED FACTS

The following facts were stipulated:

1. Appellant, Lulu Umih, is an experienced licensed registered nurse.
2. On August 19, 2015, appellant was functioning as a Nurse Supervisor at Hudson County Corrections.
3. On said date Nurse Dirshant brought to Nurse Umih's attention that Nurse Umih made an error in medication transcription.
4. Appellant was hired by the County of Hudson on July 1, 2002.

SUMMARY OF RELEVANT TESTIMONY

Respondent's Case

Eric Taylor testified as follows:

He is a lieutenant with the Hudson County Department of Corrections (Department). He oversees daily operations of the medical staff and discipline for nurses employed by the Department at the Hudson County Correctional Facility (Jail). He is familiar with the discipline record of appellant.

The lieutenant reviewed both the Final Notice of Disciplinary Action (FNDA) and the Preliminary Notice of Disciplinary Action (PNDA) regarding an incident which occurred at the Department involving. (R-1 and R-2.)

He prepared a Disciplinary Action form requesting that major discipline be imposed upon appellant for an incident which occurred on August 19, 2015. (R-3.) This was done after he reviewed the report prepared by Claudette Blake that recommended appellant be suspended pending an investigation. (R-4.)

He also prepared a Notice of Immediate Suspension for appellant, effective - August 24, 2015. (R-5.) Appellant has not worked for the Department since that time.

The lieutenant then reviewed the job description for a nurse supervisor, outlining the duties for this position. (R-6.)

Appellant has been the subject of prior disciplinary actions, as reviewed by the Lieutenant, as follows:

1. FDNA dated March 12, 2009, wherein appellant was suspended for twenty days, ten of which were held in abeyance per a settlement. The PNDA regarding this discipline sets forth the charges. (R-7a and P-1.)

2. FDNA dated September 19, 2008, wherein appellant was suspended for fifteen days, five of which were held in abeyance per a settlement. The PNDA regarding this discipline sets forth the charges. (R-7b and P-2.)

3. Notice of Minor Disciplinary Action January 26, 2007, wherein appellant was suspended for five days. The PNDA regarding this discipline sets forth the charges. (R-7c.)

The lieutenant has no personal knowledge of the incident which occurred August 19, 2015, which led to the disciplinary matter herein.

Jane Lowe testified as follow:

She is Director of Nursing at the Jail. She is employed by CFG Health Systems, LLC, (CFG) a vendor contracted by the Department to supervise nursing at the Jail. Nurses are Hudson County employees. Ms. Lowe is a registered nurse (RN) and has thirty-four years of nursing experience. She is also a certified corrections health professional.

There is a standardized procedure to follow to correct medication errors. The Hudson County Department of Corrections Health Services Policies & Procedures Manual sets forth in writing what procedure to follow when there is a medication error. (R-10.) Appellant received a copy of R-10 as evidenced by her signature on the receipt form for the manual. (R-11.)

If an error in medication is made the nurse should correct the Medication Administration Record (MAR) form. (R-13 and R-13a.) This is done by placing a line through the incorrect medication and making an entry below with the correct

medication. This is done so others viewing the form are aware of the error. The proper procedure is to cross out the error, but never erase it or cover it over. This is basic procedure and is taught in nursing school. The error is also to be reported to a supervisor, the medical provider, and the patient/inmate examined to determine if there are any adverse effects from the wrong medication. A Medication Variance Report is also to be completed. (R1-15.)

The Civil Service Job Description for a Nurse Supervisor was also reviewed. (R-6.) This would be applicable to appellant.

Ms. Lowe first learned of the medication error on August 20, 2015, from Angela Dirshant, a nurse employed at the jail. Appellant was Ms. Dirshant's Nursing Supervisor on August 19, 2015. Ms. Lowe ordered the patient/inmate to be examined by the medical provider. Appellant had not reported the medication error to Ms. Lowe at this time. Ms. Lowe ordered both appellant and Ms. Dirshant to provide written reports regarding the medication error. (R-8 and R-9.)

Ms. Lowe and Ms. Blake ordered appellant to provide a supplemental written report. (R-12.) Thereafter Ms. Blake issued her report recommending the suspension of appellant. (R-4.)

Ms. Lowe reviewed the MAR form. (R-13 and R-13a.) R-13 is the uncorrected form, with the original label for Dilantin, a seizure medication, removed and a label for the correct medication, Neurontin, put in its place. R-13a is the corrected MAR form.[i]

Both basic nursing practice and the Civil Service job description functions were not followed. Appellant could have called Ms. Lowe at any time but was not contacted by appellant.

[i] Ms. Lowe reviewed the original of R-13a and compared it to R-13.

Ms. Lowe reviewed the Physician's Orders regarding the patient/inmate and noted an arrow pointing up indicates an increase in dose. (R-14.) Ms. Lowe also noted that any question regarding a medication should be clarified.

The initial written report submitted by appellant was accurate, but not complete. (R-9.) Appellant's supplemental report was much more extensive and complete. (R-12.)

Ms. Lowe prepared the Medical Variation Report regarding the error in medication. (R-15.) Had Ms. Dirshant not advised Ms. Lowe of the error in medication she would not have known.

Angela Dirshant testified as follows:

She is a registered nurse and is employed by the Department at the Jail. On August 19, 2015, appellant was her Nurse Supervisor. She has been employed by the Department for four years.

She is familiar with the Policies & Procedures Manual and has received a copy. (R-10 and R-11.)

The procedure to follow if there is a medication error is to notify your supervisor or the charge nurse, refer the patient/inmate to the doctor or nurse practitioner, complete a Medication Variance Report, and correct the medication order on the MAR by putting a line through the incorrect medication and entering the correct medication.

On August 19, 2015, the patient/inmate who received the incorrect medication spoke with her to advise he thought he was not getting the correct medication. This was around 6:00 p.m. Ms. Dirshant then pulled the patient/inmate chart and took it to appellant to review it together. The chart was compared to the MAR and found the error. (R-13 and R-13a.) The patient/inmate was receiving Dilantin instead of Neurontin. Ms. Dirshant gave appellant the MAR form and the patient/inmate chart.

Ms. Dirshant followed up the next day as she became aware the patient/inmate had not yet been examined. She advised the day supervisor and they both reported the medication error to Ms. Lowe. Ms. Dirshant had not seen the revised MAR form until the next day.

Claudette Blake testified as follows:

She is a Health Services Administrator and oversees the entire medical operation at the Jail. She is an employee of CFG. Ms. Blake is a nurse and has been for twenty years. She was so employed on August 19, 2015, and was aware of the medication error incident that occurred on that date. She was informed of this by Ms. Lowe. She participated in the investigation and wrote a report regarding it. (R-4.) She recommended the immediate suspension of appellant pending an investigation. Ms. Blake has no authority to discipline nurses. She makes recommendations for discipline to the Department. Ms. Blake also reported the incident to the New Jersey Board of Nursing.

Ms. Blake viewed the original MAR form[ii] and noted it was obvious the page was torn and a label for Neurontin was placed on top. She also noted the label date and original date differ. The label is dated August 20, 2015. The order is dated August 13, 2015.

She is familiar with medication variance procedure. Once an error is discovered a Medication Variance Report is completed. (R-15.) The MAR form is then corrected by drawing a line through the incorrect medication; entering below what the change is; and placing a new label on the MAR. That procedure was not followed in the present matter. Placing the label for Neurontin where the label for Dilantin was is falsification.

When appellant was asked by Ms. Blake why she replaced the label she replied that she panicked and wanted to correct her error. Appellant had the authority to place

[ii] R-13a is a photocopy of the original MAR form made during the hearing.

a new label on the MAR. Appellant did not have the ability to change the label date in the computer.

Appellant's Case

Lulu Umih, appellant, testified as follows:

She is a registered nurse and was employed by the Department at the Jail as a Nurse Supervisor. She had worked for the Department since 2002. Her shift on August 19, 2015, was 1:30 p.m. to 9:30 p.m. Her duties were to meet with the outgoing Nurse Supervisor, count narcotics, oversee the unit and any medical emergencies, and transcribe physician's orders. She did both administrative and nursing duties.

The medication error that occurred on August 19, 2015, was brought to her attention by Ms. Dirshant. She reviewed the Physician's Orders, R-14, and thought the order for Neurontin was for Dilantin. Dilantin is what Ms. Umih entered on the MAR. (R-13.) If she thought the order was unclear she would have asked the provider for clarification. When she verified with Ms. Dirshant that there was a transcription error she immediately went into the computer and discontinued the Dilantin and printed a new label for Neurontin. Ms. Umih stated repeatedly during her testimony "my honest mistake." She stated she did not want the nurses to give the wrong medication. She handed the MAR form with the new label to Ms. Dirshant. It was not her intention to hide the error. Ms. Dirshant did not say anything to Ms. Umih about the new label. Ms. Umih never asked Ms. Dirshant to lie. Ms. Lowe was not at the Jail when the medication error was discovered. She admitted she made a mistake removing the Dilantin label from the MAR. She was going to report the medication error the next day but was not able to as it was already reported to Ms. Lowe. Ms. Umih confirmed she wrote R-9 and R-12. She stated her biggest concern was for nurses to not commit the error with the medication.

Ms. Umih knew the correct procedure to follow with a medication error. She knew how to correct the MAR properly but did not do so. She did not complete a

Medication Variance Report. (R-15.) She did not report the medication error to Ms. Lowe. She did not notify the provider doctor or nurse practitioner.

Ms. Umih reviewed the Physician's Orders, P-14, and stated she could not determine if it was for Neurontin. She confirmed that she did not seek a clarification from the provider.

Ms. Umih acknowledged she received the Policies & Procedures Manual, R-10, and understood she was responsible to know its contents.

She could have had the patient/inmate examined when the medication error was discovered, but did not.

Ms. Umih confirmed that she was the subject of three prior disciplinary matters.

Credibility

When witnesses present conflicting testimonies, it is the duty of the trier of fact to weigh each witness's credibility and make a factual finding. In other words, credibility is the value a fact finder assigns to the testimony of a witness, and it incorporates the overall assessment of the witness's story in light of its rationality, consistency, and how it comports with other evidence. Carbo v. United States, 314 F.2d 718 (9th Cir. 1963); see Polk, supra, 90 N.J. 550. Credibility findings "are often influenced by matters such as observations of the character and demeanor of witnesses and common human experience that are not transmitted by the record." State v. Locurto, 157 N.J. 463 (1999). A fact finder is expected to base decisions of credibility on his or her common sense, intuition or experience. Barnes v. United States, 412 U.S. 837, 93 S. Ct. 2357, 37 L. Ed. 2d 380 (1973).

The finder of fact is not bound to believe the testimony of any witness, and credibility does not automatically rest astride the party with more witnesses. In re Perrone, 5 N.J. 514 (1950). Testimony may be disbelieved, but may not be disregarded

at an administrative proceeding. Middletown Twp. v. Murdoch, 73 N.J. Super. 511 (App. Div. 1962). Credible testimony must not only proceed from the mouth of credible witnesses but must be credible in itself. Spagnuolo v. Bonnet, 16 N.J. 546 (1954).

Lieutenant Eric Taylor testified in a direct and straightforward manner. He acknowledged he had no direct knowledge of the facts in this matter. His testimony was short and set forth the disciplinary process for the present matter and introduced appellant's prior disciplinary history. I deem him credible.

Director of Nursing Jane Lowe was a most credible witness. She testified in a direct manner. She answered questions without hesitation. I deem her very credible.

Nurse Angela Dirshant was a compelling witness. She testified without hesitation regarding the medication error and what she did to correct it. Some of her actions did not put her in the best light. However, she did not attempt to spin the facts to make her look better. I deem her very credible.

Health Services Administrator Claudette Blake testified directly without hesitation. She explained procedures to be followed and why she recommended that appellant be disciplined. Her manner was professional. I deem her credible.

Appellant, Lulu Umih, was not credible. In fact, her testimony strains credulity. While she admitted she was aware of the protocol when there is a medication error she failed to follow any of it. Her explanation was two-fold: she wanted to protect her fellow nurses from making the same error; and, it was an "honest mistake." Neither is believable or credible. Appellant's demeanor while testifying was of someone trying to spin the facts to her favor. Repeatedly stating "honest mistake" does not make it so. I deem her not credible.

FINDINGS OF FACT

I **FIND** the following **FACTS**:

1. Appellant is a registered nurse and was employed by respondent as a Nurse Supervisor at the Jail on August 19, 2015.
2. Angela Dirshant is a registered nurse and was employed by respondent as a nurse on August 19, 2015.
3. CFG is a vendor who supplies medical facility supervision for respondent at the Jail.
4. Jane Lowe an employee of CFG and was the Director of Nursing at the Jail on August 19, 2015.
5. Claudette Blake is a registered nurse employed by CFG as Health Services Administrator at the Jail. She was so employed on August 19, 2015.
6. Lieutenant Eric Taylor is employed by respondent and was the responsible for the discipline of nurses at the Jail supervised by CFG. He was so employed on August 19, 2015.
7. A Medication Administration Record is a form utilized to document patient/inmate medications at the Jail. (R-13 and R-13a.)
8. A Medication Variance Report is a form utilized by CFG and respondent to document any medication errors. (R-15.)
9. A Physician's Orders is a form utilized by CFG and respondent for the purpose of providing prescribed medications to a patient/inmate. (R-14.)
10. It was part of appellant's duties to transcribe prescriptions from R-14 to R-13.
11. Should there be a medication variance the proper procedure to follow is: notify the supervisor; notify the provider so that the patient/inmate can be examined to determine if there are any ill effects from the incorrect medication; correct the MAR; and, complete a Medication Variance Report.
12. The proper procedure to correct a MAR after a medication variance is to draw a line through the incorrect medication, but not to erase or cover it, and note the correct medication.

13. Sometime prior to August 19, 2015, appellant transcribed the incorrect medication onto R-13. The correct medication, as noted on R-14, was Neurontin. Appellant transcribed Dilantin, a seizure medication, onto the MAR and placed a label for this mediation on the MAR.
14. Appellant misread R-15 in making this error.
15. Appellant never asked the provider for a clarification of the medication.
16. The handwritten prescription for Neurontin on R-15 was legible as Neurontin, but could have been misread. A clarification should have been requested.
17. As a result, the patient/inmate received the incorrect medication Dilantin for six days.
18. The error was discovered on August 19, 2015, when Nurse Dirshant brought this information to appellant, her Nursing Supervisor.
19. Appellant was aware of the proper protocols and procedures to follow with a medication variance. Appellant was aware of, and received a copy of R-10. (R-11.)
20. Appellant, despite being aware of the proper procedures to follow with a medication variance did none of them. Appellant failed to notify her supervisor, Lowe. Appellant failed to notify the provider so that the patient/inmate could be examined to determine if there were any ill effects from the incorrect medication. Appellant failed to complete a Medication Variance Form.
21. Appellant failed to correct the MAR form to reflect the medication variance.
22. Appellant falsified the MAR form by printing a label for the correct medication, Neurontin, and removing the label for Dilantin. Appellant then placed the Neurontin label in the place where she removed the Dilantin label.
23. Appellant, admittedly, knew this was not proper.
24. Appellant's assertion that these omissions and actions were an "honest mistake" is ludicrous and not believable. Appellant's further assertion that

her actions were to protect other nurses is likewise ludicrous and not believable.

25. Appellant falsified the MAR to hide her mistake and avoid discipline.

26. Appellant is charged under PNDA, R-2, with the following: insubordination; conduct unbecoming a public employee; neglect of duty; incompetency, inefficiency or failure to perform duties; and other sufficient cause.

27. The FNDA, R-1, sustained the charges of Incompetence, inefficiency or failure to perform duties; neglect of duty; and, other sufficient cause.

28. Appellant was the subject of three prior disciplinary proceedings, two major and one minor. All three matters were concluded by stipulations of settlement with appellant pleading guilty to the charges. (R-7a through R-7c.)

LEGAL ANALYSIS AND CONCLUSION

The Civil Service Act, N.J.S.A. 11A:1-1 to -12.6, governs a civil service employee's rights and duties. The Act is an important inducement to attract qualified personnel to public service and is to be liberally construed toward attainment of merit appointments and broad tenure protection. See Essex Council No. 1, N.J. Civil Serv. Ass'n v. Gibson, 114 N.J. Super. 576 (Law Div. 1971), rev'd on other grounds, 118 N.J. Super. 583 (App. Div. 1972); Mastrobattista v. Essex County Park Comm'n, 46 N.J. 138, 147 (1965). The Act also recognizes that the public policy of this state is to provide appropriate appointment, supervisory and other personnel authority to public officials in order that they may execute properly their constitutional and statutory responsibilities. N.J.S.A. 11A:1-2(b). In order to carry out this policy, the Act also includes provisions authorizing the discipline of public employees.

A public employee who is protected by the provisions of the Civil Service Act may be subject to major discipline for a wide variety of offenses connected to his or her employment. The general causes for such discipline are set forth in N.J.A.C. 4A:2 2.3(a). In an appeal from such discipline, the appointing authority

bears the burden of proving the charges upon which it relies by a preponderance of the competent, relevant and credible evidence. N.J.S.A. 11A:2-21; N.J.A.C. 4A:2-1.4(a); Atkinson v. Parsekian, 37 N.J. 143 (1962); In re Polk, 90 N.J. 550 (1982). The evidence must be such as to lead a reasonably cautious mind to a given conclusion. Bornstein v. Metro. Bottling Co., 26 N.J. 263 (1958). Therefore, the judge must "decide in favor of the party on whose side the weight of the evidence preponderates, and according to the reasonable probability of truth." Jackson v. Del., Lackawanna and W. R.R., 111 N.J.L. 487, 490 (E. & A. 1933). This burden of proof falls on the agency in enforcement proceedings to prove violations of administrative regulations. Cumberland Farms v. Moffett, 218 N.J. Super. 331, 341 (App. Div. 1987).

This forum has the duty to decide in favor of the party on whose side the weight of the evidence preponderates, in accordance with a reasonable probability of truth. Evidence is said to preponderate "if it establishes 'the reasonable probability of the fact.'" Preponderance may also be described as the greater weight of credible evidence in the case, not necessarily dependent on the number of witnesses, but having the greater convincing power. State v. Lewis, 67 N.J. 47 (1975). The evidence must "be such as to lead a reasonably cautious mind to a given conclusion." Bornstein v. Metro. Bottling Co., 26 N.J. 263, 275 (1958). The burden of proof falls on the appointing authority in enforcement proceedings to prove a violation of administrative regulations. Cumberland Farms v. Moffett, 218 N.J. Super. 331, 341 (App. Div. 1987). The respondent must prove its case by a preponderance of the credible evidence, which is the standard in administrative proceedings . Atkinson, supra, 37 N.J. 143. The evidence needed to satisfy the standard must be decided on a case-by-case basis.

An appeal to the Merit System Board requires the Office of Administrative Law to conduct a de novo hearing and to determine appellant's guilt or innocence as well as the appropriate penalty. In re Morrison, 216 N.J. Super. 143 (App. Div. 1987).

The sustained charges in the Final Notice of Disciplinary Action are incompetency, inefficiency or failure to perform duties in violation of N.J.A.C. 4A:2-

2.3(1); neglect of duty in violation of N.J.A.C. 4A:2-2.3(7); and other sufficient cause in violation of N.J.A.C. 4A:2-2.3(11).

There is no definition in the New Jersey Administrative Code for neglect of duty, but the charge has been interpreted to mean that an employee has failed to perform and act as required by the description of their job title. Neglect of duty can arise from an omission or failure to perform a duty and includes official misconduct or misdoing, as well as negligence. Generally, the term "neglect" connotes a deviation from normal standards of conduct. In In re Kerlin, 151 N.J. Super. 179, 186 (App. Div. 1977), neglect of duty implies nonperformance of some official duty imposed upon a public employee, not merely commission of an imprudent act. Rushin v. Bd. of Child Welfare, 65 N.J. Super. 504, 515 (App. Div. 1961). In the instant matter there is absolutely no question appellant is guilty of neglect of duty. She admitted as much in her testimony. There is also no question that appellant is guilty of incompetency, inefficiency and failure to perform duties. Again, appellant admitted to the same. She knew what the protocol was when a medication variance occurred and intentionally did not follow it. Nor did she ask for a clarification of what the proper medication was when she incorrectly transcribed Neurontin as Dilantin.

In determining the reasonableness of a sanction, the employee's past record and any mitigating circumstances should be reviewed for guidance. W. New York v. Bock, 38 N.J. 500 (1962). Although the concept of progressive discipline is often cited by appellants as a mandate for lesser penalties for first-time offences,

> that is not to say that incremental discipline is a principle that must be applied in every disciplinary setting. To the contrary, judicial decisions have recognized that progressive 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, or when application of the principle would be contrary to the public interest.
>
> [In re Hermann, 192 N.J. 19, 33-4 (2007) (citing Henry v. Rahway State Prison, 81 N.J. 571).]

Although the focus is generally on the seriousness of the current charge as well as the prior disciplinary history of the appellant, consideration must also be given to the purpose of the civil service laws. Civil service laws "are designed to promote efficient public service, not to benefit errant employees . . . The welfare of the people as a whole, and not exclusively the welfare of the civil servant, is the basic policy underlining the statutory scheme." State-Operated Sch. Dist. v. Gaines, 309 N.J. Super. 327, 334 (App. Div. 1998). "The overriding concern in assessing the propriety of the penalty is the public good. Of the various considerations which bear upon that issue, several factors may be considered, including the nature of the 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, 465.

In the instant matter the nature of the offense is egregious. The health of a patient/inmate was put at serious risk. When the medication variance was discovered the appellant attempted to cover it up. Appellant's prior disciplinary record demonstrates a history of patient neglect. Appellant has two prior major disciplinary matters which resulted in suspension. Both were the subject of settlement agreements wherein appellant pleaded guilty to the charges. Neither mitigate in her favor.

The credible evidence substantially preponderates in favor of respondent.

I **CONCLUDE** that the respondent has demonstrated by a preponderance of the credible evidence that that appellant was guilty of all the charges set forth the Final Notice of Disciplinary Action.

I further **CONCLUDE** that the penalty of removal is appropriate.

ORDER

It is hereby **ORDERED** that appellant's appeal is **DENIED**;

It is further **ORDERED** that all charges contained in the Final Notice of Disciplinary Action dated January 6, 2016, are **AFFIRMED**, and the penalty of removal is **AFFIRMED**.

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, P.O. 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.

July 12, 2016
DATE

THOMAS R. BETANCOURT, ALJ

Date Received at Agency: July 12, 2016 /db

Date Mailed to Parties: July 12, 2016 /db

APPENDIX

List of Witnesses

For Appellant:

Lulu Umih, appellant

For Respondent:

Eric Taylor

Jane Lowe

Angela Dirshant

Claudette Blake

List of Exhibits

For Appellant:

P-1 Disciplinary Action Form for Appellant with an effective date of April 13, 2009

P-2 Disciplinary Action Form for Appellant with an effective date of October 1, 2007

For Respondent:

R-1 Final Notice of Disciplinary Action dated January 6, 2016

R-2 Preliminary Notice of Disciplinary Action dated August 25, 2015

R-3 Disciplinary Action dated August 25, 2015

R-4 Report from Claudette Blake, RN dated August 24, 2015

R-5 Notice of Suspension dated August 24, 2015

R-6 Civil Service job description for Supervisor of Nurses

R-7 Disciplinary File:

R-7(a) Final Notice of Disciplinary Action dated March 12, 2009; Preliminary Notice of Disciplinary Action dated February 2, 2009; Recommendation for Disciplinary Action dated January 29, 2009; Stipulation of Settlement dated March 5, 2009; and, memo from Roderick T. Baltimore, Esq. dated September 8, 2008

R-7(b) Final Notice of Disciplinary Action dated September 19, 2007; Preliminary Notice of Disciplinary Action dated June 11, 2007; Stipulation of Settlement dated August 17, 2007

R-7(c) Notice of Minor Disciplinary Action dated January 26, 2007; Preliminary Notice of Disciplinary Action dated January 2, 2007; Recommendation for Disciplinary Action dated December 13, 2006; New Stipulation of Settlement dated February 23, 2007

R-8 Incident Report dated August 20, 2015, Nurse Dirshant

R-9 Incident Report dated August 20, 2015, by Nurse Umih

R-10 Hudson County Department of Corrections Health Services Policies & Procedures Manual

R-11 Signature page for receipt and review of R-10

R-12 Handwritten statement of appellant dated August 24, 2015

R-13 (a) photocopy of Medication Administration Record
(b) Photocopy of complete Medication Administration Record

R-14 Physician's Patient Order Form

R-15 Medication Variance Report