H.E. NO. 2012-4

STATE OF NEW JERSEY
BEFORE A HEARING EXAMINER OF THE
PUBLIC EMPLOYMENT RELATIONS COMMISSION

In the Matter of

STATE OF NEW JERSEY (MILITARY/
VETERANS AFFAIRS),

Respondent,

-and-

Docket No. CO-1998-051

COMMUNICATIONS WORKERS OF
AMERICA, LOCAL 1040,

Charging Party.

SYNOPSIS

A Hearing Examiner of the Public Employment Relations Commission finds that the State of New Jersey, Department of Military and Veterans Affairs did not violate the New Jersey Employer-Employee Relations Act when it terminated Dr. Virginia DeGuzman from the New Jersey Veterans Memorial Home in Paramus, New Jersey. The Charging Party argued that DeGuzman had filed many grievances and letters concerning her terms and conditions of employment for which she was retaliated against leading to her termination. The State argued -- and the evidence demonstrated -- that DeGuzman committed two serious patient errors unrelated to her protected activity which affected patient care approximately eight months apart and which led first to a suspension and then her termination for cause. The Hearing Examiner concluded that the termination was unrelated to DeGuzman's exercise of protected conduct, and that the State would have taken the same action even absent the employees exercise of protected conduct.

A Hearing Examiner's Report and Recommended Decision is not a final administrative determination of the Public Employment Relations Commission. The case is transferred to the Commission, which reviews the Report and Recommended Decision, any exceptions thereto filed by the parties, and the record, and issues a decision that may adopt, reject or modify the Hearing Examiner's findings of fact and/or conclusions of law. If no exceptions are filed, the recommended decision shall become a final decision unless the Chair or such other Commission designee notifies the parties within 45 days after receipt of the recommended decision that the Commission will consider the matter further.

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Appearances:

For the Respondent,
Paula T. Dow, attorney general
(Geri Benedetto, Deputy Attorney General)

For the Charging Party,
Weissman and Mintz, attorneys
(David Tango, of counsel)

**HEARING EXAMINER'S REPORT
AND RECOMMENDED DECISION**

On August 8 and October 14, 1997, and October 18, 1999, CWA Local 1040, AFL-CIO (Charging Party or CWA) filed an unfair practice charge and amended charges against the State of New Jersey (Department of Military & Veterans Affairs) (Respondent or State) alleging that Respondent violated 5.4a(1), (2) and (3) of the New Jersey Employer-Employee Relations Act, N.J.S.A. 34:13A-1 et seq.[1/] (Act).

1/ These provisions prohibit public employers, their (continued...)

The original charge contained allegations concerning three people. It alleged that in June 1997, Dr. Virginia DeGuzman, a physician at the New Jersey Veteran's Memorial Home (Home) in Paramus received multiple criticisms in her Performance Assessment Review (PAR), and a written warning and a written reprimand ostensibly for filing a grievance against Doris Neibart, the Home's Chief Executive Officer; it alleged that in June 1997 Head Cook Bernice Jackson was threatened for filing a petition regarding working conditions and was suspended in July 1997 ostensibly for filing a grievance; and, it alleged that in July 1997, Head Nurse Santosh Puniani was disciplined because she filed a grievance. The Charging Party concluded its charge alleging that several officials at the Home engaged in coercion, intimidation and reprisals against DeGuzman, Jackson and Puniani because they filed grievances.

The Charging Party's first amended charge contained more specific information concerning all three employees named in the original charge and added that: DeGuzman was treated

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1/ (...continued)
representatives or agents from: "(1) Interfering with, restraining or coercing employees in the exercise of the rights guaranteed to them by this act; (2) Dominating or interfering with the formation, existence or administration of any employee organization; (3) Discriminating in regard to hire or tenure of employment or any term or condition of employment to encourage or discourage employees in the exercise of the rights guaranteed to them by this act."

disparately; in September 1997 Jackson was berated by a supervisor; and, that Employee Relations Officer Howard Shaffrin engaged in conduct that had a chilling effect on Puniani's protected rights.

The second amended charge alleged that in August 1999, the State terminated DeGuzman in retaliation for her exercise of protected conduct.

Procedural Background

The original Complaint and Notice of Hearing (C-1)[2/] was issued on December 11, 1997, assigning the case to Hearing Examiner Stuart Reichman. The original Answer admitted certain facts but denied the State violated the Act.

On May 22, 1998, this case was reassigned to Hearing Examiner Charles Tadduni. He conducted a pre-hearing conference on September 14, 1998, attempting to resolve this matter. The Charging Party withdrew the allegations concerning employees Jackson and Puniani, and the parties considered a settlement proposal regarding DeGuzman but the case did not settle.

This case was scheduled for hearing on a number of dates which were cancelled by both parties. A second pre-hearing conference was held on June 8, 1999 which resulted in another settlement proposal which was ultimately rejected.

2/ Exhibits marked "C" refer to Commission exhibits, "CP" refer to the Charging Party's exhibits and "R" refer to Respondent's exhibits.

The second amended charge was filed on October 18, 1999 (C-4). The Hearing Examiner amended the Complaint to include that charge, resulting in the State filing its Amended Answer (C-5) on November 19, 1999 admitting certain facts but denying it violated the Act. The State specifically denied discriminating or retaliating against employees and asserted it acted with legitimate governmental and business justifications.

A third pre-hearing conference was held on November 19, 1999 attempting to resolve the matter, but no resolution was reached. At that time the departmental disciplinary proceeding regarding DeGuzman's termination was ongoing and the Department of Health had not yet released its report regarding DeGuzman's medical performance. Consequently, the hearing was delayed.

Throughout the year 2000, the Hearing Examiner inquired into the status of this case. In July 2000, a complaint was filed by DeGuzman against the State in federal court alleging DeGuzman was wrongfully discharged. By letter of August 31, 2000, the Charging Party sought to delay any hearing in favor of arbitration on minor discipline (a suspension) which interacted with the termination.

In late 2000 or early 2001, the Charging Party appealed her five day suspension to arbitration. By April 2011, the parties agreed to proceed first on the grievance and to hold the unfair

practice hearing in abeyance. That arbitration did not occur until early 2002.

By letter of April 11, 2002, the Charging Party requested the unfair practice case remain on inactive status pending the federal court litigation. The parties joined in the same request in October 2002. The parties renewed that request in March and August 2003. In October 2003, the Hearing Examiner was notified that DeGuzman's federal action had been dismissed, but the Charging Party requested the charge continue to be held pending appeal. That request was renewed in April 2004. In October 2004, the Hearing Examiner was advised that the federal appeal upheld the motion to dismiss, but the Charging Party requested this charge be held until it could determine what action to take. In November 2004, the Charging Party requested a pre-hearing conference. The conference was held on March 8, 2005. Hearings were scheduled for September 2005. In July 2005, the parties requested the hearing be adjourned to give them another opportunity to settle the case. A pre-hearing conference was held in November 2005, and hearings were scheduled for January and February 2006. However, in December 2005 another pre-hearing conference was conducted and the State indicated its intention to file a motion for summary judgment. The parties agreed to adjourn the hearing and allow the motion to proceed. Due to numerous joint requests by the parties, the motion for summary

judgment and answer by the CWA were delayed; the last of which was received by December 2006.

On January 25, 2007, the Commission issued its decision denying the motion for summary judgment. State of New Jersey (Department of Military and Veterans Affairs), P.E.R.C. No. 2007-41, 33 NJPER 2 (¶2 2007). A pre-hearing conference was held on October 25, 2007. On June 4, 2008, Hearing Examiner Tadduni recused himself from considering this matter due to a conflict which had arisen. On June 11, 2008, the Director of Unfair Practices reassigned this matter to Hearing Examiner Stuart Reichman. Hearings were scheduled for November 2008 but the parties requested more time for discovery. Hearings were rescheduled for March and April 2009.

Hearings were held in this matter on March 11, April 28, August 4 and December 16, 2009, at which the parties examined and cross-examined witnesses, argued orally and presented documentary evidence.[3/]

The State moved to dismiss the Complaint in this matter after the Charging Party rested its case. I denied that motion. The State made another motion to dismiss at the conclusion of the hearing (4T125-4T126). The CWA opposed the motion (4T126-4T127). I reserved on the motion at that time. Having considered all the

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3/ The Transcripts will be referred to as "1T," "2T," "3T" and "4T" respectively.

facts, arguments and briefs in this matter I will decide this case based upon the entire record rather than by motion.

Post hearing briefs were received -- after granting a joint request for additional time -- on July 2, 2010. Based upon the entire record, I make the following:

FINDINGS OF FACT

1. The State of New Jersey (Department of Military & Veterans Affairs), CWA Local 1040, AFL-CIO, and Dr. Virginia Guzman are public employer, public employee representative and public employee within the meaning of the Act.

2. CWA represents primary level supervisory and professional employees employed by the State of New Jersey and, in particular, employees working at the New Jersey Veterans Memorial Home in Paramus (Paramus V.A.). Among the titles covered by the unit represented by CWA at the Paramus V.A. is the Physician Specialist 1 title (C-1). DeGuzman held the title of Physician Specialist 1 and was represented by CWA while employed by the Paramus V.A. from 1992 until her termination effective September 8, 1999 (CP-31; 1T88, 1T95).

3. DeGuzman was first hired by the State and assigned to the Paramus V.A. as a part-time per diem staff physician, but became full-time in December 1992 working five days a week (Monday-Friday), eight hours per day (6:30 a.m. to 2:00 p.m.) and

assigned to care for approximately 120 residents in residential Units A/B and C/D (1T88, 1T90, 1T92, 1T146, 2T13).

DeGuzman is trained in internal medicine, pediatrics and family practice and is board certified in one or all of those fields (1T86). DeGuzman has been recognized and won awards from various medical societies and featured in Who's Who as an honored physician (1T86-1T87). DeGuzman is currently in private practice with her husband and has been a physician for over 40 years (1T87).

4. The Paramus V.A. is a skilled nursing care facility whose residents are veterans or spouses of veterans who can no longer be taken care of at home or in a boarding home due to medical problems (1T93, 2T13, 3T42-3T43). The Paramus V.A. has 336 beds and employs a staff of approximately 400 professional and non-professional employees. At any given time there are between 300 and 320 residents (4T6). There are 137 State facility homes like the Paramus V.A. nationally (4T8).

5. The Paramus V.A. is divided into six residential units - A/B, C/D, K/L, M/N, T/V, and R/S with 55 to 60 residents assigned to each unit (1T90, 3T43). One unit is a specialty unit; all Alzheimer's residents are assigned to that unit (3T43). There is a supervisor assigned to each unit (1T90).

6. The facility is audited by the state and federal governments as well as internally (4T6). There are policies,

programs and mandates from both the state and federal governments and internally with the objective to provide the maximum care to the residents in the safest environment (4T7). Nursing homes are rated one through five by the State Department of Health and Human Services (DHHS) - five being the best rating (4T8). According to Chief Executive Officer (CEO) Dorris Neibart, the Paramus V.A. is currently rated 4, a rating that she is proud of and considers to be outstanding (4T8).

7. When a resident is admitted to the Paramus V.A., the resident is assigned to an interdisciplinary team comprised of a physician, nurses, dieticians and therapists (physical, occupational and speech). The team meets initially after the resident's admission, then again after a couple of weeks, and regularly thereafter on a monthly basis to discuss the resident's care. The team develops a plan of care (POC) for the resident which is put into the resident's chart (1T29-1T31, 1T89, 1T93, 1T146, 2T13, 2T101-2T102, 3T88-3T89).

8. In addition to the POC, each resident's chart contains a face sheet, doctors' orders, progress notes, nurses notes, laboratory results, consultations, physical and occupational therapy reports, and any "do not resuscitate" (DNR) instructions (1T28-1T29, 1T31, 1T148, 2T14-2T15). The chart is reviewed during the interdisciplinary team's monthly plan of care meetings and by the doctor assigned to care for the resident during the

resident's mandatory 30-day assessment. The doctor also checks the chart as needed if a problem arises (2T47-2T48).

Nurses review the residents' charts regularly on their shifts and are responsible for implementing the POC on a daily basis (1T29-1T30 1T94, 2T48). Nurses work seven days a week in three eight-hour shifts - 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m. (4T120).

9. The organizational chart of the Paramus V.A. has the CEO at the top with two assistant CEOs (ACEO) who were formerly known as section chiefs reporting to the CEO (4T6). The clinical ACEO is in charge of the clinical staff consisting of all medical professionals, including doctors, nurse practitioners, the director of nursing, assistant director of nursing, nurses, therapists (speech, physical and occupational), dieticians and social workers as well as the quality assurance staff (4T6-4T7). Directly below the clinical ACEO is the medical director (4T7). Nurse Practitioners currently report to the medical director (4T7). The other ACEO is in charge of non-clinical, non-professional staff including maintenance, housekeeping and dining personnel (4T6).

10. Dorris Neibart is CEO of the Paramus V.A. and has overall responsibility for the facility and the care of its residents (4T6). Neibart has a bachelor's degree in nursing and a master's degree in public administration. She has been a

licensed nursing home administrator since 1981 and employed by the Paramus V.A. for at least 15 years (4T4-4T5).

11. Dr. Javed Yousaf has held the position of medical director at the Paramus V.A. since July 1, 1997 (3T42). He graduated from medical school in Pakistan and did his residency at the University of Medicine and Dentistry of New Jersey (3T42). He is board certified in both internal and geriatric medicine (3T42).

As medical director, Yousaf is responsible for overseeing the medical care of all of the residents and supervising the medical staff, including doctors and nurse practitioners as well as performing administrative duties, such as attending monthly and quarterly meetings and creating policy and procedures for the medical staff (3T44, 3T86-3T87). Yousaf also has clinical responsibilities as a physician and, as such, his duties, among others, include examining residents for their 30-day assessments and admitting new residents (3T84, 4T44). As of August 2009, Yousaf was full-time medical director and provided direct care to residents with the assistance of three nurse practitioners who report to him (3T44, 3T86).

12. In 1997 through 1999, there were two staff physicians besides Yousaf - DeGuzman and Dr. Pasquale Campanile as well as one nurse practitioner, Janet Reynolds (3T45, 4T11). At that time, Yousaf worked part-time or 20 hours per week and was

on-call every three days and three nights (1T91). DeGuzman and Campanile worked full-time or 40 hours per week with on-call responsibilities for nights and weekends (1T92). Yousaf had the authority in these years to discipline only the doctors, but currently can also discipline nurse practitioners (3T114).

13. The three physicians were responsible for admitting new patients, 30-day assessment and annual physical examinations for residents assigned to their units, and handling day-to-day medical problems of residents (3T46). The physicians also attended interdisciplinary care team meetings and were on-call for certain nights and weekends (1T91-1T92).

14. During the 1997-1999 period at issue in this hearing, the units were divided evenly between the three physicians (3T45). Units A/B and C/D with approximately 115 residents were assigned to DeGuzman, while T/B and M/N were assigned to Campanile (4T45-3T46). Although at that time he was a part-time doctor as well as medical director, Yousaf did not have a reduced case load as compared to the two other doctors; he took care of residents in Units K/L and R/S in addition to his other administrative duties (3T45, 3T147). DeGuzman did not have a double load compared to the other two physicians (3T45). Only when covering for another physician did anyone have responsibility for more residents, but this was not on a regular

basis, and DeGuzman was never permanently assigned a double load (3T45-3T46).

15. Then as now, the doctors relied on nurses for day-to-day information about the residents and trusted that the information given by the nurses was accurate (1T148). For example, the doctor was notified by the nurses if there were a change in the resident's medical status, such as a significant weight loss (1T93). These changes and any problems were noted by the nurses in the physician's book for each resident. The book was reviewed by the doctor when they came on duty in the morning (1T93, 1T146-1T147, 2T48). If problems arose while a doctor was on duty, the nurse told the doctor about the problem, otherwise the doctor was called (1T94, 1T147). Despite the nurses' daily responsibilities regarding the residents' medical care and implementation of the plans of care, the doctor was, and is ultimately responsible for decisions about treatment and care of the residents (3T88, 3T90-3T91).

16. The 30-day assessment involves a brief physical examination of the resident by the physician. The physicians usually examine approximately 15 residents at a time for a 30-day assessment (3T92). As part of the 30-day assessment, the physician fills out a form answering various questions pertaining to the assessment and explaining any changes that have occurred

since the last assessment - basically documenting all important events between monthly assessments (3T48-3T49).

After the 30-day examinations, the physician typically sits down with the nurse in charge to review the resident's chart for any medications, lab work, and consults that have occurred in the previous 30 days; the review usually takes place at the nurse's station (2T103-2T104, 3T47, 3T51-3T52). In particular, the physician reviews the physician order sheet that lists the resident's medication orders which come every month from the pharmacy (R-12; 4T50).

Any changes in orders are made by the physician, and all medications, if prescribed, must be reordered once a month for every resident (R-13; 3T47, 3T49-3T50). Medications are only ordered for 30 days, so if not reordered, the medication is stopped (3T50). Any changes in orders will often be picked up by the pharmacy and noted by the pharmacist in the chart (3T51). Only a doctor can order medications (2T105).

17. When Yousaf conducts a 30-day assessment, he reviews all the resident's medications and orders with the charge nurse to make sure that everything is accurately reflected in the chart (3T51-3T52, 3T93). If there is a medication that he needs lab results for, Yousaf will look for them in the chart, particularly if the nurse cannot locate the results (R-12; 3T52).

For example, if Yousaf sees a medication such as Lanoxin, he knows that he has to check the resident's blood level, because if it is too high, it can be detrimental to the patient (3T52-3T53). Also, when the blood thinner Coumadin is prescribed, reasonable medical practice calls for asking the nurse for the PT/INR (prothrombin/international normal ratio) test results before reordering this medication (R-12; 3T53). If the nurse can't find the results in the resident's chart, Yousaf will not reorder the Coumadin until the results are located, because if the resident's blood level is too thin, receiving Coumadin can cause spontaneous bleeding (3T53). This medication requires strict monitoring (3T54).

If something emergent comes up in the unit while Yousaf and the charge nurse are reviewing the charts, they stop the review, take care of the situation and then return to the review, so as not to divert attention from the important task at hand (3T93).

18. When physicians write an order, they expect that the nurses and staff will carry it out (1T150, 3T94). Sometimes, orders are called in (3T94, 3T96). The PT/INR test is often called in, because it is an important, if not emergent, test (3T94, 3T96). Swallowing evaluation results may be called in with a recommendation as to a course of treatment (3T97). When a result is called in, the nurse will notify the on-call doctor directly if it is important; otherwise the results are entered

into the physician's book (3T98). As long as the physician has the correct information, the physical report is not needed in order to provide or prescribe a course of care for the resident, and the physical report can be received later (3T97-3T98).

21. However, a mistake can be made, so the doctor and nurse in charge review the medications one by one at the 30-day assessment and, in particular, any changes that may have been made since the last assessment (3T51). Although the nurses and others take care of the residents and review charts, Yousaf and Neibart maintain that the ultimate responsibility for following up on a physician's order rests with the physician (3T54, 4T21).

Ruby Nickie-Duncan, a nursing supervisor at the Paramus V.A. for the past 20 years understands that nurses are responsible for the daily care of residents and are required to carry out a doctor's orders (1T63). For instance, if there is a test that is done and the results come back, the nurse must advise the doctor. Also, if a test is missing or not done, the nurse is supposed to notify the doctor (1T33). Any abnormal test result requires that the nurse call the doctor to advise of the result, or, if it can wait until the next day, she enters the result in a binder for review by the doctor when she/he comes in the next day (1T52). However, Nickie-Duncan agrees and understands that ultimately the responsibility for a doctor's order rests with the doctor who wrote it (1T31-1T33, 1T63).

DeGuzman's Protected Activity

22. Beginning in 1997, DeGuzman felt that management was watching her every move and unfairly targeting her (2T81, 3T8-3T9). As a result, DeGuzman filed several grievances to correct what she believed to be unfair write-ups and criticisms by management (2T81). Some grievances were sustained, some were not sustained, and some were settled. No discipline was withdrawn without DeGuzman filing a grievance; DeGuzman surmised that if she had not filed these grievances, she would have been terminated much earlier, namely in 1997 not in 1999 (2T81-2T82, 2T95-2T96, 3T9). The following are summaries of DeGuzman's grievances.

23. On April 9, 1997, DeGuzman filed a grievance (CP-3) regarding excessive overtime assignments as a result of having 10 consecutive on-calls at night. DeGuzman asserted that because of her excessive workload and overtime caused by a shortage of medical staff, the quality of medical care would be compromised (CP-3; 1T95-1T96). The grievance was resolved when DeGuzman was given some time off, and her schedule was changed (1T96, 2T73).

24. On April 16, 1997, DeGuzman filed a grievance that she was being discriminated against as a minority in violation of the parties' collective negotiations agreement (CP-5; CP-9). CWA maintained that the parties' collective agreement was violated

because DeGuzman was harassed, intimidated and not treated with dignity and respect by Neibart (CP-8).

Specifically, DeGuzman was upset with treatment by CEO Neibart resulting from an incident on April 11, 1997 regarding Neibart's ordering DeGuzman to sign a document called a collaborative agreement. That agreement permits a nurse practitioner to take care of residents under a physician's license. DeGuzman was asked to sign a collaborative agreement permitting Nurse Practitioner Janet Reynolds to take care of residents over a weekend when both Yousaf and Campanile were away and DeGuzman was the only physician on-call.

The grievance asserted that when DeGuzman objected to signing the agreement, Neibart screamed at her and arrogantly directed her to sign the document that DeGuzman felt could endanger her license. DeGuzman accused Neibart of being unprofessional when she instructed Director of Nursing Pat O'Hara to follow DeGuzman to make sure she did what she was told, namely to reexamine residents that had already been examined by Reynolds. DeGuzman felt that she was being subjected to this treatment because she was a graduate from a medical school in the Philippines (CP-5).

DeGuzman was particularly sensitive to the collaborative agreement issue because in 1994 she had been asked by ACEO Lucy Hertel to sign another collaborative agreement with a nurse

practitioner. DeGuzman was concerned at that time that the nurse practitioner, who she didn't know, would be working under DeGuzman's medical license, so she contacted the County Medical Society for advice. DeGuzman was informed that any collaborative agreement must conform to standards established by the Division of Consumer Affairs (CP-6).

Since DeGuzman had been given this advice in 1994, she refused Neibart's request in 1997 to sign the collaborative agreement, because, she concluded, her license was on the line and she did not know Reynolds (1T101-1T102). Unlike in 1994, DeGuzman thought she was given no choice by Neibart about signing the agreement (1T103). Neibart told her that if she didn't sign the collaborative agreement, then she (DeGuzman) would be responsible for all the residents that Reynolds took care of since both Yousaf and Campanile were on vacation (1T103).[4/]

Neibart did not agree that she (Neibart) acted inappropriately in this instance, particularly since nurse practitioners are highly educated beyond the requirements for a registered nurse and work under the umbrella of a physician (4T9). Nurse practitioners often have specialties, and those who work at the Paramus V.A. are usually geriatric nurse

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4/ According to DeGuzman, later that day, Assistant CEO Hertel called DeGuzman to apologize for Neibart's behavior (1T103). Hertel did not testify. I cannot credit this testimony since DeGuzman's testimony constitutes hearsay with no residuum of evidence on the record to support it.

practitioners (4T9). Nurse practitioners can do physicals and prescribe medication under a physician's supervision (4T9). This requires a collaborative agreement between the nurse practitioner and the physician who assumes oversight of the nurse practitioner (4T9-4T11). The use of nurse practitioners has become common throughout the industry and has mushroomed in the last ten years (4T10).

Neibart explains that on April 11, 1997, a Friday, DeGuzman was going to be the only on-call doctor because both Yousaf and Campanile were out of the country until the following Monday (4T11). Nurse Practitioner Reynolds was working and had done all of the necessary resident examinations (4T11). Neibart considered Reynolds as a long time, highly skilled and educated employee (4T11). Neibart asked DeGuzman if she would sign a collaborative agreement with Reynolds which would allow her (Reynolds) to take care of the residents for the weekend unless there was a problem, in which case Reynolds would contact DeGuzman. Neibart needed an answer quickly to ensure coverage for the residents that weekend (4T11, 4T14). According to Neibart, DeGuzman gave her an ambiguous answer and did not commit at that time to sign the agreement (4T11, 4T41).

When Neibart still got no answer by 2:30 p.m. that day, Neibart again approached DeGuzman for a response about the collaborative agreement. DeGuzman told Neibart that she wanted

to call her attorney and would give Neibart a response on Monday (CP-7B; 4T44). That, however, would be too late to ensure coverage of the residents over the weekend (CP-7B; 4T13-4T14). Moreover, the other doctors would be back by Monday, and it would no longer be necessary for DeGuzman to sign the collaborative agreement (4T14). Neibart told DeGuzman that she had the option to sign the agreement or to assume full responsibility for Reynolds' resident load, including repeating all of the physicals that Reynolds had already performed (4T14, 4T42). Neibart told DeGuzman that if she chose the latter, she would be paid overtime for any time spent beyond her normal work hours (CP-7A; CP-7B). DeGuzman opted not to sign the agreement and to stay. DeGuzman was paid overtime for that weekend (4T14).

Neibart denies yelling at DeGuzman during their discussion, but admits taking a firm stance because she needed an answer from DeGuzman before the weekend (4T42). Neibart's insistence that DeGuzman decide whether she was going to sign the agreement or do the overtime was not meant as a punishment but as a necessary action to ensure coverage of residents over the weekend by either the nurse practitioner assisting DeGuzman under a collaborative agreement or by DeGuzman acting as covering physician for all of the residents, in which case there would be no need for a collaborative agreement (4T43, 4T48-4T49).

Neibart wanted DeGuzman to make the decision before the weekend and sent her a directive to that effect because it was necessary to establish the weekend coverage for the residents (4T45). Neibart describes her written directive to DeGuzman as polite but firm (CP-7B; 4T46). According to Neibart, physicians have always signed collaborative agreements (4T50). But the choice was DeGuzman's, to take care of all the residents without a nurse practitioner or to sign the collaborative agreement as a mechanism to make DeGuzman's life easier by not having to cover all the residents herself (4T50).

Neibart issued several memos about DeGuzman's refusal to sign the collaborative agreement. On April 11, 1997, Neibart issued the following to DeGuzman:

> I am directing Dr. DeGuzman to sign for Janet Reynolds patient load utilizing Dr. DeGuzman's license, or to assume full responsibility of Janet's patient load in Dr. Yousaf's absence [sic].
>
> Dr. DeGuzman is given the choice of signing the contract for Janet Reynolds, Nurse Practitioner to work under her license and direction or to assume full responsibility of Janet Reynolds' patient load in Dr. Yousaf's absence or taking care of Janet's patients in Dr. Yousaf's absence.
>
> The patients have to be cared for and protected at all times, the doctor being primary caretaker. [CP-7A]

Also on April 11, 1997, Neibart sent DeGuzman a memo entitled "directive for Medical Coverage during primary

caretaker's absence" (CP-7B). In that memo Neibart again directed DeGuzman to sign for Janet Reynolds as covering physician or to assume full responsibility of Reynolds' patient load in Dr. Yousaf's absence. Handwritten on the bottom of the memo is a note from Neibart:

> The decision must be made in order to cover the patients, and it must be done now. Dr. DeGuzman wants me to wait till Monday 4/14/97, so she can call her lawyer. Obviously we have given her time now, but we cannot wait till Monday. [CP-7B]

By memo dated April 14, 1997 (a Monday), DeGuzman responded to Neibart that Neibart could not order her to sign any document that could be detrimental to her license and asked Neibart to stop ordering her to sign the collaborative agreement for Reynolds (CP-5). Additionally, DeGuzman complained that her caseload which included Yousaf's while he was on vacation was impossible for one person to complete. DeGuzman alerted Neibart that she had given the Administration a copy of the County Medical Society's 1995 response (CP-6) to DeGuzman's concern about another collaborative agreement she had been asked to sign (CP-5).

Thereafter, on April 15, 1997, Neibart sent DeGuzman a letter summarizing the events of Friday, April 11 (CP-8; 4T15). Neibart explained that Reynolds' collaborative agreement with Yousaf was in effect and valid and that DeGuzman would not,

therefore, be required to sign a collaborative agreement. I infer that it was no longer necessary for DeGuzman to sign the agreement. That issue was moot. Neibart also explained in the memo that to lighten DeGuzman's caseload and address her (DeGuzman's) concern about being the only physician in-house with Yousaf and Campanile on vacation, DeGuzman had to cooperate in order for Reynolds to see some of DeGuzman's resident caseload. Neibart told her that Reynolds was sufficiently credentialed and licensed and would refer residents to DeGuzman if the condition of the resident required them to be seen by a physician (CP-8). Neibart concluded that she expected DeGuzman to fulfill her responsibility as a primary care physician, particularly in covering for medical staff who are on vacation or sick leave, but that she (Neibart) was not requiring DeGuzman to sign the collaborative agreement (CP-8).

Despite the Neibart memo (CP-8), DeGuzman filed a grievance on April 16, 1997, over this incident claiming she was threatened and harassed by Neibart (CP-9; 4T14). The grievance was heard finally on June 4, 1997, by Hearing Officer Carl Natter, an Employee Relations Officer (CP-9). Management maintained that it was necessary for the collaborative agreement to be signed on April 11 in order to provide proper care for the residents and denied that the situation involved harassment or lack of mutual respect (CP-9). The parties did not reach an agreement at the

step 1 hearing regarding the grievance, but Neibart attended the hearing for management together with Employee Relations Officer (ERO) Howard Shaffrin (CP-9; 1T112, 4T51). DeGuzman claims that an appeal of this grievance is pending, but Charging Party produced no documents to support this assertion (1T112, 2T78-2T81, 3T5, 3T20). According to DeGuzman, after her termination, all outstanding grievances were put on hold while she pursued her termination appeal (3T19). It is unclear whether this grievance is still pending, but I find that there is no evidence that the grievance was appealed by either DeGuzman or CWA.

25. On April 21, 1997, DeGuzman sent Neibart, ACEO/Section Chief Luci Hertel and Director of Nursing O'Hara a memo about physician coverage alerting them to the fact that from April 21 through April 25, 1997 DeGuzman would be the only physician in the facility (CP-4). DeGuzman was concerned that she would not be able to provide adequate coverage to the residents (1T98). DeGuzman does not recall if she received any extra help after sending this memo (1T98, 2T74).

26. DeGuzman felt that she was being generally harassed at this time and asked her CWA representative to file a general harassment complaint, defending herself against what she felt were unwarranted disciplines and criticisms in her Performance Assessment Reviews (PARS) - e.g. countersigning an order for

Silvadene, using the term crater, missing a TB in-service (1T124, 2T81, 3T7-3T9, 3T28).[5/] A grievance was filed on June 19, 1997 alleging that she is generally being harassed and intimidated for having filed the CP-9 grievance against Neibart (CP-17; 4T14).

DeGuzman describes her feelings at this time as follows:

> And I don't know if you can imagine how hard to work taking care of all these residents and everything is being thrown to you, you are being watched all over the place, every small thing you make is being criticized. [1T124]

On November 26, 1997, a hearing decision was issued, and the grievance was denied (CP-17). DeGuzman did not appeal to Step 2 (CP-17; 3T22-3T23).

27. On June 20, 1997, DeGuzman filed a grievance seeking the removal of a criticism raised in her PAR fact sheet concerning DeGuzman's use of Silvadene, a drug commonly used to treat burns and sometimes for ulcerations of the skin (CP-13; 1T121). Yousaf felt DeGuzman had violated the standard of practice regarding treatment of an ulcer by using Silvadene and put a note in DeGuzman's PAR (CP-13). When DeGuzman looked at the resident's chart later, she discovered that another physician had originally ordered the treatment, and she had just

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5/ DeGuzman first described her grievance (CP-17) as a preemptive strike, but then retracted this description on redirect describing the filing of the grievance as a defense to what she considered to be unwarranted scrutiny and discipline by management (2T81, 3T7). I do not find this distinction material.

counter-signed the order. DeGuzman felt she was being harassed by Yousaf (1T123). The grievance was sustained at step 1. Hearing Officer Howard Shaffrin determined that no hearing was necessary, since the fact sheet comments about the use of Silvadene were rescinded (CP-13). DeGuzman was given exactly what she had requested in her grievance (1T127, 2T88).

On June 20, 1997, Yousaf issued a follow-up memo to DeGuzman and Campanile prohibiting the use of Silvadene at the Paramus V.A. to treat decubitus ulcers, because it was a costly drug which was to be used judiciously and only with Yousaf's approval, if recommended by a consultant (CP-14). According to DeGuzman, there had never previously been such a policy on the use of Silvadene (1T127, 2T88).

28. Connected to the use of Silvadene was a July 1, 1997 grievance filed by DeGuzman resulting from a write-up about DeGuzman using the term "crater" to describe a resident's medical condition and her counter-signing another doctor's order for Silvadene when the doctor was not employed by the Paramus V.A (CP-15). According to Yousaf, no matter how busy his schedule, it is part of his job as medical director to make sure the medical records accurately reflect the medical terminology and that wounds are staged properly (3T136).

The grievance was settled by the removal of the critical notations on DeGuzman's PAR fact sheet and by the issuance of two

memos by ACEO Section Chief Louis LaMola (CP-16; 1T128-1T129, 2T88-2T89, 3T136). One memo acknowledged that the facility does not use the word "crater" when describing medical conditions, and the other confirmed that it was not the practice of the Paramus V.A. to have primary physicians employed by the Paramus V.A. countersign medical orders written by physicians not employed by the V.A., and that the nursing staff can only execute orders written by the resident's primary physician (CP-16).

29. Also, on July 1, 1997, DeGuzman filed a grievance challenging a written warning she received on June 20, 1997 from Yousaf regarding her failure to attend mandatory tuberculosis training (CP-10; 1T112). According to DeGuzman, the training was given on her first day back from vacation and she forgot to go (1T113). On July 3, 1997, Employee Relations Officer (ERO) Shaffrin sustained the grievance, and DeGuzman was notified by Yousaf that the written warning was rescinded at the Step 1 grievance (CP-10; 2T92, 3T132).[6/]

6/ DeGuzman recalls that her colleague Dr. Campanile told her he missed a mandatory training in blood born pathogens but that he only got a reminder from Yousaf and was not disciplined (1T115-1T116). DeGuzman, however, admits that she is not aware of any arrangement that management might have made with Campanile to excuse his attendance or any mitigating circumstances that might have involved Campanile (2T94). Campanile did not testify. Based on DeGuzman's anecdotal testimony and no testimony from Campanile or any other witness corroborating the hearsay testimony, I do not find that DeGuzman was treated disparately in this instance as the factual underpinnings were not established to be

(continued...)

30. On July 1, 1997, DeGuzman filed another grievance about a reprimand she received for failing to write an NPO (nothing by mouth) order for a resident scheduled for oral surgery under general anesthesia (CP-11). The reprimand was signed by ACEO Hertel and served by Yousaf (CP-11).

In regard to the reprimand, DeGuzman explained that she called Nurse Nickie-Duncan and asked her whether the resident was scheduled for oral surgery the next day and was told by Nickie-Duncan that it had been rescheduled. Thus, DeGuzman determined that it was not necessary to write an NPO for the resident (1T118).

There was a Step 2 hearing on the grievance. Nickie-Duncan testified. ERO F. Marcus Stabile sustained the grievance, and the reprimand was removed because management had not proven that DeGuzman made a mistake (CP-12; 1T58-1T60, 1T119, 2T91).

31. On February 9, 1998, DeGuzman filed a grievance alleging that she was not being treated with dignity and respect by Yousaf as a result of an incident that occurred several days before. According to the grievance, DeGuzman was taking care of residents in Unit C/D, when Yousaf appeared holding a letter written by DeGuzman in which she objected to the assignment of two new admissions when two other physicians were available in

6/ (...continued)
comparable.

other units. In the letter, DeGuzman informed Yousaf that she would do her best under the circumstances to provide proper medical care but feared that her efforts would not be sufficient as a result of the assignment of the two admissions (CP-18).

According to DeGuzman, Yousaf challenged her about the letter in an arrogant, loud and belligerent voice in front of Neibart and other colleagues. DeGuzman felt humiliated by this treatment (CP-18; 1T132-1T133). Yousaf disagreed that he treated DeGuzman unprofessionally and disrespectfully in front of colleagues at the nurses station as described in the grievance but understood that DeGuzman had a right to grieve any issue (3T137).

Whether or not the incident occurred as described by DeGuzman, DeGuzman did not pursue the grievance beyond step 1. She decided to just stop the grievance since she and Yousaf were both professionals (1T134, 3T6). It is unclear what happened at the Step 1 hearing.

32. On February 26, 1998, DeGuzman and Campanile sent Section Chief LaMola a memo with copies to Yousaf and Neibart, documenting the tremendous increase in workload and informing them that despite their best efforts, DeGuzman and Campanile felt that the Paramus V.A. may not be able to avoid liability that might arise from not being able to address all the problems. They requested help and support (CP-19; 1T135). The next day,

LaMola sent Yousaf, DeGuzman and Campanile a notice about a mandatory meeting on March 2, 1998 to address these concerns (CP-19; 3T155).

The minutes of the March 2 meeting reflect that LaMola responded to Campanile and DeGuzman's concerns about the overload of residents by reminding them the main function of the physician is to care for the residents and that regardless of case load they are responsible for that care. LaMola informed them that the nurse practitioners support them during vacations and that Yousaf could approve overtime, if necessary. DeGuzman complained about valuable time lost with medicare billing and discussions with residents' relatives and about being questioned about staying overtime to cover emergencies. Yousaf responded that in an emergency where the doctor is required to stay overtime, a note should follow the next day to him about the incident. He reminded DeGuzman and Campanile that overtime could not be allowed on a regular basis, and that paperwork had to be done within regular working hours, although admissions could be completed the next day except for a Friday admission (CP-19; 1T136).

33. On April 6, 1998, DeGuzman wrote Yousaf a letter about an incident that occurred on March 20, 1998 when Yousaf was covering unit A/B in her absence (CP-21). According to DeGuzman, a consultant examined a resident in the Bergen Regional Medical

Center clinic and wanted the resident admitted to the hospital. Without finding out why the consultant wanted the resident admitted, Yousaf instructed the nurse to wait until Monday, March 23, for DeGuzman to take care of it because she knew the resident. No medical documentation was made at that time to the chart or physician's book.

According to DeGuzman, the consultant wanted the resident to be admitted to the hospital as soon as possible because the resident had no pulse in the right femoral area. However, as Yousaf instructed, the resident waited three days until DeGuzman came back and arranged to have a vascular specialist in the emergency room see the resident who was then admitted to the hospital, because a complete occlusion of the right femoral and iliac artery was found. The patient could have lost his leg.

In her letter, DeGuzman asked Yousaf in the future to address any medical problems immediately and to document any information to minimize jeopardizing their licenses (CP-21; 1T142-1T144, 2T97-2T98, 3T11-3T12). DeGuzman wrote the letter because she and Yousaf did not communicate constructively with each other at this time, and she was concerned about the resident not getting optimum care in her absence (2T100, 3T11, 3T26).

According to Yousaf, he received a call on Friday, March 20 after he had left the facility that a resident that DeGuzman had sent to the Bergen Regional Surgical Clinic had returned to the

Paramus V.A. with a recommendation that he be sent for surgery (3T156). Yousaf did not have the resident's chart and asked the nurse why the resident was sent back to Paramus and not straight to the emergency room (3T156). The nurse was not sure. So, Yousaf tried to call the surgeon, but the clinic was closed (3T156).

Yousaf concluded that if it was such an emergency - e.g. that the resident was going to lose his foot, the surgeon would never have sent the resident back to the Home because of possible liability, but would have sent him from the clinic directly to the emergency room which is 100 yards distance from the clinic (3T156-3T158). Yousaf determined, therefore, that the resident's situation was not an emergency (3T157). Nothing happened over the weekend, and the resident had surgery on Monday (3T157).

Yousaf never responded to DeGuzman's letter (CP-21) nor did LaMola (1T144). DeGuzman personally spoke to Nurse Derrig who she copied on the letter, but Derrig also gave her no response (1T144-1T145).

34. On May 11, 1998, Yousaf sent DeGuzman a memo after she left the facility without informing either himself or Lou LaMola. He apprised her that a physician must cover units at all times and cautioned her that in the future, if she had to leave unexpectedly, she had to personally inform him (CP-25).

DeGuzman responded the next day that she was very sick the day before and had requested Dr. Campanile who was on duty in the employee clinic to examine her. Campanile instructed her to leave for the day and told her that he would call Yousaf (CP-25). DeGuzman attached to her memo a copy of the Physician Coverage memo for patient units listing the covering physicians assigned to each unit when the physician in charge is absent for any reason including due to illness (CP-25). It does not appear that she filed a grievance over this incident nor was she disciplined by Yousaf as a result of leaving the facility.

35. According to DeGuzman, at a meeting with medical staff on June 1, 1998, there was a general discussion about hiring. DeGuzman asked if the facility would hire a physician instead of hiring another nurse practitioner (CP-26). DeGuzman pointed out that unlike other facilities, the Paramus V.A. did not have three physicians, because Yousaf only worked part-time. DeGuzman states that Neibart then screamed at her and slammed her hand on the table. The meeting was recorded (CP-26). According to DeGuzman, she was stunned by Neibart's reaction since DeGuzman had only been expressing her opinion (CP-26). The meeting continued, but Neibart got up and walked out while the meeting was still being conducted (CP-26).

After the meeting, when DeGuzman asked LaMola for the meeting tape, he refused telling DeGuzman that it was an

inappropriate request, and that the tape would be reused for other meetings, taped over and erased (CP-26). DeGuzman asked if she could get a copy through her union representative. LaMola told her he would speak to ERO Stabile (CP-26). On June 2, 1998, a CWA representative requested a copy of the tape (CP-26). LaMola responded a couple of days later directing CWA to make the request to the Office of Attorney General since the tape related to an unfair practice charge (CP-26).

Neibart denies screaming at DeGuzman during the June 1998 meeting (4T53). Neibart also does not recall slamming her hand on the table (4T54). I credit Neibart. Charging Party could have called any of the attendees, including DeGuzman's co-worker Dr. Campanile, but did not. I draw a negative inference from the failure to call witnesses to corroborate DeGuzman's testimony. See State v. Clawans, 38 N.J. 162, 170 (1962).

Nevertheless, on June 2, 1998, DeGuzman filed a grievance seeking a written apology and a copy of the June 1, 1998 meeting tape (CP-26). DeGuzman thinks that this grievance is pending because it was not withdrawn by the union, although no documents were produced at the hearing in this matter to support that an appeal is pending (2T94, 3T6, 3T21). According to DeGuzman, after her termination, any outstanding grievances were put on hold while she pursued the appeal of her termination (3T19). However, the grievance form itself has no check mark indicating

that DeGuzman appealed to Step 2 (3T22). Accordingly, I do not find that DeGuzman appealed the Step 1 decision.

36. On August 20, 1998, DeGuzman received a counseling by ACEO LaMola regarding two entries DeGuzman made on January 23, 1998 in the interdisciplinary progress notes of a resident. In the second entry, DeGuzman noted that the resident was eating his lunch. However, a nurse taking care of the resident noted shortly after lunch that the resident's appetite was poor which was consistent with the condition of the resident. The counseling noted that DeGuzman's notation created confusion in the resident's medical records and lacked specific times when she made the lunchtime observation (CP-27). The counseling explained that interdisciplinary progress note forms had to be fully completed including specific times when an event occurs. The counseling noted that the matter was serious, resulting in the facility receiving a deficiency rating from the Department of Health (CP-27). It is unclear when the deficiency determination was received by the Paramus V.A., but I infer that it was proximate in time to the counseling given to DeGuzman.

On August 20, 1998, DeGuzman filed a grievance regarding the counseling and asked that the counseling form be removed from her personnel record (CP-27). The grievance was not sustained because DeGuzman did not bear the burden of proof (CP-27). ERO Stabile determined that the counseling was a corrective step, not

a disciplinary action, and was appropriately handled by LaMola as a result of the facility receiving the deficiency determination based on the manner in which DeGuzman made the entry in the resident's progress notes. Stabile also rejected DeGuzman's claim that she was retaliated against for her use of the parties' grievance procedure since DeGuzman presented no explanation of how her use of that procedure resulted in LaMola retaliating against her (CP-27). DeGuzman thinks that this dispute is still pending, although no document was produced to support that an appeal was filed (2T95).

37. On August 20, 1998, DeGuzman sent a letter to LaMola copying Yousaf, Niebart, Stabile and the CWA representative regarding what she described as a shortage of doctors due to Dr. Campanile's sick leave absence. DeGuzman felt that the shortage would endanger patient care and requested full doctor coverage during his absence. DeGuzman also informed LaMola that she could not take any responsibility for any errors or incidents as a result of Campanile's absence (CP-28).

On August 26, 1998, Neibart responded to DeGuzman:

> Please be advised that as a physician, you are responsible for any medical related decision(s) that you make or should have made for any resident(s) under your care while on duty, or when responding to a call from the facility. [CP-28]

38. On February 25, 1999, DeGuzman submitted a vacation request for December 27, 1999 to return on January 3, 2000

(CP-29; 1T186). The request was not approved (CP-29). DeGuzman filed a grievance, and the vacation request was granted at the step 1 grievance by ERO Shaffrin on May 6, 1999 (CP-29; 1T188, 2T95).

Knowledge of Protected Activity

39. Yousaf was aware that DeGuzman filed a number of grievances that had to be answered by management (3T129-3T130). Yousaf was involved in the processing of the grievances, that he admits took time, but denies that he retaliated against her or felt animosity about her filing of the grievances (3T130, 3T151-3T154). According to Yousaf, all grievances are important, should be taken seriously and investigated no matter the subject of the grievance (3T131). He believed grievance handling to be part of his job as medical director (3T131). Yousaf also feels that resolving labor disputes is good for labor relations and is part of being a manager (3T151-3T152).

40. Neibart also acknowledges that DeGuzman filed many grievances which were all processed like any other grievance by the ERO (4T16, 4T53). DeGuzman, Neibart maintains, had every right to file grievances and all were appropriately processed (4T16). Neibart never held anything against her for filing the grievances (4T53). As CEO she encourages staff to pursue their rights (4T53).

Neibart does not often go to hearings which are usually attended by the ERO and witnesses, although she did attend the hearing for the collaborative agreement grievance which was filed against her (CP-9; 4T56). The ERO typically gathers all the information regarding a grievance or discipline and provides expertise and guidance for the application of disciplinary guidelines (R-1; 4T115).

Adverse Personnel Actions

41. DeGuzman had two disciplinary actions brought against her that led eventually to her termination. The first involved failure to follow up on a swallowing evaluation she had ordered for which she received a five-day suspension (J-1). The second discipline regarded failure to follow up on PT/INR blood test results she ordered resulting in the hospitalization of a resident for Coumadin toxicity as well as surgery resulting from that condition (J-2).

In both of these incidents she was charged with a B.2 offense under the New Jersey Department of Military and Veterans Affairs, Corrective and Disciplinary Action Booklet (R-1). R-1 contains a table of offenses and penalties for all employees working for the New Jersey Department of Military and Veterans Affairs. These guidelines are used in the ordinary course of business at the Paramus V.A. and set out progressive discipline

for various offenses in order to assure the safety and care of residents (4T18).

A B.2 offense is a performance offense, specifically, "[n]eglect of duty, loafing, idleness or wilful failure to devote attention to tasks which could result in danger to persons or property (R-1)." The penalty for a first offense under this section is a minimum five day suspension up to a maximum of removal. A second offense requires removal (R-1; 4T19).

The Swallowing Evaluation

42. On May 7, 1998, DeGuzman received a five-day suspension for her first B.2 offense when she ordered a swallowing evaluation in August 1997 for a resident, M.P., who had dysphasia - a tendency to choke - but for five months never followed up to determine whether the evaluation report came back from the East Orange Veterans Administration (EOVA), the facility where the test was conducted (CP-24; 4T20). Basically, DeGuzman was disciplined for not following up on her own written order (CP-24; 4T22, 4T70). DeGuzman received the minimum of the B.2 offense range (five-day suspension) for this first offense (R-1; CP-24; 4T21-4T22). DeGuzman appealed the suspension but her appeal, that was heard by an outside hearing officer, was not upheld after a second step hearing (4T22-4T23). Neibart was aware of the discipline, went along with it and agreed with it (4T107). Neibart felt the discipline was just and fair (4T107).

43. Neibart describes the incident that led to the five-day suspension. On December 4, 1997, Neibart was in her office when Director of Nursing Pat O'Hara came running in to tell her that a resident was choking. Neibart ran out of her office to either the dining room or day room where the resident was situated, but by the time she arrived, the choking episode had ended (4T20, 4T57-4T58). Neibart was told by a staff member that a swallowing evaluation had been ordered for M.P. a long time ago, but that the results were never returned (4T20). Neibart asked who ordered it and was told that DeGuzman had ordered the evaluation (4T20). Neibart asked why the result was not back for five months and then called DeGuzman who was in the facility, but unaware of the choking incident (4T20, 4T58, 4T60).

44. Usually when an emergency occurs, doctors who are responsible for the resident are paged (4T62). In this instance, Neibart's office was close by so the Director of Nursing went to Neibart's office (4T63). Neibart doesn't know why she was summoned by O'Hara, and DeGuzman was not paged (4T63).

45. DeGuzman was surprised both that M.P. choked, and that she was not paged immediately (1T164, 1T167). When DeGuzman contacted Ruby Nickie-Duncan, the supervisor for Unit A/B, she was told that M.P. was being fed in the Unit A/B day room one-on-one, not the dining room as DeGuzman was first mistakenly told (1T156, 1T166). According to DeGuzman and Nickie-Duncan, no one,

including Nickie-Duncan, could confirm that there was a choking incident involving M.P., and there was no documentation in M.P.'s chart that such an incident occurred on December 4 (1T39-1T41, 1T43, 1T72, 1T167-1T168). Whether there was a choking incident or not is immaterial. I find that there was some incident requiring medical attention involving M.P., that O'Hara summoned Neibart because of the incident, and it was at that time that Neibart discovered the missing swallowing evaluation report. When DeGuzman went to find the report, she also learned for the first time that the evaluation report had not been received at the Home (1T156).

46. Neibart denies yelling at DeGuzman but said that she told her firmly to fax the East Orange Veteran's Affairs (EOVA) hospital and request the result immediately (4T21). Neibart considered DeGuzman's lapse serious because choking can lead to death (4T21). Also, if a doctor writes an order and it is important enough to write, it is the doctor's ultimate responsibility to follow up to make sure that the order is carried out to protect the safety of the resident (4T21).

47. DeGuzman admits that on July 16, 1997, she ordered the swallowing evaluation for M.P., a resident who was a bilateral amputee, blind, diabetic and a chronic smoker, because M.P. had problems with coughing due to his smoking and had dysphasia, a problem swallowing (CP-22; 1T151-1T152, 1T159, 2T109, 3T12). At

the request of the family, the swallowing evaluation ordered by DeGuzman was conducted at the EOVA in August 1997 (1T152). At the same time, the dietician in the Paramus facility suggested a soft diet for M.P., consisting of pureed food (1T152-1T153). After the August 1, 1997 swallowing evaluation, M.P. was fed one-on-one by staff in the Unit A/B day room (1T153, 2T109-2T110, 3T12).

48. Basically, DeGuzman also admits that she never followed up to get the swallowing evaluation report until the December 4 choking incident despite several opportunities to do so. Specifically, on August 21, 1997, DeGuzman examined M.P. for a 30-day assessment (2T109). DeGuzman looked at his chart which contained her order for the swallowing evaluation (2T109). The swallowing evaluation was not in the chart, but DeGuzman admits she never followed up to find out where it was at that time (2T109-2T111). Similarly, on September 9, 1997, there was a notation by the dietician in the doctor's book that the EOVA called and recommended all liquids thickened to nectar consistency for M.P. (CP-2; 2T115). DeGuzman saw this notation, but it did not remind her that she ordered the swallowing evaluation in July and the report had not yet been received at the Home (2T115).

M.P. was also examined by DeGuzman on September 15, 1997 for his 30-day assessment (2T111). Once again, DeGuzman looked at

his chart, but, according to DeGuzman, she would not know if the evaluation report was not there unless someone from her interdisciplinary team told her because "I cannot do everything (2T113)."

Once again, DeGuzman never followed up on the swallowing evaluation after M.P.'s 30-day assessment on October 19, 1997 or his examination in November 1997 (2T117, 2T120). Four months after the swallowing evaluation in December 1997, DeGuzman still did not know the results of the test that she ordered (1T165-1T166, 2T122).

49. The results of the evaluation did not come in right away because the protocol at EOVA changed (1T153-1T154, 3T13-3T14). In the past, the report was sent back with the resident after the evaluation. After the protocol change, a permission form signed by the family or the resident had to be obtained and the social worker had to be given the consent in order to get the evaluation report (1T154-1T155). DeGuzman only learned about the new protocol on December 4, 1997, when she was summoned by Neibart because of the incident involving M.P. and learned that there was no swallowing evaluation report in M.P.'s chart (1T155-1T156, 1T166, 2T122, 3T13-3T14). DeGuzman then requested the final report (1T162, 3T15).

50. As a result of the December 4, 1997 incident, Nickie-Duncan was ordered to investigate and prepare an unusual

occurrence report regarding the incident (CP-1). Nickie-Duncan's report, entitled "Final Investigation Unusual Occurrence", was issued on December 18, 1997 (CP-1). In the report, Duncan confirmed that DeGuzman ordered the evaluation and that on September 9, 1997, a speech pathologist from EOVA called with recommendations based on M.P.'s evaluation and spoke to Nurse D'Amico and Dietician San Andres giving them an order for thickened liquids to be given to M.P. At that time, the Paramus dietician requested a copy of the evaluation report. No report was sent but Nickie-Duncan wrote in her investigation, under the subheading "Conclusion", that every opportunity was taken to place M.P. under constant supervision when it became apparent that he was having difficulties swallowing (CP-1). Nickie-Duncan noted that all residents sent for a swallowing evaluation must have a signed Release of Information Permission Form with them (CP-1).

Finally under the heading "Recommendation", Department Head Patricia O'Hara (1T77) wrote:

> Swallowing eval was done on 8-1-97 and Dr. DeGuzman called for the result on 12-4-97 - this was a great lapse in time & could have resulted in a problem for the resident. All results should be obtained ASAP for the proper treatment of the resident. [CP-1]

Nickie-Duncan admits that since doctors examine residents at least once every 30-days whether there is a problem or not,

DeGuzman would have examined M.P. and reviewed his binder in August, September, and November 1997 (1T65-1T70). DeGuzman never noticed that the swallowing evaluation that she ordered in July 1997 was never received (1T66). Nickie-Duncan also admits that every doctor should identify what was not followed-up when they do the 30-day assessment (1T66). In this case, DeGuzman should have followed-up and called EOVA for M.P.'s swallowing evaluation report herself because it is not the sole duty of the nurse to follow-up but the doctor has the ultimate responsibility to follow up on his or her orders (1T67).

51. Yousaf also conducted an investigation as a result of the December 4, 1997 incident (3T107). Yousaf concluded that the 30-day assessment form has a question regarding whether a consult was done (R-13). When DeGuzman did the 30-day assessments on M.P. in the months after the swallowing evaluation was ordered, DeGuzman should have noticed that there was no swallowing evaluation report and should have asked the nurse to get the report (3T56-3T58). Yousaf contends that a good physician knows what is going on with his/her patients (3T58). The order for the swallowing evaluation was in M.P.'s chart, but the report was not (3T58). The doctor is responsible for ordering medications and lab work for the residents assigned to them (3T59). No other staff can place such orders (3T59). That is standard medical practice (3T59).

Even though it appeared from the chart that DeGuzman had followed up on the September 9, 1997 verbal recommendation from the EOVA speech pathologist, namely to thicken all of M.P.'s liquids to nectar consistency, Yousaf examined the chart and determined that she did not follow other specific aspiration precautions, such as a chin tuck maneuver or instruction not to use a straw, because DeGuzman did not get the swallowing evaluation report (J-1 at M-1; 3T172-3T173). There are certain universal precautions taken with all residents who have Dysphasia or swallowing problems such as being fed one-on-one, sitting up when fed or taking small bites (3T174). The universal precautions are different than the specific ones that were ordered for M.P. as a result of the swallowing evaluation, precautions that were not in place because DeGuzman never followed up to get the report (3T172, 3T175).

52. As a result of the swallowing evaluation incident, a new policy (CP-23) was put in place on March 5, 1998, enunciating (1) the manner in which to deal with swallowing evaluations and (2) a requirement to send consent forms at the time of the evaluation. The policy also created a new form to track any consents (CP-23). Although Neibart did not draft CP-23, she approved it, gave comments and signed it (4T38-4T39, 4T68, 4T114). Neibart wrote on the correction plan that it was necessary to follow up on evaluations that were ordered in a

timely manner, that this policy must be strictly adhered to and that appropriate action should be taken whenever necessary for the responsible person to be disciplined if the policy is not followed (CP-23; 4T114).

Yousaf also played a role as medical director in developing these new policies and protocols (3T108). As medical director, he was not aware of lapses with respect to receiving reports from EOVA before the December incident.

53. DeGuzman appealed the five-day suspension (CP-24). There was a departmental hearing, and a report was issued on May 25, 1999 by Hearing Officer Samuel Hart (J-1). The Hearing Officer found in pertinent part that:

> There is no evidence or testimony that convinces the Hearing Officer that the Appellant's failure to follow up on consultations has resulted in the resident's choking. The issue at hand is the charge that the Appellant's neglect of duty, loafing, idleness or willful failure to devote attention to tasks **could** have resulted in danger to persons or property.
>
> It is clear to the Hearing Officer that Doctor DeGuzman, as a result of failing to properly use the doctor's notes in conjunction with the POC, did not follow up on the results of the swallowing evaluation of [M.P.] between 8/1/97 and 12/3/97.
>
> Based on the testimonies and evidence presented, the Hearing Officer believes that management has clearly borne the burden of proof and the action taken is sustained. [J-1]

No one else was disciplined as a result of the December 4 incident (1T178, 3T111). In 1999, Yousaf could only discipline the doctors he supervised (3T114). At present, he can also discipline nurse practitioners (3T114). Other medical staff are supervised by their department heads and the facility's CEO (3T115).

54. Although Yousaf initially recommended that DeGuzman be disciplined for the lapse in following up on the swallowing evaluation, Section Chief Lucy Hertel processed it and was responsible for the five-month delay between charging and suspending DeGuzman - December 4, 1997 to May 7, 1998 (J-1; 3T159, 3T165).

The Coumadin Incident

55. On August 30, 1999, DeGuzman was served with a Preliminary Notice of Disciplinary Action seeking her termination and charging her with incompetency, inefficiency or failure to perform duties as well as neglect of duty, loafing, idleness or willful failure to devote attention to tasks which could result in danger to persons or property (CP-30A; 2T10).

56. Specifically, the charge asserted that:

> (1) Since April 25, 2000, [DeGuzman] failed to follow the professional standards of practice, DHSS regulations, and [her] own medical orders for properly monitoring PT [prothrombin times] and INR [international

normalization ratio][7/] values for the administration of appropriate doses of Coumadin to Resident [T.G.].

(2) From May 10, 1999 through June 1, 1999, [DeGuzman] failed to follow-up [her] own orders for weekly PT and INR blood work. On June 1, 1999, the resident's INR was 4.2.

(3) From June 28, 1999, through August 22, 1999, [DeGuzman] failed to follow-up on [her] own orders for weekly PT and INR blood work.

(4) As a result of [her] negligence in performing [her] duties as reflected above in paragraphs (2) and (3), [T.G.] was admitted to Valley Hospital in Ridgewood, N.J. and with a PT value of 65.2 and INR of 20.6, and a diagnosis of Coumadin overdose leading to hemorrhagic bursitis. Emergency intervention by the hospital staff was necessitated to reverse the life-threatening blood values. On August 28, 1999, [T.G.] required surgery for the relief of the hemorrhagic bursitis.

(5) During the entire period from April 25, 1999 to date, [DeGuzman] failed to notify Administration and Medical Director, Dr. Yousaf, that all of [her] orders were not being followed. Such notification, early on, could have avoided injury to the resident. [CP-30A]

57. On September 2, 1999 the preliminary notice was amended to add a sixth specification;

(6) The conduct reflected above in paragraphs (#1) through (#5) is similar to conduct for which [DeGuzman] [was] disciplined for in 1998 under DD230.05/B-2 [CP-30B].

7/ The INR was devised for the purpose of monitoring patients who have become stabilized on oral anticoagulant therapy such as Coumadin. The therapeutic range for patients with mechanical heart valves is 2.5 to 3.5 (CP-33).

This was her second B.2 violation, the first being the five-day suspension for the swallowing evaluation incident (2T129). Under the disciplinary guidelines set out by the Department of Military Affairs (R-1), a punishment for a second offense is removal (2T163).

58. On September 8, 1999, a second amended preliminary notice was filed attaching the decision of the informal pre-termination hearing on September 8, 1999 at which management presented its supporting evidence with no response from DeGuzman. The decision of the department designee was that there was reason to believe that the charges were supported by the evidence and that it was not in the public interest for DeGuzman to remain on duty (CP-30C).

59. On September 16, 1999, DeGuzman received a letter from Director of the Division of Veterans' Health Care Services, Joseph D. Loudermilk, informing her that her employment with the State at the New Jersey Veterans' Memorial Home at Paramus was terminated effective September 8, 1999 based on the specifications in the preliminary notices of disciplinary actions, and scheduling a hearing for September 23, 1999 (CP-30A, CP-30B, CP-31).

Basically, the disciplinary action leveled against DeGuzman was for not following up on lab tests that she ordered to monitor

blood levels for a resident who was prescribed Coumadin (J-2; 4T23-4T24). DeGuzman kept reordering 2.5 milligrams of Coumadin to be given on a daily basis to the resident without checking for eight weeks, even during the resident's 30-day assessments, that the tests were not being performed (4T23-4T24). The resident was admitted to Valley Hospital on an emergency basis after a bleed out into his elbow where it was determined that he had Coumadin toxicity (4T24). The condition required an emergency surgical procedure to release the blood (4T24).

60. As CEO, Neibart has the authority to overturn a hearing officer's decision (4T124). Neibart felt, however, that the discipline was just and fair (4T107). Although Neibart considered DeGuzman's length of service, this did not mitigate the termination because DeGuzman's actions were considered to be gross malpractice (4T112). If Neibart had overturned DeGuzman's termination, her decision would have been reviewed by the Department of Military and Veterans Affairs (DMVA) (4T124).

61. By letter dated September 27, 1999, DeGuzman informed Employee Relations Coordinator Allan Staudtmauer that she was appealing her termination from the Paramus V.A. and requested notice of the rescheduled hearing date (CP-32).

62. DeGuzman disagreed with the charges against her as well as her termination. DeGuzman explains that all residents get the team care approach, and, under her perception of the team model,

everybody is equally responsible for the care of residents with, apparently, no one primarily responsible (1T89, 2T155). In the case of T.G., according to DeGuzman, there was a systemic breakdown, and she was not the only one at fault, everybody was failing, but she was the only one terminated. The team, including herself, the nurses, the consultant pharmacist, and the orthopedist who was consulted at the end, failed T.G. (2T151-2T152, 2T163, 3T17-3T18).

DeGuzman admits, however, that it would be good practice if the doctor who ordered the test followed up on the test (2T153). But she contends that she can't keep asking the nurses if they followed through on her orders for tests, and that the consultant pharmacist who oversees the chart should have told her if something was missing (2T155).

Nevertheless, DeGuzman concedes, that from June 28, 1999 through August 22, 1999, although she examined T.G. on multiple occasions, she did not look at T.G.'s PT/INR levels (2T150). As a result, DeGuzman never notified Dr. Yousaf, the nurses or anyone else that critical lab work that she had ordered was not being performed, because she never noticed that it was not done (2T153-2T154). Even though the tests were not done, T.G. continued to receive a daily dose of Coumadin as per her orders (2T151).

63. Coumadin is a medication prescribed for thinning the blood where a particular condition and diagnosis requires it (3T59-3T60). For instance, it would be prescribed for atrial fibrillation which is an irregular heart beat in order to prevent strokes (3T60). The prescribed dose is specific to the individual receiving it and, therefore, must be monitored, sometimes weekly or monthly, in order to determine based on blood analysis how much Coumadin to prescribe (4T23, 4T73). PT/INR are tests that are required when a resident is receiving certain medications, such as Coumadin. PT/INR tests monitor changes in the blood which can result in bleeding if too much Coumadin is given or in atrial fibrillation if not enough Coumadin is administered (3T60-3T62, 4T23).

64. The protocol for ordering blood work is that after the doctor orders it, the nurse fills out a lab slip and then the phlebotomist draws the blood which is sent to the Valley Hospital laboratory for analysis (1T56, 2T42-2T43, 3T112, 4T77-4T78). For certain tests like the PT/INR test, the results are called in to the unit, and then the report is sent by fax to the Paramus V.A. and put into the residents' charts by the unit secretary (2T43, 3T112).

65. A physician's written orders are done at the nurse's station with both the physician and nurse present (2T18). DeGuzman does orders for approximately 15 residents at a time

(2T18). First, DeGuzman checks the resident and then she looks at the chart (CP-33; 2T18). Based on the notes DeGuzman made when she examined the resident, she looks at the chart, sits with the nurse and asks if there was any change since the prior 30 day assessment, such as if the resident was hospitalized or there was a change of weight or the resident had a fall (CP-33; 2T18-2T20). The nurse helps DeGuzman flip through the pages of the chart (2T19). The nurse tells her if there is a lab report such as a PT/INR or urinalysis (2T29).

66. Despite DeGuzman's contention that no one is primarily responsible for the failure in this instance to check the lab results before ordering the Coumadin, I find it is the physician's ultimate responsibility, and he/she is liable for not doing that job (1T63, 3T113-3T114, 3T149, 4T74). For instance, although a nurse's job includes filling out lab slips and her failure to fill out lab slips is a serious infraction, there is no team approach in regard to ordering and reordering medication and checking results or monitoring effects. Specifically, if Coumadin were ordered, the lack of PT/INR lab results would raise a red flag at the 30-day assessment and trigger immediate action to remedy the situation (3T113). It is not the nurse's primary responsibility to check the resident's chart to see if the PT/INR test result is in the chart (3T117).

67. Even DeGuzman agrees that it is imperative for the treating physician to individualize the dosage of Coumadin for each patient by monitoring the patient's blood levels through the PT/INR test (2T130). When T.G. was admitted to the Paramus V.A., he was already on Coumadin (2T28). DeGuzman continued to prescribe Coumadin for T.G.'s atrial fibrillation and ordered weekly tests for PT/INR levels (2T28, 2T139).

For instance, on May 6, 1999, DeGuzman noted in T.G.'s doctor's order sheet the results of his PT/INR test from April 27, 1999 and ordered T.G.'s dose of Coumadin increased from one milligram to two milligrams (R-2; 2T131-2T133). The Coumadin was being administered once a day at night because the PT/INR lab work is reported late in the day (2T28-2T29). Most of the time because the lab work comes in late, the nurses take the call because they are on duty 24/7 (2T29).

68. Tests were again taken on May 10, 1999 and indicated that T.G.'s PT level was high while his INR level was low (R-3; 2T134-2T135). It is unclear what, if any, change was made to the Coumadin order for T.G. However, on May 25, 1999, DeGuzman examined T.G. for his 30-day assessment but noted his April 27, 1999 PT/INR lab results, not the more recent May 10 lab results nor did her 30-day assessment reflect the May 6 order to double T.G.'s Coumadin dose to two milligrams (R-3; R-4; 2T136-2T138). DeGuzman conjectures that possibly the May 10 lab report was not

in T.G.'s chart, because the unit secretary did not file it by May 25, 1999, when DeGuzman conducted the 30-day assessment (2T139).

69. But on June 1, 1999, she noticed T.G.'s INR was high at 4.2, so she immediately stopped the Coumadin for that day (2T29-2T30). Yousaf agrees that, in this instance, DeGuzman acted correctly (3T171).

DeGuzman then did a 30-day assessment on June 22, 1999 (CP-33; R-5) after examining T.G. (CP-33; R-5). DeGuzman's assessment noted results from a PT/INR lab tests taken on June 11, 1999 upon which she relied (R-6; 2T142)). However, T.G. had more recent PT/INR lab test results dated June 14, 1999 which were not mentioned in the June 22 30-day assessment (CP-33; R-7; 2T143). On June 22, 1999, DeGuzman issued standing orders for weekly PT/INR tests for the next 30 days on T.G. and for two milligrams daily of Coumadin (R-8; 2T144). DeGuzman also ordered a repeat PT/INR test for June 25, 1999 (R-8; 2T30-2T31).

70. Despite DeGuzman's standing orders for weekly PT/INR tests, the last PT/INR test was performed for T.G. on June 28, 1999 (R-9; 2T145, 2T150-2T151). Indeed, DeGuzman's July 20, 1999 30-day assessment of T.G. (R-11) and her medication orders of that date (R-10) indicate that DeGuzman ordered the continuation of weekly PT/INR tests and administration of two milligrams of Coumadin (R-10; 2T146). However, nowhere in R-11 or R-10 does

DeGuzman note the results of the June 28 lab work or that T.G.'s lab work for all of July was not being done (R-10, R-11; 2T146-2T148). DeGuzman's explanation for this lapse is that she failed to note that the lab work was not done, because, as a standing order, it should have been (2T146).

71. In T.G.'s standing medication and lab orders dated August 17, 1999 (R-12), DeGuzman again ordered weekly PT/INR tests as well as the daily administration of two milligrams of Coumadin. In T.G.'s 30-day assessment report dated August 17, 1999 (R-13), the only lab reports noted in R-13 were a urine analysis and culture (2T149).

DeGuzman admits that from June 28, 1999 through August 22, 1999, she did not look at T.G.'s PT/INR levels again because the tests were not done, and she was not told they were not being done (2T150). Nevertheless, even though the tests were not done, T.G. continued to receive two milligrams daily of Coumadin (2T151). DeGuzman never notified Dr. Yousaf, the nurses or anyone that critical lab work that she had ordered was not being done, because DeGuzman never noticed it was not done (2T153-2T154). DeGuzman feels that it is the nurses duty to make sure the lab test is done, and no member of the team told her the lab test was not done (2T52, 2T139).[8/]

8/ On May 7 and June 3, 1999, Consultant Pharmacist Larisa Berano who is responsible for reviewing resident charts (continued...)

72. As a result of the failure to check T.G's blood levels since June 1999, on August 22, 1999, T.G. was admitted to Valley Hospital emergency room and examined by an emergency room doctor as well as DeGuzman's husband, Dr. Francis DeGuzman, who was, coincidentally, on-call at the hospital and who diagnosed T.G. with a Coumadin overdose and hemorrhagic bursitis (R-14; R-15; 2T155-2T156, 2T159). When T.G. was admitted on August 22, 1999 his PT level was 65.2, normal range is 11 to 14.5, and his INR level was 20.6, normal range is 3 to 4 (R-16; 2T158).

73. On August 27, 1999, Section Chief Hertel received a call from T.G.'s daughter who was extremely upset by his Coumadin overdose and what she termed "no acceptable explanation about the Coumadin monitoring from the staff and treating physician (CP-36)." Hertel spoke to Neibart (4T25). Neibart directed Yousaf to review T.G.'s chart (3T62-3T63).

After reviewing T.G.'s record, Yousaf issued a statement finding that DeGuzman did not meet accepted standards of good medical practice in the manner in which she prescribed Coumadin for T.G. (R-17; 3T65). Yousaf determined that Coumadin had been

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8/ (...continued) randomly as a safety measure to identify missing lab reports, filled out lab review forms for the C/D unit (CP-35). The consultant pharmacist makes recommendations to the doctor and provides a report regarding any lab work that is over due (CP-35; 3T119-3T120). The consultant, however, is not an employee of the facility. In the case of T.G. his chart was not randomly reviewed and so was not identified by the pharmacist as a problem (3T120).

ordered for months for resident T.G. without anybody reviewing his PT/INR results; these actions or inactions eventually led to T.G.'s illness and hospitalization requiring surgery (R-2 through R-16; 3T64-3T65, 3T115). Yousaf's report concluded that DeGuzman's failure to follow the standards of professional medical practice "placed [T.G.] at risks, which could have been life threatening, and in fact actually led to a negative outcome for this resident (R-17)."

Specifically, Yousaf rejects DeGuzman's explanation that the unit secretary might not have put the most recent blood work in a resident's file as a reasonable excuse for DeGuzman's failures (3T75). Although it is possible that the secretary might not have put a lab result in the resident's chart, DeGuzman should have asked for the PT/INR results before reordering Coumadin (3T75). DeGuzman should not have reordered Coumadin without reviewing the lab results (3T75-3T76). As Yousaf explains, although it is common for the doctor to sit down with the nurse and review a resident's chart, if the chart contains an order for Coumadin and for a weekly PT/INR test, DeGuzman or any doctor should look for the lab results before signing the order for Coumadin (3T76).

74. T.G.'s Coumadin overdose triggered both an internal and external investigation (CP-36, CP-38). For the internal review, DeGuzman as well as Section Chief Lucille Hertel and Nurses

Jessie Bargwa, Debbie Katterman, Marie Favaro, Barbara Perez and Marian Johnston gave statements(CP-36; 2T54-2T55).

75. In DeGuzman's statement, she explained that on the Friday (August 20, 1999) before T.G. was admitted to Valley Hospital, DeGuzman had examined T.G. and diagnosed bursitis since his elbow was warm and reddened (CP-36; R-18; 2T57). At that time she called an orthopedist who told her without examining T.G. to give him antibiotics and observe him (2T27). The orthopedist came in to examine T.G. on August 22, 1999 and observed a mass in his elbow necessitating a transfer to Valley Hospital (CP-37; 2T58). According to DeGuzman, the orthopedist never mentioned in his report or to DeGuzman anything about T.G.'s PT/INR lab results (2T65).

76. As a result of the internal report done by the Paramus V.A., not only was DeGuzman terminated, but Unit Supervisor Debbie Kattermann was given a five-day suspension, because she sat with DeGuzman and went over T.G's chart during the 30-day assessments (J-2; 4T28, 4T88). Kattermann was also suspended, because she had supervisory responsibility for all of the nurses in her unit who failed to follow procedure (4T114, 4T118). However, since it was Kattermann's first B.2 offense, she was not terminated but got a five-day suspension in accordance with the established disciplinary program (R-1; 4T28).

Three other nurses, who admitted not checking T.G.'s PT/INR results before administering the Coumadin ordered by DeGuzman, were not disciplined (4T91, 4T93). However, Neibart has a recollection that they received oral warnings based on statements that Director of Nursing O'Hare made to Neibart before O'Hare retired. I find Neibart's testimony on this issue was not reliable and at times contradictory (4T116, 4T119-4T120). I do not find as a fact that these nurses were given oral warnings or disciplined in any other way (4T112). The other nurses, who worked the evening shift (3:00 p.m. to 11:00 p.m.) when the Coumadin was administered to T.G. without PT/INR test results, were also not disciplined even though they could have been identified (4T121-4T122).

Additionally, two nurses involved with the care of other residents later identified by DHHS as not being properly monitored for PT/INR levels and who had prior disciplinary actions on their record resigned of their own volition before they were going to be terminated (J-2; 4T32, 4T75-4T76, 4T115, 4T122-4T123). Neibart did not, however, force them to resign (4T77).

77. Also, as a result of the Coumadin incident, the Department of Health and Human Services (DHHS) followed up with an audit and went through all resident charts (CP-38). The Department determined that in the instance of Resident T.G. who

was hospitalized, the Coumadin toxicity was primarily due to DeGuzman's oversights, although the nursing staff also failed to provide necessary care and services to T.G. (CP-38; 4T30, 4T101). The audit identified 3 other residents (not under DeGuzman's care) who had also been prescribed Coumadin without monitoring of blood levels, but none of these residents experienced any overdose nor were they hospitalized as a result of the lack of monitoring. Moreover, the time period during which they were not monitored was much less than the eight week period of T.G. who was in DeGuzman's care (CP-38; 4T31). Because there were only 4 residents out of approximately 320 residents identified, representing 1 percent of the resident population, Yousaf did not feel that there was a systemic breakdown (3T127).

The Department gave the Paramus facility a "G" deficiency rating which is a very serious deficiency establishing that there was actual harm to a resident (CP-38; 4T28-4T29, 4T99). Deficiencies are progressive and range from "A" which is minor to "L" which is the most serious (4T28-4T29). Annual audits by the department are also done regularly and a report is sent to the facility (4T29). The facility's existence depends on the results of the audits (4T29). Neibart took the incident involving T.G. very seriously because he could have died (4T99). When a deficiency is cited, the facility is required to write a plan of correction (4T117).

78. Prior to the T.G. incident, there was no protocol regarding the administration of Coumadin, namely requiring the nurse to check the PT/INR results first before administering the medication or calling the doctor if reports are missing (2T31-2T32, 2T34, 2T41). On August 29, 1999, Section Chief Hertel issued a memo to the nursing staff requiring that PT/INR lab results be reviewed before the administration of any anticoagulant (CP-34).

79. Yousaf was not disciplined for this incident and has never been disciplined (3T127). Specifically, in 2000, he was not disciplined for an incident involving a resident under his care who had broken a leg (3T146). The resident, S.V., alleged that the broken leg went undiagnosed for weeks (3T146). Yousaf was not disciplined for the alleged incident, because, he asserts, he was not responsible for what happened (3T146, 3T160).

S.V. was a long-time resident of the Paramus facility, was bedridden and confined to a motorized wheelchair due to a neuromuscular disorder (3T160). S.V. had no sensation below the waist. His muscles were completely atrophied and his bones brittle with osteoporosis (3T160). S.V. had chronic foot wounds that caused his legs and feet to be swollen and red with frequent infections (3T160). When the nurses examined S.V. on a Friday evening they thought because of his frequent infections that he

had another one and called Yousaf at home to describe what they thought was another infection. Yousaf prescribed antibiotics.

When Yousaf came to work that Monday, S.V. was not in pain, because he had no sensation in his legs. However, when Yousaf examined him, he diagnosed what he thought was a fracture and sent him to the hospital. Because S.V.'s bones were so brittle, nothing could be done about the fracture but to amputate the leg. Yousaf later learned from S.V. that he ran into a wall with his motorized wheelchair, turning his ankle which he broke (3T160). After the amputation, S.V. remained at Paramus for another eight years in Yousaf's care (3T160-3T161).

DeGuzman's Performance Reviews

80. Performance is measured by numeric ratings - the lower the performance, the higher the number (2T65). One performance assessment review (PAR) presented by Charging Party appears to support that the numerical ratings range from 1 to 5 (CP-44). CP-44 indicates that rating 1 represents performance "significantly above standards", rating 2 "exceeds standards", rating 3 "meets standards", rating 4 is "marginally below standards" and rating 5 is "significantly below standards".

DeGuzman states that when she was initially employed by the Paramus V.A. she got really good performance ratings, but that once she refused to sign the collaborative agreement things changed (2T65). Charging Party presented DeGuzman's PARs, both

interim and final, for years 1994 through 1999. The PARs are summarized below.

81. DeGuzman's final PAR dated March 1, 1994 (CP-39), reflected a performance rating of 3. Of the six areas listed, DeGuzman was found to have met standards in three areas, although in one area her documentation needed to be more in-depth; exceeded standards in one area; but did not meet standards in quality improvement participation (CP-39).

DeGuzman wrote a response to CP-39 disagreeing with the review as to her lack of depth in documenting certain areas stating that these standards were impossible to meet due to increased patient load. She also explained that there was an interruption of the quality improvement meeting due to a shuffling of committee heads (CP-39).

82. DeGuzman's interim PAR dated July 1995 (CP-40) indicated a rating 2. Of the six areas, DeGuzman was found to have met the standard in three areas and exceeded the standard in three areas. DeGuzman signed the PAR with no comment.

83. CP-41 is DeGuzman's final PAR dated December 1995. She received a rating of 3, having met the standard in three areas; exceeded the standard in one area; but did not meet the standard in one area because residents' yearly histories and physicals were not completed to the standard of compliance 80 percent of the time.

DeGuzman disagreed with her rating of 3 and wrote a response attached to the PAR. DeGuzman explained that she and Campanile had been telling the administration that they needed help in order to keep up with the work, but nothing was done. DeGuzman noted that her first priority is taking care of sick residents as well as covering emergencies. She also pondered whether she was the only one who was not completing physicals in a timely manner and felt that she should have been given leeway due to the shortage of doctors at the V.A (CP-41).

84. CP-42 is DeGuzman's interim PAR dated May 1996. DeGuzman received a rating of 2, meeting the standards in three areas and exceeding the standard in two areas. It was found that DeGuzman brought the yearly history and physical assessments up to date. DeGuzman signed the interim PAR with no comment.

85. CP-43 is DeGuzman's final PAR dated January 1997 and consists of 3 pages. On the first page it shows that DeGuzman received a rating of 2 having generally met the standards in most areas. The second page of the exhibit is an undated final PAR. It is unclear for what year. The rating is 3 although DeGuzman was found to have met standards in four out of five areas and exceeded standard in the fifth category. The third page of the exhibit is an undated interim PAR with a rating of 3. DeGuzman met the standard in the five areas enumerated. It is unclear from the exhibit what year the last two pages represent. There is no

area for DeGuzman's signature nor was there any testimony relating to these pages so I make no findings regarding these last two pages of CP-43.

86. CP-44 is DeGuzman's interim PAR that she received in June 1997. DeGuzman was given a rating of 3. Of the five rated areas, she met the standard in all areas. The PAR is signed by DeGuzman with no comment.

87. CP-45 is an interim PAR dated June 1998. DeGuzman received a rating of 3. There is a handwritten note at the bottom of the PAR written by DeGuzman. The note is cut off at the bottom but presumably there were some areas of the PAR that she agreed with and others that she did not.

88. CP-46 is DeGuzman's final PAR dated June 1999. She received a rating of 3. There were eight areas reviewed. It was found specifically that DeGuzman met the standard in providing primary medical care to the residents of units A/B and C/D, her thirty day evaluations were current and timely, her psychoactive drug progress note comments had improved, her Q1 monitor assignment and billing documents were complete, and that DeGuzman attended all required in-services. The only criticism pertained to the quality of DeGuzman's handwriting which needed improvement because her progress notes were difficult to read.

DeGuzman signed the PAR but commented that the criticism pertaining to her handwriting was raised for the first time even though she began her employment in 1992 (CP-46).

89. Based on a review of the above-described PARS, I do not find as a fact that DeGuzman's initial PARS were any better than the ones presented at the hearing in this matter. No testimony or document supports this statement. When she first began with the Paramus V.A., DeGuzman states that her reviews were really good, although Charging Party presented no PARs for 1992 or 1993 to corroborate this testimony (2T65). There is also no specific testimony to support what DeGuzman meant by the term "really good" in describing her early PARs. Since she received mostly ratings of 3 and a couple of ratings of 2, it would appear that DeGuzman is suggesting that she received ratings of 1 in her early years. I also cannot find as a fact, based on CP-39 through CP-46, that DeGuzman's PARs varied significantly. Basically, she received ratings of 3 indicating that she met standards. There were no ratings of 4 or 5, while in one year she received a rating of 2 in her final PAR for 1997.

ANALYSIS

The CWA vigorously argued in its post-hearing brief that the State violated the Act by terminating DeGuzman because of her exercise of protected conduct, namely the filing of numerous grievances and letters concerning her terms and conditions of

employment. It claims the State's discriminatory motive for terminating DeGuzman was indicated in four distinct ways.

First, the CWA alleges the State, primarily through the actions of Neibart and Yousaf, created a climate of hostility toward DeGuzman's exercise of protected conduct, and that it (they) then retaliated against her for engaging in such conduct over a two and one-half year period. The CWA's support for that allegation are the many grievances and letters DeGuzman filed concerning her employment. Those grievances and letters were predominantly filed between April 1997 and March 1999. Many of the grievances concerned actions by management which the Charging Party considers hostile to previous grievances or letters such as the pressure DeGuzman felt to sign a collaborative agreement, general harassment, written warnings or reprimands, negative notations in her PAR, her letter of April 6, 1998 (CP-21) criticizing Yousaf, her grievance of February 9, 1998 (CP-18) regarding lack of respect, and her grievance of March 25, 1999 (CP-29) denying a vacation request. Many of the grievances were resolved in DeGuzman's favor but the CWA maintains that the totality of the circumstances supports finding the State created a climate of hostility.

Second, the CWA alleges that the timing of DeGuzman's five day suspension and her termination supports drawing an inference that the State's motivation for disciplining her was retaliatory

because they occurred not long after engaging in protected activity. The CWA begins its support for that allegation by arguing that the suspension -- which as the first B.2 violation became the linchpin for the termination -- was suspicious because patient M.P. did not actually choke on December 4, 1997, and because the discipline for the alleged incident did not occur until May 7, 1998.

The CWA argued that the alleged choking incident of December 4, 1997 occurred just over five months after DeGuzman filed a grievance on June 19, 1997 (CP-17) alleging she was being harassed and intimidated for filing a matter in April 1997. It argued that her suspension on May 7, 1998 was just a month after DeGuzman sent a letter to Yousaf (CP-21) criticizing his care of a particular patient, and twelve weeks after DeGuzman filed a grievance (CP-18) accusing Yousaf of being disrespectful to her. The Charging Party also alleged DeGuzman's termination occurred five months after she grieved the denial of her vacation request (CP-29). The CWA argued that the timing of these events suggests the State fabricated the December 1997 choking incident in order to discipline DeGuzman for engaging in protected conduct.

Third, the CWA alleges the State treated DeGuzman disparately as compared to other employees in both suspending and terminating her. It argues that several medical professionals had failed to properly perform their duties regarding the incident leading to

DeGuzman's suspension yet only she was disciplined. It claims, for example, that a floor nurse failed to inform doctors of the swallowing evaluation even though the results had been called in to the Home. The CWA also argued that several nurses involved in the Coumadin incident that led to DeGuzman's termination were not disciplined for failing to fill out lab slips, and failing to check for PT/INR blood levels.

Fourth, based upon the above factors, the CWA maintains that the State's reason for terminating DeGuzman was pretextual. It explains that argument in its brief:

> Given the climate of hostility toward her protected activity at the Home during this time period, the date of the alleged choking incident is important because with every grievance challenging an unjust discipline or improper write up on her PAR that she filed in 1997, and with every victory she obtained through the grievance process, the State grew more and more hostile to the point where they fabricated a choking incident in order to discipline DeGuzman. [at 29]

Finally, the CWA combined the above arguments and inferred that the State had not demonstrated a legitimate business reason apparently for either DeGuzman's suspension or her termination. Based upon its allegation that the choking incident was fabricated, it contends the resultant suspension was really in retaliation for her protected conduct, and that since the suspension was discriminatory, the termination -- which was

predicated upon the validity of the suspension as a B.2 offense -- was pretextual.

The test for determining if an employer's conduct is discriminatory and in violation of 5.4a(3) of the Act was established by the New Jersey Supreme Court in Bridgewater Tp. v. Bridgewater Public Works Assn., 95 N.J. 235 (1984). Under Bridgewater, no violation will be found unless the Charging Party has proven, by a preponderance of the evidence on the entire record, that protected conduct was a substantial or motivating factor in the adverse action. This may be done by direct evidence or by circumstantial evidence showing that the employee engaged in protected activity, the employer knew of this activity and the employer was hostile toward the exercise of the protected rights. Id. at 246.

If an illegal motive has been proven and if the employer has not presented any evidence of a motive not illegal under our Act, or if its explanation has been rejected as pretextual, there is sufficient basis for finding a violation without further analysis. Sometimes, however, the record demonstrates that both motives unlawful under our Act and other motives contributed to a personnel action. In these dual motive cases, the employer will not have violated the Act if it can prove, by a preponderance of the evidence on the entire record, that the adverse action would have taken place absent the protected conduct. Id. at 242. This

affirmative defense, however, need not be considered unless the Charging Party has proved, on the record as a whole, that union animus was a motivating or substantial reason for the personnel action. Conflicting proofs concerning the employer's motives are for the hearing examiner and Commission to resolve.

The decision on whether a Charging Party has proved hostility is based upon consideration of all the evidence, including that offered by the Respondent, as well as the credibility determinations and inferences drawn by the hearing examiner. Rutgers Medical School, 13 NJPER 115, 116 (¶18050 1987).

There is no dispute in this case that CWA satisfied the first two of the three Bridgewater requirements. DeGuzman clearly engaged in protected conduct and the State (i.e., Neibart and Yousaf) were well aware she engaged in such conduct. As in most a(3) cases, however, the issue here is whether the State was hostile to that conduct, and if so, whether the State demonstrated a legitimate business justification for its actions and would have taken the same action had there been no protected conduct.

Regardless of how one assesses the events between 1997 and 1999, and the many grievances and letters DeGuzman filed/sent, there was obviously a poor relationship between DeGuzman and Neibart and Yousaf. At the very least, it appears Neibart and Yousaf did not like DeGuzman on a personal level. While I cannot be certain whether some of the many events occurring prior to

August 1999 constituted hostility, there is enough evidence to infer that some of the incidents affecting DeGuzman preceding that date may have been in reaction to DeGuzman's previous grievances and/or letters. Consequently, for analysis purposes I will assume, without finding, that some of the actions by Neibart and/or Yousaf may have been motivated by hostility toward DeGuzman's exercise of protected conduct.

In accordance with Bridgewater, once a charging party proves all three elements, an illegal motive (by the employer) has been established and the burden then shifts to the employer to establish that the adverse action would have occurred even absent the protected conduct, which is commonly referred to as a "dual motive" for the employer's action. Thus, if the employer establishes a motive for its action which is a legal and legitimate business reason, then the employer will not have violated the Act even if it was also partially motivated by prohibited union animus.

Here, the CWA in its post-hearing brief, boldly asserts there is no need to consider a dual motive analysis. It appears to argue that the State did not have a legitimate business reason to suspend DeGuzman over the "choking incident" because the State, allegedly, fabricated that incident (the choking) merely as a way to discipline DeGuzman for the exercise of protected conduct. The Charging Party argues that the alleged choking incident on

December 4, 1997 and the discipline imposed on May 7, 1998 were pretextual, intended as a way to justify the suspension. The suspension is relevant, the CWA argues, because it constituted the first B.2 violation which was then relied upon to dismiss DeGuzman after the Coumadin incident which then became the second B.2 violation and, based on the State's theory of the case, justified the termination.

While the CWA correctly argues that the suspension is relevant because as the first B.2 violation it combined with the Coumadin incident as the second B.2 violation to justify DeGuzman's termination, the Charging Party's argument that that incident was pretextual and, therefore, in violation of the Act, must be viewed in the proper legal context. The Act contains a six months statute of limitations N.J.S.A. 34:13A-5.4(c). Events or actions outside those six months cannot be the basis of a violation of the Act. The charge in this case was initially filed on August 8, 1997 and first amended on October 14, 1997. Therefore, those charges dealt with events occurring no earlier than February 8, 1997. The second amended charge was filed on October 18, 1999 covering events back to April 18, 1999, easily including the termination which occurred on September 8, 1999 (CP-31). But DeGuzman's suspension for failing to follow up on the swallowing test regarding patient M.P. was on May 7, 1998. The Charging Party never amended its charge to allege that the

suspension or the "choking" incident in December 1997, violated the Act. Thus, while consideration of the facts concerning the suspension are appropriate in order to understand how they -- in conjunction with the Coumadin facts -- formed the basis of the State's justification for terminating DeGuzman, the suspension is not appropriately before me for a determination of whether it violated the Act.

Notwithstanding that legal impediment, having considered the plethora of facts and legal arguments I find the State has satisfied its Bridgewater requirement and proved that it would have terminated DeGuzman for legitimate business reasons even absent her exercise of protected conduct.

The Charging Party relied on the use of key labor relations terms to help prove its case. It argued that the State was "hostile" to DeGuzman's exercise of protected conduct (filing grievances and sending letters concerning her terms and conditions of employment); the "timing" of the alleged choking incident and the subsequent suspension and termination were suspicious; the suspension and termination were "pretextual," used only as a pretext to terminate DeGuzman because of her exercise of protected conduct; and, that in both the swallowing test and the Coumadin incidents, DeGuzman received "disparately" harsher discipline than other employees involved in those incidents.

Hostility

For analysis purposes, I have already assumed, without finding, that some of the State's actions towards DeGuzman for exercising protected conduct in 1997 may have been hostile. Any prior hostility, however, does not establish that the swallowing test incident or the Coumadin incident were based upon union animus. In both incidents DeGuzman actually failed to properly follow-up on patient care. Those incidents, which will be discussed further below, were combined to form the basis for the termination. The events or actions that occurred prior to July 1999 which led to the assumed hostility, were not at all related to the facts constituting DeGuzman's failures concerning the swallowing or Coumadin incidents.

Timing

The Charging Party's timing argument is not particularly strong upon close examination. Remember, the swallowing test and Coumadin incidents were not fictitious, they actually occurred. The CWA claimed the timing of the alleged choking incident was suspicious because it occurred just over five months after DeGuzman's harassment grievance in June 1997. But I consider that time frame, standing alone, already represents a reasonable separation between the grievance and the December event.

Nevertheless, DeGuzman was not disciplined over an alleged choking of patient M.P., the Hearing Officer found no evidence of choking. DeGuzman was disciplined for failing to follow up on her own order for a swallowing evaluation. DeGuzman had ordered the swallowing evaluation on July 16, 1997. The evaluation was completed on or about August 1, 1997. DeGuzman performed her 30-day assessment examinations of M.P. (including reviewing her chart) on August 21, September 15, October 19 and in November, but despite a note from the dietician in the doctor's book that the EOVA (the facility that did the swallowing evaluation) called and recommended thickened liquids for M.P., it did not remind DeGuzman to ask for the actual report until December 4, 1997. DeGuzman admitted she ordered the evaluation (2T109), and admitted she did not follow-up on that order nor seek the report before December 1997 (2T109-2T111). Given those undisputed facts there is no relationship nor timing issue between DeGuzman's June grievance and her failure to ask for the swallowing report until December 1997.

The CWA also claimed that the timing of the State's discipline of DeGuzman in May 1998 over her failure to obtain the swallowing report was suspicious because it was one month after DeGuzman criticized Yousaf in her letter of April 6, 1998 (CP-21) and twelve weeks after filing a grievance against him. That timing argument is also weak.

Two investigations were conducted of the December 4 swallowing/choking incident. Nursing Supervisor Nickie-Duncan issued an "unusual occurrence report" on December 18, 1997 (CP-1). She found that although a dietician requested the evaluation report, none was sent. In testimony she noted that DeGuzman had the ultimate responsibility to follow up on her orders. The Director of Nursing noted in CP-1 that all evaluation reports should be obtained as soon as possible.

Yousaf conducted his own investigation of the incident and concluded that certain recommendations in M.P.'s swallowing evaluation were not followed because DeGuzman did not follow-up to get the report. While he recommended DeGuzman be disciplined, Yousaf did not process the discipline, he attributed the delay in issuing the discipline on May 7, 1998 to his supervisor, Section Chief Lucy Hertel. Charging Party has made no claim that Hertel was hostile toward DeGuzman's protected activity.

While the delay in issuing the suspension seems long, it is hardly suspicious. Based upon DeGuzman's admitted failure to obtain the swallowing report it is not surprising she was disciplined, and given the fact Hertel was responsible for the delay in its issuance, the timing of the suspension seems unrelated to DeGuzman's complaints about Yousaf or her exercise of protected activity.

The CWA also alleged the timing of DeGuzman's termination on September 8, 1999 was suspicious because it came five months after she grieved the denial of her vacation request. I find there was no relationship between DeGuzman's vacation grievance and her termination. The termination was based upon the facts of the Coumadin incident. DeGuzman conceded she continued to give patient T.G. Coumadin between June 28 and August 22, 1999 without asking for or properly reviewing the weekly blood tests (2T150-2T151). She was disciplined for failing to follow-up on her blood test orders and for continuing to administer Coumadin without reviewing the blood test results. There is no dispute she failed to follow up in those areas and the discipline - termination - was implemented shortly after her failure was discovered in late August 1999 which was completely unrelated to her vacation grievance which, incidentally, she won in May 1999.

<u>Pretext</u>

The Charging Party's pretext argument is primarily based upon its claim that the State fabricated the December 4, 1997 "choking incident" and that three other residents were receiving Coumadin without adequate blood tests. The Charging Party seems to draw the inference of fabrication from evidence -- including the hearing officers report -- that resident M.P. didn't actually choke. Although I believe that M.P. did not choke on December 4,

1997, I do not draw an inference of fabrication. I find insufficient evidence to support the fabrication allegation.

While M.P. may not have been choking on December 4, 1997, he did have a swallowing problem and had some issue that day that resulted in Director of Nursing O'Hara assuming he was choking. The Charging Party's pretext argument, in fact, suggests that the State is merely using the swallowing incident as a way to punish DeGuzman for the exercise of protected conduct. I find that she would have received some discipline for her failure to timely obtain the swallowing evaluation even if she had not engaged in protected conduct.

The Charging Party cannot dismiss away the reality of the incident nor put the blame on certain nurses. Whether M.P. was choking or not, DeGuzman's failure to follow up on her own swallowing evaluation order was a serious mistake for which discipline was not unreasonable. If the State -- Neibart and Yousaf -- were determined to terminate DeGuzman because of her exercise of protected conduct they could have done it based upon the swallowing incident alone because a first B.2 offense is a minimum of five days but up to a maximum of removal. But the State did not remove her over that incident, nor did it even move quickly to suspend her. The State's handling of that incident did not signal animus. Moreover, at the time of the swallowing

incident, the Home could not have known that another serious incident involving DeGuzman would subsequently occur.

The CWA claimed the Coumadin incident was a pretext to terminate DeGuzman due to her exercise of protected conduct because when it was discovered that three other patients received Coumadin without proper monitoring by their doctor (not DeGuzman) that doctor was not disciplined. But none of those residents needed to be hospitalized as a result of the failed monitoring, and the lack of monitoring was for a shorter period. Here, DeGuzman had been warned after the swallowing incident that another B.2 type incident would result in termination, and the episode with T.G. proved to be a serious incident that could have cost a life. Given the warning to DeGuzman and the egregiousness of the incident affecting T.G., the State did not need a pretext to discipline DeGuzman for that incident.

Disparate Treatment

The Charging Party's claim that DeGuzman was treated disparately in both her suspension and termination is based upon its belief that nurses in both instances were as culpable as DeGuzman but were not terminated. While it is not the purpose of this hearing to determine why more employees were not disciplined over these incidents, the facts show that DeGuzman, as the doctor

administrating to the patients, had a higher level of responsibility than the respective nurses.

In the swallowing incident, the actions -- or inactions -- of certain nurses is not condoned, but DeGuzman's failure to follow up on her own order over a lengthy period of time was sufficient basis to justify discipline regardless of how the nurses were treated. In the Coumadin incident DeGuzman was not the only employee disciplined. Nursing Supervisor Kattermann received a five day suspension for what was her first B.2 violation because she -- like DeGuzman -- had reviewed T.G.'s chart during 30-day assessments and did not question the absence of required blood tests. Two other nurses who may have been involved resigned to avoid the imposition of discipline. Although not all nurses involved in the Coumadin incident were disciplined, DeGuzman had primary and Kattermann secondary responsibility in this matter. Once again, while the actions -- or inactions -- of other nurses is not condoned, DeGuzman's egregious failure to properly monitor T.G.'s blood and Coumadin levels was sufficient basis to justify discipline.

Most Bridgewater cases, like this one, are fact intensive. Having thoroughly reviewed the facts and arguments I conclude that DeGuzman had primary control in both the swallowing and Coumadin incidents. Her failure to properly manage those two matters were unrelated to the exercise of her protected conduct and not caused

or created by Yousaf or Neibart. I do not believe -- nor do I now find -- that her exercise of protected conduct was a motivating factor in her suspension or termination, and I find the State would have issued such discipline due to her own egregious errors even absent any history of protected conduct. Consequently, the Charging Party has not established a 5.4a(1) or (3) violation.[9/]

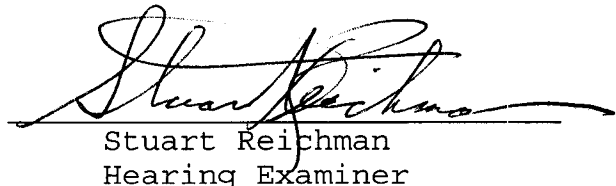
There was insufficient evidence to support a 5.4a(2) violation.

CONCLUSIONS OF LAW

The State did not violate 5.4a(1), (2) or (3) of the Act by discharging Dr. Virginia Deguzman.

RECOMMENDATION

I recommend the Commission **ORDER** the complaint be dismissed.



Stuart Reichman
Hearing Examiner

DATED: November 15, 2011
Trenton, New Jersey

Pursuant to N.J.A.C. 19:14-7.1, this case is deemed transferred to the Commission. Exceptions to this report and recommended decision may be filed with the Commission in accordance with N.J.A.C. 19:14-7.3. If no exceptions are filed, this recommended decision will become a final decision unless the Chairman or such other Commission designee notifies the parties

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9/ Although for analysis purposes, I considered that some of the State's actions affecting DeGuzman could be inferred to constitute hostility, I have not found that any of the State's actions actually constituted a violation of the Act.

within 45 days after receipt of the recommended decision that the Commission will consider the matter further. N.J.A.C. 19:14-8.1(b).

Any exceptions are due by November 28, 2011.