Health & Hospitals Corp. (Harlem Hospital Ctr.) v. Triana

OATH Index No. 282/17 (May 30, 2017)

Respondent, a dietician, failed to competently perform nutrition assessments for several patients over a six-month period, including recommending oral diets for patients who were on "nothing by mouth" status, recommending a tube feeding formula with insufficient calories for a patient who was severely malnourished, and failing to perform or to timely complete accurate assessments for high risk patients. Respondent's errors placed patients' health at risk. Despite being counseled about the quality of his assessments and being provided with relevant training, respondent was unable to improve his job performance. ALJ recommended termination of respondent's employment.

NEW YORK CITY OFFICE OF ADMINISTRATIVE TRIALS AND HEARINGS

In the Matter of
HEALTH AND HOSPITALS CORPORATION (HARLEM HOSPITAL CENTER)
Petitioner
-against-
MIGUEL TRIANA
Respondent

REPORT AND RECOMMENDATION

NOEL R. GARCIA, *Administrative Law Judge*

This is a disciplinary proceeding referred by petitioner, the Health and Hospitals Corporation (Harlem Hospital Center) ("Corporation"), pursuant to section 7.5 of the Personnel Rules of the Corporation. The charges allege that respondent Miguel Triana, a clinical dietician, engaged in numerous instances of misconduct and incompetence, including failing to perform or to timely complete accurate assessments of nutritional status for high risk patients, submitting improper dietary recommendations, and recommending oral diets to patients who failed swallow tests or who were being tube fed, amongst other charges. In all, petitioner alleges respondent provided inadequate assessments for 12 patients (ALJ Ex. 1). The Corporation alleges that the charges constitute misconduct and/or incompetence under Rule 7.5 of the NYC Health and

Hospitals Personnel Rules and Regulations and violations of the Nutrition Screening Assessment and Reassessment Policy (Pet. Exs. 1, 2).

A trial on the charges was conducted before me on October 14 and 28, 2016. Petitioner relied on documentary evidence and the testimony of two witnesses, including respondent's supervisor. Respondent testified on his own behalf, and also offered the testimony of a former coworker and documentary evidence.

At the conclusion of the trial, respondent's counsel moved to dismiss the case on the grounds that a Step 1a conference was held without the respondent or his attorney present. Respondent's counsel submitted a post-hearing memorandum of law on November 18, 2016, asking for dismissal of the charges on the same grounds. Petitioner submitted a response on December 8, 2016.

For the reasons provided below, respondent's motion to dismiss the charges is denied, and the evidence is sufficient to sustain the charges. A penalty of termination of employment is recommended.

PRELIMINARY ISSUE

Respondent's title is covered by the 2007-2009 Pharmacists and Dieticians Unit Collective Bargaining Agreement ("CBA") (Pet. Reply at 3). Article VI of the CBA sets out the grievance procedure for an employee who disputes certain disciplinary action. Following the notice and statement of charges being served upon respondent, an informal Step 1a conference was scheduled pursuant to the CBA. Respondent's attorney requested an adjournment of the Step 1a conference, which petitioner denied. The Step 1a conference was held on August 12, 2015, with neither respondent nor his attorney present (Resp. Mem. at 1-2; Pet. Reply at 2; Tr. 300, 303, 307).

At trial, respondent argued for the first time that his procedural due process rights were violated because petitioner denied respondent the right to appear with his attorney at the Step 1a conference, and asserted that dismissal of all the charges was the appropriate remedy. In its post-hearing memorandum of law, respondent added that it "is immaterial that [r]espondent would have an opportunity to present evidence at a subsequent OATH hearing" because respondent had a "right to take steps which may obviate the necessity to have a hearing before OATH in the first place" (Resp. Mem. at 2-3). In support, respondent relied on *Chambers v. Mississippi*, 410 U.S.

284 (1973), which he argued stood for the proposition that "[n]o state procedural rule may operate to deprive a defendant of her constitutional right to due process to offer evidence in her defense" (Resp. Mem. at 3).

Respondent's argument is unavailing. OATH precedent is clear that failure to hold a Step 1a conference or procedural defects with that conference are not grounds for the dismissal of disciplinary charges. *See Health and Hospitals Corp. (Lincoln Medical and Mental Health Ctr.) v. Thomas*, OATH Index No. 531/04 at 2 (May 4, 2004) ("Procedural defects in conducting the informal conference, as required by the collective bargaining agreement, does not preclude jurisdiction of this tribunal to conduct the section 75 hearing. The appropriate course of action would be for respondent to file a grievance to resolve the question of whether the terms of the collective bargaining agreement had been violated."); *Dep't of Transportation v. Duck*, OATH Index No. 624/91 at 4-5 (Mar. 8, 1991) ("[N]o rule of law or other rule or regulation exists which would divest this tribunal of jurisdiction over the . . . charges merely because respondent failed to receive an informal conference as to those charges. Whether the respondent was entitled to an informal conference . . . is not a jurisdictional issue. It is a grievable matter, which in no way affects this tribunal's jurisdiction. If respondent requested an informal conference and failed to receive one, then he should have grieved it."); *Dep't of Correction v. James*, OATH Index No. 305/89 at 6 (May 31, 1990) ("[T]he failure to provide such conference did not deprive this tribunal of jurisdiction to hear the pending disciplinary charges . . . the Department's failure to provide respondent with an in-house informal conference was clearly harmless error and neither prejudiced respondent in his ability to reach an informal settlement of this matter nor his ability to defend against the charges on their merits."). Instead, pursuant to the CBA, the appropriate course of action to address this issue would have been for respondent to file a grievance in a proper forum within 120 days from the August 12, 2015 Step 1a conference. Respondent failed to do so.

Furthermore, respondent's reliance on *Chambers v. Mississippi* is misplaced. In *Chambers*, the Supreme Court held that in a criminal trial, defendant's due process rights were violated when he was denied the opportunity to cross-examine a key witness who had previously confessed to the crime. 410 U.S. at 302. The same due process concerns do not apply here because in this administrative trial, respondent was not denied the opportunity to cross-examine witnesses or to challenge any evidence against him. Instead, respondent participated in a

settlement conference here at OATH and then exercised his right to proceed to trial, where he was afforded the opportunity to put on a full defense to the charges.

Therefore, because petitioner's refusal to reschedule the informal conference is not grounds to dismiss the charges, nor did it preclude respondent from engaging in settlement discussions or from defending himself at trial, respondent's motion to dismiss is denied.

ANALYSIS

Respondent has been employed as a clinical dietician at Harlem Hospital since October 9, 2001. Both respondent and his supervisor, Ms. Leary, testified as to respondent's duties as a dietician, and such testimony was largely undisputed.

Respondent's duties and training

As a clinical dietician, respondent's main duties included assessing a patient's dietary needs and completing a nutrition assessment, as well as providing and evaluating nutritional care services to patients assigned to him (Pet. Ex. 1). Specifically, upon a patient's admission to the hospital, a nurse identifies whether or not the patient is at nutrition risk, and if that risk is moderate or high (Tr. 20). If such risk exists, a dietician must perform a nutrition assessment for the patient. A nutrition assessment must be completed within 24 hours if the patient is a high nutrition risk, or within 72 hours if the patient is a moderate nutrition risk (Tr. 20-21). If a patient is high risk on the initial assessment, then a reassessment must be completed within three days. If a patient is a moderate risk on the initial assessment, then a reassessment must be completed within seven days (Tr. 21). If during the assessment or reassessment the patient is found to have malnutrition, the dietician must then perform an assessment identifying the malnutrition and providing a recommended course of action to address the condition (Tr. 22-23).

Respondent testified that he was assigned to the 13th floor of the hospital, where he would perform assessments for 17 to 20 patients a day (Tr. 332-33). Respondent provided care for patients on the 14th floor and the intensive care units if a dietician assigned to those areas was absent (Tr. 332). In all, there were a total of five dieticians assigned to respondent's unit, including respondent (Tr. 332).

On a typical day, respondent "was the dietician that opened at 7:00 o'clock," and had "to take care of every call and complaint that happened between 7:00 to 8:15" (Tr. 333). After that,

respondent stated that he would assess the patients assigned to him for that day (Tr. 333-34, 336). Respondent would receive a list of patients from an online program on his work computer (Tr. 336-37). For each patient assigned to him, respondent's responsibilities included: collecting data from the patient's medical chart; interviewing the patient; determining the patient's age, height, weight, weight change history, diet history, and use of any medication; assessing the patient's ability to chew and swallow; and noting the patient's skin integrity (Resp. Ex. C; Tr. 333-34). Respondent would use the collected data to make any necessary calculations, such as determining a patient's body mass index ("BMI"), or the amount of calories or protein the patient required (Resp. Ex. C). Respondent testified that he took written notes of the information he collected, and that he would input the data into the hospital computer system after he completed his visits to all of his assigned patients (Tr. 338). Once the data was entered into the computer system, respondent would make a dietary recommendation (Tr. 336).

Ms. Leary emphasized that when a dietician performs an assessment, the dietician must also address pressure ulcers and carefully monitor any weight change. Ms. Leary explained that a pressure ulcer is a skin or tissue injury that occurs frequently in critically ill patients who are "on their back" for a significant period of time, but who are not turned and positioned properly or who do not receive adequate nutrition (Tr. 23-24). Consequently, patients who either have or are at risk of developing a pressure ulcer have increased nutritional needs, and require higher levels of calories, proteins, and fluids. As a result, it is "critical" for a dietician to assess pressure ulcers to ensure that a patient receives the increased nutrition that "plays a key role" in preventing or healing such ulcers (Tr. 23). Ms. Leary stated that she frequently discussed the importance of addressing pressure ulcers with the clinical dieticians, and that any dietician "inherently" knows that "nutrition is a critical part of [addressing] pressure ulcers" (Tr. 24).

Ms. Leary testified that assessing a patient's weight change is also a "key component of our assessments and reassessments," and that weight change needs to be monitored and addressed throughout a patient's hospital stay (Tr. 24-25). Ms. Leary stated that hospital dieticians were provided training on how to calculate and address weight change, including guidelines for determining significant versus non-significant weight change (Tr. 25).

Petitioner submitted evidence that respondent was present for various "in-service" and webinar trainings including: Nutrition Screening Assessment, Reassessment/Follow-up Policy; Identifying and Documenting Malnutrition; Comprehensively Addressing Malnutrition in

Hospitalized Patients; Usual Body Weight and % Weight Change; How to Write a PES Statement; Overview of Nutrition Care Process and PES Statement Writing Workshop; and Protein Delivery in the Critically Ill Patient: Are We Giving Enough? (Pet. Exs. 3-9).

Petitioner's evidence

Petitioner alleges that from August 2014 to January 2015, respondent failed to provide timely and accurate assessments or reassessments to 12 patients, and that respondent's failure to competently perform his duties placed patients' health at risk (ALJ Ex. 1). Petitioner's main witness, Ms. Leary, was employed as a clinical nutrition manager for Harlem Hospital from August 2013 to January 2016 (Tr. 15).

As part of her duties, Ms. Leary held monthly meetings with dieticians under her supervision, and reviewed their patient assessments and related medical charts (Pet. Ex. 10; Tr. 39). As early as September 2013, Ms. Leary began noting and addressing with respondent deficiencies with his work (Pet. Ex. 28). Petitioner submitted into evidence respondent's performance evaluations for the relevant time period, each of which noted respondent's failure to follow assessment policies and procedures, and his general inability to competently perform assessments, while also listing steps for improvement (Pet. Ex. 28). Petitioner offered into evidence Ms. Leary's monthly clinical nutrition chart reviews for the months of February to June 2014. These charts contained Ms. Leary's notes regarding respondent's deficiencies with his patient assessments along with suggested plans for improvement, and were signed by respondent (Pet. Ex. 10). Lastly, petitioner presented an e-mail from Ms. Leary to respondent that summarized a meeting she had with respondent in September 2013. That e-mail contained suggestions to assist respondent in prioritizing his workload and for completing his assessments and reassessments, and "tools" that Ms. Leary created to help respondent keep organized (Pet. Ex. 10; Tr. 39).

Nevertheless, petitioner alleges that respondent continued to make similar mistakes in his work, and that such mistakes placed patients' health at risk (ALJ Ex. 1; Pet. Exs. 11, 28; Tr. 9-12, 482). On January 22, 2015, Ms. Leary sent a detailed memorandum notifying the hospital's labor relations department about the continuing issues with respondent's work (Tr. 41; Pet. Ex. 11). The issues identified by Ms. Leary in the memorandum cover many of the charges here, including respondent's alleged failure to complete timely assessments or reassessments, to

correctly assess patients, to address pressure ulcers and malnutrition, and to properly address nutritionally pertinent information (Pet. Ex. 11).

At trial, respondent admitted or did not contest some of the specifications, but denied the remaining charges.[1]

Charges admitted (Specifications 1(a), (b); 7(a); 11(c), (d); 12(b), (d)-(g); 13(a), (b), (e); 15; 16)

Specification 1(a), (b)

Specification 1(a) and (b) alleges that "[o]n or about August 3, 2014," respondent failed to perform an "accurate assessment of nutritional status" for high risk patient RP because he noted that (a) RP "was at less than 25% meal intake," and that (b) RP "had an oral diet," when RP was tube feeding.

Respondent admitted to both subparts (a) and (b) of this specification by stating, "I make a mistake. Is very, is very, is very common when you have a lot of work to make mistakes like that. If the patient is on tube feeding, you know, to put 25% intake. Remember that I collect information from several patients, okay, and then at the end, when I start inputting in the computer the information, I can really make mistakes like this" (Tr. 353-54).

Specification 7(a)

Specification 7(a) states that "[o]n or about September 2, 2014," respondent failed to perform an "accurate assessment of nutritional status" for patient JB because he "failed to do a malnutrition assessment." In response, respondent stated "yes" when asked if he failed to do a malnutrition assessment for JB, and testified that he "overlooked" it (Tr. 366-67).

Specification 11(c), (d)

Specification 11(c) and (d) states that "[o]n or about December 8, 2014," respondent "jeopardized patient's safety when he submitted improper recommendation(s)" and failed to perform "an accurate assessment" for high risk patient AD by (c) failing to note or address AD's acute kidney injury, and (d) by noting that AD was obese, when AD was of normal weight.

[1] At trial, petitioner withdrew Specifications 11(g), (i); 17; and 18. Due to scrivener's error, Specification 10 did not contain a charge.

Respondent admitted to Specification 11(c) by stating, "Yes, I failed to, to note that the patient have acute kidney injury" (Tr. 379). He admitted Specification 11(d) by stating, "Yes, I overlook because the BMI calculated was 20.8. That is that the, the patient have a normal weight" (Tr. 380). Respondent added that he performed the BMI calculation himself, and that the result showed that AD was within the normal weight range, but he instead noted AD as obese in his assessment (Tr. 380-81).

Specification 12(b), (d)-(g)

Specification 12(b), (d)-(g), alleges that "[o]n or about January 12, 2015," respondent failed to perform "a comprehensive or accurate reassessment" for high risk patient CA by (b) failing to note or address CA's significant weight change, and that after CA died, respondent nevertheless noted that CA was able to (d) chew and (e) swallow, and that respondent (f) prescribed CA a regular diet, and (g) noted that CA had a diet tolerance between 40-59% meal intake.

Respondent admitted Specification 12(b), failing to note CA's significant weight change, by stating that "I didn't address it because I didn't note it . . . I didn't see it. Remember that I was covering just for one day that patient. This is not my regular patient" (Tr. 395). Respondent admitted to Specification 12(d)-(g). Pursuant to the medical records and the testimonial evidence, the events alleged in Specification 12(d)-(g) occurred on January 15, 2015, the day CA expired. The medical records revealed that CA was hospitalized for a brain hemorrhage and that "although [CA] was awake, he was unresponsive throughout the entire stay . . . [and] was unable to follow any commands." The medical records noted that on the day in question, CA "was weaned off life support" and pronounced dead at 1:00 p.m. (Pet. Ex. 19 at 120).

While respondent first testified that he visited CA at around 8:00 a.m. on January 15, 2015, and that CA was able to chew, he subsequently changed his testimony, and admitted on cross-examination that he observed CA on a ventilator and intubated, and that a patient in this condition cannot chew or eat food (Tr. 397-98; 447-48). Respondent also admitted that he noted in his assessment that CA was able to chew and swallow, that he prescribed for CA a regular diet, and that CA had a meal intake of 40 to 59%, but that these statements were inaccurate (Tr. 447-48).

It bears mentioning that respondent's admissions and the medical records evidenced that CA was unable to chew, swallow or consume food because CA was on a ventilator and intubated, and not because CA had died, as alleged in the specification. Similarly, the allegations encompassed by Specification 12(d)-(g) occurred on January 15, 2015, and not January 12, 2015. However, as this matter was fully litigated at trial, and because respondent admitted to the charges, the charges described in Specification 12(d)-(g) are amended to conform to the evidence. *See Health and Hospitals Corp. (North Central Bronx Hospital) v. Cross*, OATH Index No. 315/97 at 7-8 (Jan. 27, 1997) (where the petition alleged misconduct on September 23, 1995, but the evidence pertained to September 3, 1995, and where it was clear that respondent fully understood which date was at issue and was able to defend the charge in spite of the error, the administrative law judge amended the petition to conform to the proof); *Police Dep't. v. Coll*, OATH Index Nos. 245/95, 252/95 at 7 (Feb. 16, 1995) (where the petition alleged that respondent "did kick and/or strike with a nightstick" but the trial evidence showed that respondent punched complainant, and where post-trial amendment of the petition to conform to the proof would not surprise or prejudice respondent, such amendment was granted).

Specification 13(a), (b), (e)

Specification 13(a), (b), and (e), alleges that "[o]n or about January 15, 2015," respondent failed "to complete a comprehensive or accurate assessment" for patient CM by: (a) recommending an oral diet when CM had failed a swallow test; (b) stating that CM was able to swallow but also noting that CM had difficulty swallowing; and (e) noting that CM had a meal intake between 25-50%, but instead CM was on "nothing by mouth" status.

Respondent admitted to Specification 13(a) by stating, "Well, I have to admit that I didn't see that note or I was, I was so busy that I overlook it" (Tr. 399). The note respondent was referring to was contained within CM's medical records, and stated that CM had failed a swallow test (Tr. 399-400). Respondent admitted to Specification 13(b) by stating, "I admit that the patient have problem swallowing, but I make a mistake . . . and then put that the, the patient can swallow. Because I admit that the patient have difficulty swallowing" (Tr. 400). Lastly, in relation to Specification 13(e), respondent stated, "[it] [i]s a mistake . . . my mistake" (Tr. 400).

Specification 15

Specification 15 states that "[o]n or about November 8, 2014," respondent failed "to complete an accurate or comprehensive assessment" for patient MM. Respondent admitted that his assessment for MM was inaccurate because "here the mistake was that the patient is obese . . . and I do the calculation for somebody that is a normal weight" (Tr. 404). Respondent further admitted that "when the patient is obese . . . you want that the patient lose weight and then I overlook that . . . the patient, you know, is overweight . . . and that's the reason why . . . this is not correct, the calculation . . . ." (Tr. 405).

Specification 16

Specification 16 states that "[o]n or about November 13, 2014," respondent failed "to complete a comprehensive assessment" for high risk patient DB when the assessment "was due on November 14, 2014, but was not completed." Respondent admitted that he did not complete the assessment, but stated that it was because of his assigned volume of work (Tr. 411).

To the extent respondent attempted to justify any of the above charges by blaming an alleged high volume of work, such argument is without merit. Prior OATH decisions have rejected this defense where an employee did not make a contemporaneous complaint about workload to management, and did not file a grievance. *See Law Dep't v. Lawrence*, OATH Index No. 1312/10 at 11 (March 30, 2010), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 11-36-A (May 11, 2011) (no evidence that respondent "had made his supervisor aware of his massive backlog, or that he felt overworked"); *Transit Auth. v. Felix*, OATH Index No. 1206/09 at 46 (June 16, 2009) (despite being "upset about her workload, respondent did not file a grievance with management protesting that she had more work than everybody else . . . ."); *Law Dep't v. Stanley*, OATH Index No. 1540/05 at 5 (June 15, 2005), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 06-08-SA (Jan. 9, 2006) ("Respondent's admitted failure to mention to [her supervisor] any problems with completing this assignment further confirms . . . that it was neglect and apathy, not overwork, which caused the data entry to go undone.").

While it was uncontested that respondent was repeatedly counseled as to the quality and timeliness of his work, there was no evidence submitted that respondent ever expressed to his superiors that his work deficiencies were caused by his workload. Indeed, it is significant that respondent never made such a complaint despite being fully aware that any inaccurate or untimely assessment could lead to serious consequences for a patient's health (Tr. 355-56, 371,

393-94). Respondent specifically admitted that he never filed a grievance regarding his assigned volume of work (Tr. 434-35). In sum, the evidence established that respondent's admitted errors were caused by his own carelessness and incompetence, and not by his workload.

Respondent presented the testimony of Maria Bryant on this point, but her testimony was wholly unpersuasive. Ms. Bryant was a dietician at Harlem Hospital, and opined that the number of dieticians on the staff was not sufficient for their caseload (Tr. 420-22). She added that there were "many times" when there were less than five dieticians working on any given day (Tr. 422). However, this witness's credibility was undermined by the fact that respondent had testified on Ms. Bryant's behalf at her disciplinary trial at OATH, and she now appeared to be returning the favor (Pet. Ex. 31 at 4; Tr. 429). More importantly, her testimony did not explain why, if respondent believed that he was committing errors or failing to complete assessments because he was overworked, he never filed a grievance or made such a complaint to his supervisor.

Therefore, based on respondent's admissions, the above charges should be sustained.

Charges not contested (Specifications 2(c), (d); 4; 6(c); 7(b))

Specifications 2(c), (d)

Specification 2(c) and (d) states that "[o]n or about August 6, 2014," respondent failed "to complete a comprehensive or accurate reassessment" by noting that high risk patient RP (c) was able to chew, and that (d) he was at less than 40% meal intake, when RP was instead tube feeding. It was uncontested that respondent noted in the assessment that RP was "able to chew" and was "at less than 40% meal intake" (Tr. 86-87; Pet. Ex. 12 at 31). However, Ms. Leary's testimony and the medical records established that RP was not consuming meals orally because RP was being tube fed on the day in question (Pet. Ex. 12; Tr. 87). As respondent did not offer any rebuttal to the credible evidence presented, Specification 2(c) and (d) should be sustained.

Specification 4

Specification 4 states that "[o]n or about August 11, 2014," respondent failed "to complete a timely comprehensive reassessment of nutritional status" for a high risk patient. The evidence established that respondent's assessment of the patient was completed on August 6, 2015, and that under the heading "Dietician Assessment Risk Status," respondent noted "high" (Pet. Ex. 12 at 31; Tr. 87). Ms. Leary credibly testified that, as here, when a patient is deemed at

high risk, the Nutrition Screening and Reassessment Policy requires the dietician to reassess the patient within three days (Pet. Ex. 3 at 433; Tr. 87). Therefore, the reassessment was due on August 9, 2014, but respondent did not complete the reassessment until August 11, 2014 (Pet. Ex. 12 at 33; Tr. 88). As respondent did not provide an explanation for the delay, the charge should be sustained.

Specification 6(c)

Specification 6(c) states that "[o]n or about August 12, 2014," respondent failed "to complete a comprehensive or accurate assessment of nutritional status" for patient EW by (c) failing to do a malnutrition assessment. Respondent's assessment showed that EW had a BMI of 17 on the date in question (Pet. Ex. 14 at 57). According to Ms. Leary's credible testimony, a BMI of less than 18.5 is considered underweight, and requires a separate malnutrition assessment to be completed "at the time of the assessment or reassessment" (Tr. 96-98). Nevertheless, the hospital computer records established that respondent never performed a malnutrition assessment despite noting EW's low BMI (Pet. Ex. 14 at 60; Tr. 97). As respondent did not address his failure to perform the malnutrition assessment, the charge should be sustained.

Specification 7(b)

Specification 7(b) states that "[o]n or about September 2, 2014," respondent failed to perform an "accurate assessment of nutritional status" for patient JB because he "failed to note and/or address wound healing for a pressure ulcer as a goal" for JB. Although respondent noted in the assessment that JB had a Stage 4 pressure ulcer, he did not make a recommendation to promote healing of the wound (Pet. Ex. 15 at 62-63). Ms. Leary credibly testified that respondent should have included such a recommendation in his assessment (Tr. 104). As respondent offered no rebuttal to this charge, Specification 7(b) should be sustained.

Charges contested or not proven (Specifications 2(a), (b); 3(a)-(c); 5; 6(a)-(b); 8(a), (b); 9; 11(a), (b), (e), (f), (h); 12(a), (c), (h); 13(f); 14)

Specification 2(a), (b)

Specification 2(a) and (b) states that "[o]n or about August 6, 2014," respondent failed "to complete a comprehensive or accurate reassessment of nutritional status" for high risk patient

RP because RP was suffering from a pressure ulcer, but respondent (a) noted in his assessment that RP did not have a pressure ulcer, and (b) failed to address RP's pressure ulcer.

The evidence established that on August 5, 2014, a nurse entered the following information on RP's medical record, under the section for "Skin Status": "Lesion: ulcer; Location: buttock(s); Stage: stage 2 partial thickness" (Pet. Ex. 12 at 29; Tr. 85). In answer to the question "Skin Intact?" the nurse wrote "No" (Pet. Ex. 12 at 29). Ms. Leary testified that an ulcer is a type of lesion, and that a pressure ulcer is an ulcer manifested in a pressure area of a patient's body, such as the buttocks (Tr. 85, 214-18). Ms. Leary explained that therefore, based on RP's medical record, RP had a pressure ulcer (Tr. 85, 216-17). However, on August 3 and 6 of 2014, respondent noted in his assessment, under the "skin integrity" section, that RP had "No Pressure Ulcers" (Pet. Ex. 12 at 25, 31; Tr. 84). Respondent argued that this notation was correct because a lesion is not a pressure ulcer (Tr. 354-55).

A credibility determination is required where, as here, the parties have presented conflicting testimony on relevant facts. In making a credibility determination, this tribunal may consider such factors as witness demeanor; consistency of the witness's testimony; supporting or corroborating evidence; witness motivation, bias, or prejudice; and the degree to which a witness's testimony comports with common sense and human experience. *Dep't of Sanitation v. Menzies,* OATH Index No. 678/98 at 2-3 (Feb. 5, 1998), *aff'd,* NYC Civ. Serv. Comm'n Item No. CD 98-101-A (Sept. 9, 1998).

During the trial, Ms. Leary provided credible and consistent testimony that was generally corroborated by the documentary evidence. Ms. Leary's demeanor was open and professional, and she appeared to be very knowledgeable in the area of nutrition. Specifically, her testimony explaining medical terminology and nutritional guidelines and procedures was thorough and easily understood.

Respondent, on the other hand, had a compelling motive to deny wrongdoing and avoid being penalized. Further, respondent's testimony was often confusing, evasive and not supported by the documentary evidence. In contesting the charges, respondent at times argued that his recommendations for patients were correct, but in fact such recommendations did not comport with common sense. In sum, Ms. Leary's testimony was more credible than respondent's.

Here, I credit Ms. Leary's consistent and common-sense testimony that an ulcer is a type of lesion and that an ulcer in the buttocks area is a pressure ulcer. I also note that respondent's assessment for RP does not mention any ulcer or lesion, despite such injury being documented in RP's medical record. Accordingly, because respondent incorrectly stated in the assessment that RP did not have a pressure ulcer, and did not address the pressure ulcer, Specification 2(a) and (b) should be sustained.

Specification 3(a)-(c)

Specification 3(a)-(c) states that "[o]n or about August 8, 2014," respondent failed "to complete a comprehensive or accurate reassessment of nutritional status" for patient JH by: (a) failing "to note and/or address" JH's significant weight change; (b) failing "to make any or appropriate nutritional recommendations" for JH's pressure ulcer; and by (c) failing "to make any or appropriate nutritional recommendations" for JH's "nothing by mouth" feeding status.

As for Specification 3(a), the medical records noted that on August 7, 2014, JH's weight was listed as 110.1 kilograms, but that on August 8, 2014, JH's weight was listed as 116.8 kilograms (Pet. Ex. 13 at 46-47). Ms. Leary testified that JH's recorded weight gain was greater than 5%, and that a weight change of 5% or more within a 30 day time span is considered significant (Tr. 91). A significant weight change requires a weight evaluation and a recommendation (Tr. 92). It was uncontested that on JH's assessment dated August 8, 2014, respondent listed JH's weight as 116 kilograms, but did not make note of JH's significant weight increase from the day before, and did not provide a recommendation to address the weight change (Pet. Ex. 13 at 44).

Respondent argued that JH's alleged weight gain was "not possible" because "[n]obody can get 13 pounds from one day to another," and that "obviously it's a mistake" (Tr. 359). However, even accepting that respondent believed that such a weight gain was impossible and that the listed weights were inaccurate, respondent's implicit but troubling argument that he could simply ignore the alleged weight gain is without merit. Instead, because respondent did not note or address JH's documented weight change, Specification 3(a) should be sustained.

As for Specification 3(b) and (c), it was uncontested that respondent noted that JH had a pressure ulcer and was on "nothing by mouth" status (Pet. Ex. 13 at 44). However, petitioner did

not present any evidence to prove that respondent had failed to provide proper recommendations to address these two conditions. Accordingly, Specification 3(b) and (c) should be dismissed.

Specification 5

Specification 5 states that "[o]n or about August 14, 2014," respondent failed to "complete a comprehensive or accurate reassessment of nutritional status" for high risk patient RP by failing "to note and/or address" RP's significant weight change.

The medical records established that on August 2, 2014, RP's weight was listed as 59.9 kilograms, but that on August 14, 2014, RP's weight was listed as 71.9 kilograms, a weight change of approximately 20% (Pet. Ex. 12 at 35, 40; Tr. 89-90). Ms. Leary credibly testified that respondent was required to note and make a recommendation to address this significant increase in RP's weight, but respondent failed to do so (Pet. Exs. 6, 12 at 41; Tr. 89-90).

Respondent argued that RP's recorded weight gain must have been a mistake because it was "impossible" for "somebody in a bed [to] get this amount of weight" (Tr. 351). Respondent added that "all the time we have to correct and ask the nurse to weigh the patients over because [of] these mistakes" (Tr. 351). Yet, there was no evidence presented that respondent made any attempt to verify or correct RP's weight, or to have a nurse do so. Moreover, no evidence was provided to support respondent's suggestion that he had the authority to ignore a patient's documented weight change if he believed such a weight change was impossible. Accordingly, because respondent did not note or address RP's recorded weight gain, the charge should be sustained.

Specification 6(a), (b)

Specification 6(a) and (b) alleges that "[o]n or about August 12, 2014," respondent failed to "complete a comprehensive or accurate assessment of nutritional status" for patient EW by (a) noting that EW had no pressure ulcer, when EW did have a pressure ulcer, and by (b) failing to address the pressure ulcer.

The evidence established that on August 12, 2014, a nurse entered the following information on EW's medical record, under the section for "Skin Status": "Lesion: Deep Tissue injury; Location: sacral area." In answer to the question "Skin Intact?" the nurse wrote "No"

(Pet. Ex. 14 at 55). Ms. Leary testified that a deep tissue injury to the sacral area is the same as a pressure ulcer (Tr. 94).

Respondent argued that EW had a deep tissue injury or lesion, not a pressure ulcer (Tr. 361). Respondent asserted that EW had a moist lesion because, according to the medical records, EW's skin was "constantly moist by perspiration and urine" (Pet. Ex. 14 at 55; Tr. 361-62). Respondent stated that "[a] moist lesion is different from a pressure ulcer. A lesion can be an ulcer, but is not a pressure ulcer. What is the differen[ce]? Lesion show excoriation and dermatitis inflammation of the skin. But pressure ulcer is a broken skin that can be infected" (Tr. 362).

On cross-examination, respondent refused to agree that a lesion was a skin wound (Tr. 438). Instead, respondent asserted that "a lesion is a skin condition created by feces, urine and sweating in the patient that irritate[s] the skin of the patient but not necessarily . . . a wound. When there is a wound, then depending on the severity of it, it [is] consider[ed] from a Stage 1 to a Stage 4 pressure ulcer and especially if this ulcer is in the sacral area that is where the pressure is" (Tr. 439). When asked if a dietician should make nutritional recommendations to address lesions, respondent replied that "[t]he recommendation that we have is for a pressure ulcers. Not for lesions" (Tr. 441). Respondent stated that lesions "are not really considered" by dieticians at Stage 1 and 2 (Tr. 441). Respondent acknowledged that in April 2016 "the council of pressure ulcer" recognized that the term "deep tissue injury" could be used to indicate a pressure ulcer, but argued that "a deep tissue injury was not recognized as a term for pressure ulcer" at the time he evaluated EW (Tr. 442).

Petitioner's evidence was credible, particularly Ms. Leary's clear and consistent testimony that a deep tissue injury to the sacral area is the same as a pressure ulcer, and requires a nutritional recommendation by a dietician. Respondent's testimony, on the other hand, was contradictory, confusing, and generally not credible. Specification 6(a) and (b) should be sustained.

Specification 8

Specification 8 alleges that "[o]n or about November 20, 2014," respondent failed to "complete a comprehensive or accurate assessment of nutritional status" for patient WJ by (a) providing "for approximately less than half" of WJ's caloric needs in his assessment, and (b) by failing "to note and/or address" the patient's malnutrition and "failure to thrive."

The evidence established that respondent stated in his assessment that WJ needed 2,430 calories per day (Pet. Ex. 16 at 74; Tr. 107). A physician noted in the medical records that WJ suffered from "severe malnutrition and failure to thrive" (Pet. Ex. 16 at 70; Tr. 105). Nevertheless, respondent recommended a tube feeding formula that only provided WJ with about 1,000 calories per day (Pet. Ex. 16 at 77; Tr. 106). Ms. Leary credibly testified that respondent's recommendation did not adequately address WJ's malnutrition and did not provide "ways to improve" WJ's nutritional status (Tr. 108).

Respondent argued that his formula recommendation was appropriate because "[w]hen a patient have a medical condition like this, you cannot recommend the amount . . . that you recommend to a normal patient, because the patient can die. You can make a liver failure or you can create a kidney failure. That's the reason because I recommend half of the amount of normally you recommend, because you cannot start full. You have to start slowly and increase depending on how the medical condition of the patient improve[s]" (Tr. 371).

Respondent's testimony was not credible. Respondent's own assessment found that WJ needed 2,430 calories a day. Yet respondent recommended a formula that provided for less than half of the required amount without explanation, and without any instruction that WJ's caloric intake should be increased slowly, as he claimed. Further, there was no corroborating evidence to support respondent's contention that providing WJ with the full amount of daily calories needed would have caused WJ harm. Instead, respondent's argument amounts to nothing more than a belated and fabricated excuse to justify his mistake of failing to recommend a formula with sufficient calories to a severely malnourished patient, and to avoid being penalized. Accordingly, because respondent did not make a recommendation that adequately provided for WJ's caloric needs, and failed to properly address WJ's malnutrition and failure to thrive, Specification 8(a) and (b) should be sustained.

Specification 9

Specification 9 alleges that "[o]n or about November 23, 2014," respondent "failed to complete a comprehensive or accurate assessment of nutritional status" for patient LM by noting that LM's feeding was inadequate, but approving "said feeding rate to continue."

In his assessment, respondent noted that LM was receiving "inadequate enteral nutrition infusion" (Pet. Ex. 17 at 78). According to Ms. Leary, this notation indicates that LM was being

tube fed but was not receiving adequate nutrition (Tr. 109). Nevertheless, under the "Care Plan" section of the assessment, respondent recommended for LM's "feeding rate" to remain the same. Ms. Leary testified that respondent's recommendation was insufficient (Pet. Ex. 17 at 78; Tr. 109-10).

Respondent failed to address why he recommended for LM's feeding rate to remain the same while noting that LM was not being adequately fed. Instead, he testified only that his "calculations" were correct. He speculated that Ms. Leary's testimony that his recommendation was incorrect was likely because LM had a pressure ulcer, and such a patient would normally receive increased amounts of calories and proteins (Tr. 373-74).

Respondent's testimony does not comport with common sense and is not credible. Therefore, the charge should be sustained.

Specification 11(a), (b), (e), (f), (h)

Specification 11(a) and (b) alleges that "[o]n or about December 8, 2014," respondent jeopardized high risk patient AD's safety by submitting improper recommendations and failing "to complete a comprehensive or accurate assessment" by recommending (a) an excessive amount of calories, and (b) an excessive amount of protein.

According to respondent's assessment for AD, respondent determined that AD needed one gram of protein and 35 kilograms of calories per kilogram of body weight ("KgIBW") per day (Pet. Ex. 18 at 87; Tr. 116-17). Notwithstanding, respondent recommended a tube feeding formula that provided AD with 2.5 grams of protein and 40 calories per KgIBW per day (Pet. Ex. 18; Tr. 112, 116-20). Also, the medical records established that AD was a high risk patient diagnosed with respiratory failure and an acute kidney injury, and who was being mechanically ventilated (Pet. Ex. 18 at 82; Tr. 111). Ms. Leary testified that a patient with acute kidney injury should not be overloaded with protein or fluids because it overworks the patient's kidneys (Tr. 111). She stated that the difference between a patient receiving 35 calories per KgIBW and 40 calories per KgIBW "is significant, especially for a patient that is on a ventilator with acute respiratory failure" (Tr. 121). Therefore, the evidence established that respondent recommended an excessive amount of calories and proteins for AD, and that those recommendations posed a risk for AD's health.

While respondent stated that his recommendations were correct, he failed to provide any reason for the discrepancy between the amount of calories and proteins he determined that AD needed, versus the higher levels of calories and proteins he recommended. Instead, his failure to explain this discrepancy suggests that respondent made a mistake that he did not want to admit. In any event, because respondent failed to provide a meritorious or credible defense to the proven conduct, Specification 11(a) and (b) should be sustained.

Specification 11(e), (f) and (h) alleges that on December 11, 14, 17 and 22 of 2014, respondent failed to complete "comprehensive or accurate" assessments by: (e) repeatedly recommending for AD a cardiac diet, but also noting that AD was on "nothing by mouth" status; (f) repeatedly noting that AD was sedated, but also noting that AD verbalized adequate understanding of the prescribed diet; and (h) repeatedly noting that AD was on "nothing by mouth" status, when AD was not.

For Specification 11(e), the medical charts and assessments established that on the four days in question, respondent recommended a cardiac diet for AD, which can only be consumed by mouth, while at the same time noting that AD was on "nothing by mouth" status (Pet. Ex. 18 at 90, 93, 96, 99; Tr. 126). Respondent admitted that "[o]bviously [it] was a mistake" to do so (Tr. 381). Respondent then argued that his recommendation for a cardiac diet was a "future recommendation" for when AD was able to consume foods orally (Tr. 381-82). However, respondent offered no corroborating evidence to support his suggestion that it was proper to provide a "future recommendation" based on a patient's possible future condition, instead of providing a dietary recommendation based on a patient's present condition. Accordingly, Specification 11(e) should be sustained.

For Specification 11(f), the evidence established that on the four days in question, respondent noted that AD was sedated, while also noting that he provided AD with verbal instructions regarding a recommended cardiac diet, and that AD "verbalize[d] adequate understanding" of the diet (Pet. Ex. 18 at 92, 95, 98, 101; Tr. 131). Ms. Leary testified that sedated means that "the patient is not alert" or conscious (Tr. 131).

In turn, respondent argued that, pursuant to the medical records, AD was sedated with propofol and fentanyl, drugs that are typically used to calm agitated patients (Tr. 383). Respondent stated that such patients can still talk and nod, and that he was able to speak to AD (Tr. 384). The crux of the charge here, however, is the apparent contradiction in documenting

that a patient was sedated, but was also able to receive and acknowledge verbal instructions regarding his diet, and not the veracity of the events as described by the charge.

Here, I credit Ms. Leary's testimony that "sedated," without more, is understood to mean that a patient is not conscious, and that respondent's assessments are contradictory on their face. Accordingly, Specification 11(f) should be sustained.

As to Specification 11(h), the evidence established that on December 11, 14, 17 and 22 of 2014, respondent noted that AD was on "nothing by mouth" status (Pet. Ex. 18 at 90, 93, 96, 99). Petitioner alleges, however, that AD was not on "nothing by mouth" status, but failed to provide any medical documentation to prove the manner of AD's meal consumption for the days in question.

Instead, petitioner relied on respondent's assessments, which noted that AD was on "nothing by mouth" status, but also recommended a cardiac diet that is consumed by mouth, and documented AD's meal intake. Due to their inaccuracy and contradictions, these assessments are too unreliable to prove that AD was not on "nothing by mouth" status. Accordingly, Specification 11(h) should be dismissed.

Specification 12(a), (c), (h)

Specification 12(a), (c), and (h) alleges that "[o]n or about January 12, 2015," respondent failed "to complete a comprehensive or accurate reassessment" for high risk patient CA by: (a) failing to "note and/or address" CA's surgical wounds; (c) failing to "note and/or address CA's "possible dehydration"; and, after CA had expired, (h) recommending for CA "additional nutrition and intervention."

For Specification 12(a), the medical records established that CA had surgical wounds, but that respondent did not note the wounds, and did not provide any recommendations to treat the wounds in his assessment (Pet. Ex. 19 at 103, 108, 111). Ms. Leary credibly testified that CA's surgical wounds should have been noted and addressed (Tr. 142-44).

Respondent admitted that he did not address the wounds but argued that CA's condition "was very bad" and that "when somebody is at that stage . . . any recommendation that you do can create more problems" (Tr. 394-95). Petitioner did not establish what recommendation should have been provide for CA under the circumstances, but did prove that respondent should

have noted the surgical wounds, but failed to do so. Accordingly, the charge should be sustained.

For Specification 12(c), Ms. Leary testified that CA's "sodium was 147 and the chloride was 111 . . . both of which can be indicators of dehydration" (Tr. 147). However, petitioner provided no medical records to corroborate her testimony or to show how respondent would have known CA's sodium and chloride levels during the time in question. It was uncontested that respondent did not note or address any potential dehydration for CA in the assessment. Instead, respondent persuasively argued that he did not see any laboratory results to indicate that CA could be dehydrated (Tr. 396). Accordingly, Specification 12(c) should be dismissed.

For Specification 12(h), the medical records established that CA died at 1:00 p.m. on the day in question, but that respondent submitted an assessment for CA with recommendations at 1:55 p.m. of the same day (Pet. Ex. 19 at 120-21). However, respondent credibly and consistently testified that, as per his daily routine, he visited CA in the morning, and that CA was still alive. He then entered his assessment into the hospital computer in the afternoon, apparently not aware that CA had expired (Tr. 391, 398). Aside from the medical records, petitioner provided no other evidence or testimony on this matter, and respondent's explanation seemed plausible. Accordingly, Specification 12(h) should be dismissed.

Specification 13(f)

Specification 13(f) alleges that "[o]n or about January 15, 2015," respondent failed "to complete a comprehensive or accurate assessment" for CM by recommending a puree diet when CM was on "nothing by mouth" status. CM's medical records and Ms. Leary's testimony showed that CM was an acute stroke patient who had failed a swallowing test (Pet. Ex. 20 at 128, 130; Tr. 155, 158). As a result, CM was being fed through a "naso-gastric tube" and was on "nothing by mouth" status (Pet. Ex. 20 at 130, 133; Tr. 155). Nevertheless, respondent recommended for CM a "cardiac puree diet," which is consumed orally (Pet. Ex. 20 at 140; Tr. 156-57).

Despite admitting that he overlooked a note from a speech pathologist stating that CM had failed a swallowing test, respondent stood by his recommendation. Respondent argued that "when a patient have a condition like [CM] have, we recommend [a] puree diet to start helping the patient to eat and avoid any nutritional condition because [of] the patient not eating because .

. . in cases like this, sometime the patient can be on NPO, or nothing by mouth, for days. And this is, and this is well-known [to] create malnutrition. And this, this is why I . . . recommend that" (Tr. 400-01).

Petitioner's evidence was credible, specifically Ms. Leary's common sense testimony that an oral diet should not be recommended for a patient who failed a swallow test and was being tube fed. Further, respondent failed to explain how he had the authority to recommend an oral diet when, according to the medical records, a physician had noted that CM was on "nothing by mouth" status. Lastly, respondent's argument that he recommended a cardiac puree diet to avoid possible malnutrition was not persuasive under the circumstances here. Accordingly, the charge should be sustained.

Specification 14

Specification 14 states that "[o]n or about October 7, 2014," respondent "failed to complete an accurate or comprehensive assessment" of patient GD. The medical records revealed that GD had "unintentional weight loss of 25 lbs. in the last 5 months," but respondent documented in his assessment that GD had a weight loss of 0% (Pet. Ex. 21 at 149, 157). While respondent did not specifically admit that he made a mistake, respondent provided no explanation as to why his assessment did not reflect GD's documented weight lost, but instead stated that "there is some mistake in the weight loss percentage, zero percent. This is a mistake" (Tr. 403). Because the evidence proved that respondent did not complete an accurate assessment for GD by failing to note GD's weight loss, Specification 14 should be sustained.

FINDINGS AND CONCLUSIONS

1. Petitioner proved by a preponderance of the evidence that on August 3, 2014, respondent failed to complete a comprehensive or accurate assessment of nutritional status for high risk patient RP by noting that RP had an oral diet and was at less than 25% meal intake, when RP was instead tube feeding. Specification 1(a), (b) should be sustained.

2. Petitioner proved by a preponderance of the evidence that on August 6, 2014, respondent failed to complete a comprehensive or accurate reassessment of nutritional status for high risk patient RP by failing to note or address RP's pressure ulcer,

and by noting that RP was able to chew and was at less than 40% meal intake, when RP was instead tube feeding. Specification 2(a)-(d) should be sustained.

3. Specification 3(a) should be sustained because petitioner proved by a preponderance of the evidence that on August 8, 2014, respondent failed to complete a comprehensive or accurate reassessment of nutritional status for patient JH by failing to note or address JH's significant weight change.

4. Specification 3(b) and (c) should be dismissed because petitioner did not establish that respondent failed to make appropriate recommendations to address JH's pressure ulcer and "nothing by mouth" feeding status.

5. Petitioner proved by a preponderance of the evidence that respondent failed to complete a timely reassessment of nutritional status for a high risk patient by completing the reassessment on August 11, 2014, when it was instead due on August 9, 2014. Specification 4 should be sustained.

6. Petitioner proved by a preponderance of the evidence that on August 14, 2014, respondent failed to complete a comprehensive or accurate reassessment of nutritional status for high risk patient RP by failing to note or address RP's significant weight change. Specification 5 should be sustained.

7. Petitioner proved by a preponderance of the evidence that on August 12, 2014, respondent failed to complete a comprehensive or accurate assessment of nutritional status for patient EW by failing to note or address EW's pressure ulcer and failing to perform a malnutrition assessment. Specification 6(a)-(c) should be sustained.

8. Petitioner proved by a preponderance of the evidence that on September 2, 2014, respondent failed to complete a comprehensive or accurate assessment of nutritional status for patient JB by failing to note or address wound healing for JB's pressure ulcer, and failing to perform a malnutrition assessment. Specification 7(a), (b) should be sustained.

9. Petitioner proved by a preponderance of the evidence that on November 20, 2014, respondent failed to complete a comprehensive or accurate assessment of nutritional status for patient WJ by recommending a tube feeding formula that provided for less than half of WJ's caloric needs and failing to

address WJ's malnutrition and failure to thrive. Specification 8(a), (b) should be sustained.

10. Petitioner proved by a preponderance of the evidence that on November 23, 2014, respondent failed to complete a comprehensive or accurate assessment of nutritional status for patient LM by noting that LM was not being adequately fed, but recommending for LM's feeding rate to remain the same. Specification 9 should be sustained.

11. Petitioner proved by a preponderance of the evidence that on December 8, 2014, respondent jeopardized high risk patient AD's safety and failed to complete a comprehensive or accurate assessment by recommending excessive amounts of calories and protein, failing to note or address AD's acute kidney injury, inaccurately noting that AD was obese, repeatedly recommending a cardiac diet while also noting that AD was on "nothing by mouth" status, and repeatedly noting that AD was sedated but then noting that AD verbalized understanding of the prescribed diet. Specification 11(a)-(f) should be sustained.

12. Specification 11(h) should be dismissed because petitioner did not establish that AD was not on "nothing by mouth" status.

13. Petitioner proved by a preponderance of the evidence that on January 12, 2015, respondent failed to complete a comprehensive or accurate reassessment for high risk patient CA by failing to note or address CA's surgical wounds and significant weight change. Also, on January 15, 2015, respondent inaccurately noted that CA was able to chew, swallow and had a diet tolerance between 40-59% of meal intake. Lastly, respondent prescribed CA a regular diet when CA was on a ventilator and intubated. Specification 12(a), (b), (d)-(g) should be sustained.

14. Specification 12(c) and (h) should be dismissed because petitioner did not establish that respondent failed to note or address CA's possible dehydration or that he improperly recommended for CA additional nutrition and intervention.

15. Petitioner proved by a preponderance of the evidence that on January 15, 2015, respondent failed to complete a comprehensive or accurate assessment for patient CM by recommending an oral diet when CM had failed a swallow test, noting that CM was able to swallow while also noting that CM

had difficulty swallowing, and noting that CM had a meal intake between 25-50% and recommending a puree diet when instead CM was on "nothing by mouth" status. Specification 13(a), (b), (e), (f) should be sustained.

16. Petitioner proved by a preponderance of the evidence that on October 7, 2014, respondent failed to complete an accurate or comprehensive assessment for patient GD by failing to note GD's weight loss. Specification 14 should be sustained.

17. Petitioner proved by a preponderance of the evidence that on November 8, 2014, respondent failed to complete an accurate or comprehensive assessment for patient MM by performing calculations as if MM was of normal weight, when MM was obese and required a recommendation that would have promoted weight loss. Specification 15 should be sustained.

18. Petitioner proved by a preponderance of the evidence that on November 13, 2014, respondent failed to perform a comprehensive assessment for patient DB. Specification 16 should be sustained.

RECOMMENDATION

Upon making the above findings and conclusions, I requested and reviewed a copy of respondent's personnel file in order to make an appropriate penalty recommendation. Respondent has worked for Harlem Hospital Center since October 9, 2001. In 2014, respondent served a 15-day suspension for misconduct. He was rated "satisfactory" on his performance evaluation for the period of October 9, 2011 to October 8, 2012, but was rated as "needs improvement" on his performance evaluations for the periods of October 9, 2012 to October 8, 2013; October 9, 2013 to January 9, 2014; January 10, 2014 to April 9, 2014; April 9, 2014 to July 8, 2014; and July 9, 2014 to October 8, 2014. Respondent was rated as "unsatisfactory" on his performance evaluation for the period of October 9, 2014 to January 8, 2015.

Here, the evidence established that respondent was consistently unable to perform his fundamental responsibilities as a clinical dietician, namely accurately assessing the nutritional status of patients and providing appropriate dietary recommendations. From August of 2014 to January of 2015, respondent failed to perform accurate or timely assessments for at least 12 patients. Despite petitioner repeatedly advising respondent that his job performance was

deficient and providing him with relevant training, respondent was unable to improve his job performance and to adequately assess patients.

Instead, respondent's misconduct and/or incompetence threatened patient safety. Termination of employment is appropriate where respondent's misconduct and/or incompetence endangered the health and safety of others. *See Health & Hospitals Corp. (Elmhurst Hospital Ctr.) v. Yao*, OATH Index No. 473/11 (Dec. 29, 2010) (termination recommended for dietician with no prior disciplinary history for falsifying a patient's record, which could jeopardize patient welfare); *Health & Hospitals Corp. (Metropolitan Hospital Ctr.) v. Ahmed*, OATH Index No. 567/05 (Jan. 7, 2005) (termination of employment recommended for assistant chemist who deleted test results, refused to follow laboratory procedures, and verbally abused supervisors); *Health & Hospitals Corp. (North Central Bronx) v. Doxen*, OATH Index No. 1577/01 at 18 (May 4, 2001) (termination of employment reflects "the seriousness of the offenses, the risks of harm to patients and the Corporation's obligation to protect patients from staff who fail to exercise proper standards of care").

Respondent himself acknowledged the significance of his responsibilities and the potential for serious consequences, including patient death, if a dietician provides an improper recommendation (Tr. 355-56, 371, 393-94). Nevertheless, respondent committed egregious errors by, for example, repeatedly recommending oral diets for patients who were on "nothing by mouth" status, recommending a tube feeding formula with insufficient calories for a patient who was severely malnourished, and repeatedly failing to note or address alarming weight change for three different patients.

Petitioner requested a penalty of termination of respondent's employment. Petitioner has a compelling interest in ensuring that its patients are provided with competent care. The proven charges all demonstrate that respondent is unwilling or unable to meet the basic duties of his job and comply with the hospital's Nutrition Screening Assessment and Reassessment Policy. Because respondent poses an unacceptable risk to petitioner and its patients, the only appropriate penalty is termination of his employment, and I so recommend.

Noel R. Garcia
Administrative Law Judge

May 30, 2017

SUBMITTED TO:

EBONÉ M. CARRINGTON
Chief Executive Officer

APPEARANCES:

ANDREA CHILAKA, ESQ.
Representative for Petitioner

K.C. OKOLI, ESQ.
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