Health & Hospitals Corp. (Henry J. Carter Specialty Hospital & Nursing Facility) v. Augustin

OATH Index No. 334/26 (Feb. 6, 2026)

Petitioner established that respondent connected a patient to a ventilator that she left on standby mode for approximately 30 minutes, which deprived the patient of oxygen, and falsified an entry into the patient's medical record. Termination of employment recommended.

NEW YORK CITY OFFICE OF ADMINISTRATIVE TRIALS AND HEARINGS

In the Matter of
HEALTH AND HOSPITALS CORPORATION (HENRY J. CARTER SPECIALTY HOSPITAL AND NURSING FACILITY)
Petitioner
- against -
ANITA AUGUSTIN
Respondent

REPORT AND RECOMMENDATION

ASTRID B. GLOADE, *Administrative Law Judge*

This employee disciplinary proceeding was referred by petitioner, the New York City Health and Hospitals Corporation ("Corporation") under section 7.5 of petitioner's Personnel Rules and Regulations. Petitioner alleges that respondent Anita Augustin, a respiratory therapist at Henry J. Carter Specialty Hospital and Nursing Facility (the "Facility"), engaged in misconduct when she connected a patient to a ventilator that she left on "standby" mode, so that the patient was deprived of proper oxygen for 30 minutes, and that she falsified Facility records (ALJ Ex. 1).

At a two-day trial, held remotely via videoconference, petitioner presented six witnesses and documentary and video evidence.[1] Respondent relied on documentary evidence. For the

[1] During cross-examination of Juliet Esan on December 15, 2025, a portion of the witness's testimony was not captured on the audio recording. Counsel agreed to proceed with reconstructing missing testimony from notes I took during the testimony. Counsel was given an opportunity to review the notes for accuracy and completeness and offer proposed corrections and supplements (Tr. 124-25, 184-85). On December 17, 2025, I forwarded to counsel my notes summarizing testimony that was not recorded in the transcript. The notes, which incorporate counsels' edits, are made

reasons below, I find that the charges are sustained and recommend that respondent's employment be terminated.

ANALYSIS

Petitioner alleges that on May 9, 2025, respondent engaged in misconduct when she connected a patient (referred to as "Patient A")[2] to a bedside ventilator, but left the ventilator on "standby" mode instead of "active" mode, and falsified Facility records by documenting that Patient A was on a ventilator while Patient A was actually in another location and not connected to that ventilator (ALJ Ex. 2). These charges are sustained.

Factual Background

Juliet Esan, Assistant Director of Respiratory Care Services at the Facility, supervises 45 respiratory therapists, including respondent (Tr. 55). She has worked at the facility for 28 years and has been in her current title since 2019 (Tr. 55, 97).

Esan testified that as a respiratory therapist, respondent manages the care of Facility patients who are connected to mechanical ventilators and those who use supplemental oxygen (Tr. 55). Patients on ventilators are "high priority patients" who rely on the machines to help them breathe (Tr. 55-56). When a patient is placed on a ventilator, the doctor orders that it be set at specified settings (Tr. 57). The Facility uses "bedside" or "stationary" ventilators, and also uses "portable" ventilators for patients who must be transported (Tr: 61-62, 105-06).

Once a patient is connected to a ventilator, respiratory therapists must perform ventilator checks ("vent checks") to ensure that the ventilator is operating at the settings the doctor prescribed and the patient is being adequately ventilated (Tr. 58). Vent checks are supposed to be performed twice per shift, when a patient is transported from one area of the Facility to the next, and when a doctor orders a change to the ventilator settings (Tr. 61). Information collected during the vent check includes the amount of air needed to ventilate the patient, respiratory rate, heart rate, and amount of oxygen the patient is receiving (Tr. 58-59).

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part of this record as ALJ Exhibit 2. *See Dep't of Buildings v. 1349 Clinton Avenue, Bronx*, OATH Index No. 634/01 at 1-2 (Jan 5, 2001) (where hearing was not properly recorded, ALJ issued a report and recommendation based on her recollection, notes, and the hearing exhibits); *Health & Hospitals Corp. (Jacobi Medical Ctr.) v. Paciullo*, OATH Index No. 1963/24 at 2 (July 24, 2025) (ALJ's notes made part of the record where testimony was not recorded).

[2] Petitioner redacted the name of the patient for purposes of confidentiality, without objection.

Respiratory therapists must manually enter information gathered during the vent check into the patient's medical records and are supposed to do so close in time to when the data is captured. To do so, respiratory therapists access PointClickCare ("PCC"), the Facility's electronic healthcare records system, by entering their designated username and password (Esan: Tr. 58, 60; Wu: Tr. 12-13, 15-16).

According to Esan, respondent was trained about the vent check process during monthly meetings with respiratory department staff about the Facility's ventilator protocols (Tr. 65-66). An agenda Esan created for the July 2024 staff meetings shows that ventilator standby mode was an item for discussion (Tr. 68-69, 72; Pet. Ex. 4). Esan testified that standby mode indicates that the ventilator is not turned on (Tr. 72). At the meeting, she told the respiratory therapists that vent checks had to be performed because it is the only way to know if a ventilator is removed from standby mode (Tr. 70). Once a ventilator is turned on, the respiratory therapist can take data from the ventilator and enter it into the patient's medical record (Tr. 69-70; Pet. Ex. 4). Respiratory Department sign-in sheets for the July 2024 meetings, captioned "Standby Mode," show a signature next to respondent's typed name (Pet. Ex. 4). A document captioned "Respiratory Inservice on Standby Mode and Policy Review" provides instructions for when a ventilator is in standby mode and notes that effective immediately, the procedure must be followed on all patient transfers, including in-house transfers and "dialysis" (Pet. Ex. 4; Tr. 68).

During staff meetings in August 2024, Esan instructed respiratory therapists to perform ventilator checks after all circuit changes to let them know that the ventilator had been removed from standby mode and data from the ventilator had to be entered in the medical record via PCC (Tr. 71-72). A sign-in sheet for the August 2024 meetings shows a signature next to respondent's typed name (Pet. Ex. 4).

Esan recalled seeing respondent at a February 2025 monthly staff meeting, and there is a signature next to respondent's typed name on the sign-in sheet (Tr. 73; Pet. Ex. 4). The agenda for the February 2025 meetings include "Dialysis Den[3] Vent Check When Resident Return Back to Unit Also for All Circuit Changes, Transport, Admissions and Procedures" (Pet. Ex. 4). During this meeting, Esan instructed the staff that ventilator checks must be conducted when patients are transferred between their rooms and the dialysis unit (Tr. 72).

[3] Referred to here as the dialysis unit.

Petitioner's written policies and procedures regarding ventilators outline practices that are consistent with Esan's testimony. The "Respiratory Care Service Policies and Procedures: Ventilator Management" policy sheet, dated July 31, 2024, requires that the respiratory care staff "conduct a ventilator check twice every shift and during admissions, transports and circuit changes" (Pet. Ex. 5). The objectives of these checks include "to evaluate and document the patient's response to mechanical ventilation at the time the check is performed" and "to assure and document" that the ventilator is operating properly (*Id.*). These policies and procedures are available to the Facility's staff in a binder in the Facility's staff room (Tr. 73-74). Esan testified that vent checks must be done in real time to show that the ventilator is functioning properly (Tr. 76). The Capsule Alarm System is an external alarm connected to the ventilator that rings on the respiratory therapist's phone and on an overhead alarm system by the patient's room whenever the machine is disconnected or there is a drop in pressure (*Id.*). As part of the vent check, respiratory therapists must verify that the Capsule Alarm System is activated so that if there is an issue with the ventilator, the staff will be alerted (Tr. 76-77; Pet. Ex. 5).

Respiratory therapists must document information obtained during the vent check in the patient's medical records via PCC immediately or as soon as possible after the information is obtained (Tr. 74; Pet. Ex. 5 at "Respiratory Care Service Policies and Procedures: Documentation of the Patient's Medical Chart" (stating that it is the policy of the Respiratory Care Service to initiate and maintain timely, meaningful, and accurate medical documentation)).

On May 9, 2025, respondent, who is typically scheduled to work three days per week, was working from 7:30 a.m. to 8:10 p.m. and had 16 patients who were connected to ventilators under her care on the third floor, which is part of the skilled nursing facility (Tr. 56-57, 60). Respondent's duties were to check the patients' ventilators to make sure they were functioning properly and at settings that had been ordered by the doctors, and to verify that the patients were responding adequately to the prescribed settings (Tr. 57). Respondent was also responsible for suctioning patients and administering medication (*Id.*). In addition to her duties on the third floor, respondent was responsible for 15 patients on the fifth floor who were not on ventilators but required oxygen support (*Id.*). She would "round on that floor for a very limited amount of time," to check the patient's equipment, described as a bottle and water (*Id.*). Respondent's duties on the fifth floor generally averaged under an hour during her shift (Tr. 57-58, 98-99).

Respondent was one of several respiratory therapists who provided respiratory care for Patient A, who was housed in room 309A on the Facility's third floor and connected to a ventilator (Tr. 19-20, 27-28; Pet. Ex. 3). After Patient A was connected to a ventilator on May 9, 2025, that was supposed to have been turned on but was not, the Facility undertook an audit of its ventilator care records for the patient.

Sonya Wu, a Nurse Informaticist who conducts data analysis for the Corporation, reviewed information entered into PCC, including ventilator records ("ventilation flow sheets") concerning Patient A for May 9, 2025 (Tr. 12-14). The audit of respiratory care provided to Patient A shows that respondent and other respiratory therapists conducted vent checks relating to Patient A on May 9 at the stationary ventilator in room 309A, which was assigned a unique number, and at a ventilator in the dialysis unit that was assigned a different number (Tr. 12-14, 18, 30-31, 35-36; Pet. Ex. 3).

A ventilation flow sheet shows that a respiratory therapist identified as Latasha Manley assessed Patient A and entered data into PCC concerning the patient on May 9, 2025, at 6:30 a.m., the "Effective Date" on the ventilation flow sheet (Tr. 19-21; Pet. Ex. 3). Wu explained that when a user opens PCC, the system asks them to select an effective date and time, which indicates when the assessment starts (Tr. 20-21, 42, 51). The ventilation flow sheet shows that the assessment occurred in Patient A's room on the third floor of the Facility and the ventilator number is the one assigned to Patient A's room (Tr. 19-20, 28; Pet. Ex. 3). Manley started making entries in PCC at 6:01 a.m., which is when the assessment was opened, and "locked" the assessment at 6:36 a.m., meaning that she entered her credentials in PCC so that the assessment could no longer be modified (Tr. 20-22; Pet. Ex. 3). To lock a ventilation flow sheet, the user has to select "save, sign, lock, and exit" on the PCC screen, and enter their PCC password (Tr. 52).

The ventilation flow sheet reflects data such as Patient A's blood oxygen saturation and heart rate, which are obtained by placing a pulse oximeter ("pulse ox") device on the patient's finger (Tr. 21-22). The ventilation flow sheet shows that during Manley's assessment, Patient A's oxygen saturation was 100 and the heart rate was 73 (Tr. 21-23; Pet. Ex. 3).

Starting at 10:30 a.m. on May 9, respondent performed an assessment of Patient A's ventilator located in the patient's room and entered data into the record via PCC (Pet. Ex. 3). The ventilation flow sheet indicates that respondent recorded Patient A's oxygen saturation as 97 and

the heart rate as 70 (Tr. 23-24; Pet. Ex. 3). The assessment was locked at 10:35 a.m. (Tr. 23-24; Pet. Ex. 3).

After respondent's 10:30 a.m. ventilator assessment, Patient A was transported to the dialysis unit while connected to a portable ventilator (Tr. 26). Esan testified that when patients on a portable ventilator arrive for dialysis, a respiratory therapist disconnects the patients from the portable ventilator and connects them to a stationary ventilator in the dialysis unit (Tr. 61-65). Vent checks are not conducted on the portable ventilators (Tr. 106).

The next ventilator assessment for Patient A on May 9 was initiated at 12:03 p.m. by Respiratory Therapist Vivia Thomas while the patient was in the dialysis unit (Tr. 24-25; Pet. Ex. 3). The ventilator number on the ventilation flow sheet corresponds to a ventilator located in the dialysis unit on the first floor in the Facility (Tr. 65). The ventilation flow sheet shows that Patient A had an oxygen saturation rate of 100 and a heart rate of 74 during the assessment (Pet. Ex. 3; Tr. 26). Under "Comments" on the ventilation flow sheet, it is noted that Patient A had been transported to dialysis at about 12:03 p.m. via a portable ventilator and was placed on a stationary ventilator during dialysis (Pet. Ex. 3; Tr. 26-27).

Omar Atega, a Charge Nurse for Dialysis Direct, which provides dialysis to patients at the Facility, was working in the dialysis unit on May 9, and recalled that Patient A was there from approximately 12:00 p.m. to 3:30 p.m. (Tr. 187-90). Consistent with his testimony, records show that Patient A arrived in the dialysis unit at 12:05 p.m. on May 9 and completed treatment at 3:30 p.m. (Pet. Ex. 8). Esan explained that patients undergo continuous treatment while in dialysis, so Patient A remained in the unit the entire time (Tr. 94).

Mirtha Fuentes, a Patient Care Technician ("PCT") whose duties include taking patients' vital signs, rode the elevator from the first floor to the third floor with Patient A, respondent, and a patient escort on May 9 at about 3:40 p.m. (Tr. 139-40). Fuentes testified that about 15 to 20 minutes later, she and Laila Bowdoin, another PCT, went to Patient A's room, turned the light on, and greeted the patient (*Id.*). Fuentes observed that Patient A was unresponsive and Bowdoin noted that the ventilator was in standby mode, meaning that it was turned off (Tr. 140-41, 147).

Recalling that she had seen respondent with Patient A in the elevator a few minutes earlier, Fuentes asked Bowdoin to call her (Tr. 141-42). When Bowdoin returned to the room, she told Fuentes that respondent had not responded when she called (*Id.*). Bowdoin looked for Patient A's vital signs, but could not find them (Tr. 141-42, 148). Fuentes left Patient A's room and called out

to respondent, who was standing in the hallway (Tr. 142-43). Fuentes "went to – close to" respondent, about ten steps away, and told her that they needed help because there was an emergency and the patient was not looking well (Tr. 143, 149). She also used hand gestures to summon respondent, who was "standing up and then she was dealing with some paper and then she didn't respond" (Tr. 143). Instead of going to help, respondent "looked at" Fuentes and then went back to what she was doing on the computer (Tr. 143-44, 150-51). Fuentes testified that she tried several times to get respondent to help her, moving closer to respondent in her subsequent efforts, without success (Tr. 161).

Unable to get respondent to assist with Patient A, Fuentes started looking for a nurse, shouting for assistance until she saw Nurse Preetika Sharda near the elevator (Tr. 143-44). Sharda ran towards Fuentes, who told her there was an emergency, and they entered Patient A's room (*Id.*). Sharda determined that Patient A was unresponsive and called respondent, who came to the room (*Id*). Fuentes recalled that Sharda told respondent that the ventilator was off (Tr. 144). Sharda administered care to the patient, and they activated the call bell to alert staff to the emergency (Tr. 144-45).

Fuentes wrote two statements regarding this incident that are consistent with her testimony. The first statement was written on May 9, 2025, the same day the incident occurred, and the second was written on August 19, 2025 (Pet. Ex. 12; Resp. Ex. D). She explained that after she wrote the first statement, her union representative told her to rewrite the statement and provided her May 9 statement to her, some of which she copied in the August 19 statement (Tr. 152, 154-55, 157). Fuentes maintained that although she might have changed some words, she essentially wrote the same version of the incident in both statements (Tr. 159-60). The August 19 version of Fuentes's statement contains some details not reflected in her May 9 statement, such as that she and Bowdoin felt "panic" when they saw the ventilator was on standby, and that the respiratory therapist did not respond when they called her (Pet. Ex. 12; Resp. Ex. D). Nonetheless, most of the material elements of the statements are the same.

Bowdoin's account was consistent with Fuentes's. Bowdoin, who had only been employed at the Facility as a PCT for two months, testified that Fuentes was training her when they entered Patient A's room (Tr. 164-65). They noticed that Patient A was looking "weird" so they examined the room and realized that the ventilator was not turned on (Tr. 165-66). Bowdoin went to the end of the hallway where respondent was sitting at a computer and was no more than five or six feet

away from respondent when Bowdoin told respondent she was needed in Patient A's room (Tr. 166-67). Bowdoin "was yelling" to respondent when she asked for help and was in a "panic" because she was a new employee and had discovered a patient who seemed deceased or on the verge of dying (Tr. 170). In response, respondent looked at Bowdoin and then looked back at her computer (Tr. 167). Bowdoin eventually went to alert the head nurse (Tr. 166-67). Bowdoin recalled that she told the head nurse that the patient looked dead and she was trying to get the respiratory therapist, who was not helping (Tr. 167-68). She also reported to the head nurse that the ventilator said "in big red letters" that it was in standby mode (Tr. 168). Bowdoin recalled that it was only when other staff responded to the emergency that respondent "started to run over" (*Id.*). Bowdoin's witness statement, written about 30 minutes after the incident, is consistent with her testimony (Pet. Ex. 10; Tr. 168).

Preetika Sharda, a nurse at the Facility, testified that on May 9, her shift ended at 4:00 p.m., and she was by the elevator at about 4:30 p.m. when someone told her that a staff member was looking for a nurse (Tr. 172-74). Sharda saw a Certified Nursing Assistant (also referred to as a PCT) standing in the corridor and approached her to see what was happening (Tr. 174). Sharda "rushed" into Patient A's room when the PCT told her that a patient looked dead (*Id.*). She could not detect a pulse or signs that the patient was breathing (*Id.*). Sharda looked at the ventilator and noted that it was not turned on (*Id.*). She then asked a PCT to call for respiratory help (Tr. 175). Sharda instructed the PCTs to summon the respiratory therapist, and they told her that they had called her "many times" but she had not come (*Id.*). Sharda "rushed" out of the room and called respondent, who "came right away" (*Id.*).

When respondent arrived in Patient A's room, Sharda showed her the ventilator and told respondent that she had forgotten to turn it on (*Id.*). Sharda recalled that respondent "said nothing. Nothing at all. She said not even like, oh my God, like, not even like [. . .] maybe surprised" (*Id.*). Sharda instructed the PCT to call a code and started to perform CPR on the patient (Tr. 176). Other nurses and medical staff subsequently entered the room to assist (Tr. 176-77). Sharda wrote a statement an hour or two after the incident that is consistent with her testimony (Tr. 177-78; Pet. Ex. 11).

Video recording of activity in the hallway outside of Patient A's room on May 9 corroborates Fuentes, Bowdoin, and Sharda's accounts (Pet. Ex. 2). The video shows respondent and a patient escort returning Patient A to room 309 on the third floor at about 4:00 p.m. (Tr. 82-

83, 119; Pet. Ex. 2). The patient escort leaves the room almost immediately and respondent exits at about 4:04 p.m. and walks out of view of the camera. Fuentes and Bowdoin walk into Patient A's room at about 4:25 p.m. (Pet. Ex. 2). The activity captured on the video is consistent with Fuentes and Bowdoin's testimony, as they are seen exiting the room and quickly walking down the hallway and out of view of the camera several times (*Id.*). Sharda is also captured on the video entering Patient A's room at about 4:30 p.m., after which there is a significant medical staff response (*Id.*). Although the video does not capture Fuentes and Bowdoin calling and gesturing to respondent for her attend to the patient because they walked out of view of the camera, they credibly testified to having done so.

Esan was in her office when she heard an overhead announcement that there had been a code blue, which signifies a medical emergency, on the Facility's third floor (Tr. 77). When a code blue emergency is called, it indicates that a patient is not breathing or is unconscious, and the Facility's respiratory therapists, nurses, and doctors must immediately respond (Tr. 77-78). Esan went to Patient A's room and saw that staff was already attending to the patient (Tr. 78). The patient had a pulse and was transferred out of the Facility, but Esan does not know what ultimately happened to the patient (Tr. 79-81).

Esan took photographs of the bedside ventilator in Patient A's room on the day of the incident, at about 7:00 p.m., because she knew the incident would be reviewed (Tr. 81). Her photographs show the ventilator status as "standby" (Tr. 81, 85, 87-88; Pet. Ex. 7). Esan explained that photographs of the ventilator screen show that on May 9, the ventilator recorded the patient's respiration and other activity until about 11:51 a.m., when the ventilator screen indicates there was no activity recorded because the ventilator was placed in standby mode (Tr. 87-89). The ventilator's next recorded activity was at 4:29 p.m., when the machine was quickly turned on and off (Tr. 88-89; Pet. Ex. 7).

In the aftermath of the emergency, Esan looked for respondent and tried to reach her by telephone, but respondent did not answer (Tr. 79). Esan was eventually able to reach respondent by telephone, and they met in Esan's office with two Respiratory Department supervisors (Tr. 79-80). Esan described respondent as "very emotional," and recalled that she asked if Patient A was okay (*Id.*). When Esan asked respondent if she had performed a vent check, respondent did not answer but agreed to make a written statement (*Id.*).

In her signed, type-written statement, dated May 9, 2025, respondent admitted that she connected Patient A to the ventilator and left it on standby mode. Respondent wrote:

> I received a phone call from dialysis to pick up the resident [redacted]. I connected the resident to the portable ventilator. I transferred the resident with the transport personnel from dialysis to the 3rd floor SNF. Upon arriving to the 3th [sic] floor SNF I disconnected the resident from the portable ventilator; and connected the resident to the bedside ventilator which was on stand-by. Patient was left on the stretcher bed in her room connected to the bedside ventilator on stand-by mode.

(Pet. Ex. 6).

Respondent did not testify or offer any witnesses on her behalf.

Patient Connected to Ventilator that was Left in Standby Mode (Specification 1)

Respondent does not dispute that on May 9, 2025, she left a patient in her care connected to a ventilator that had not been turned on (Tr. 192-93). Indeed, she admitted in her written statement that she connected Patient A to a bedside ventilator but left the ventilator on standby mode (Pet. Ex. 6). As a result, Patient A was deprived of proper oxygen from approximately 4:00 p.m., when respondent removed Patient A from the portable ventilator, to approximately 4:30 p.m., when Nurse Sharda entered the room and initiated a code blue emergency call for Patient A, who was unresponsive and did not have a pulse. In addition to respondent's admission, petitioner presented compelling, detailed, consistent, credible testimony from Fuentes, Bowdoin, and Sharda, which establishes that they found Patient A unresponsive and attached to a ventilator that was on standby mode.

Respondent offered no testimonial evidence to explain her actions, but her counsel contended that there was a staffing shortage at the Facility that created strain on the respiratory therapists (Tr. 9; Rep. Exs. A, B, C). However, Esan credibly testified that respondent's caseload on May 9 was typical for respiratory therapists at the Facility (Tr. 130-31). Further, the unrefuted evidence establishes that respondent was assigned to care for patients on two floors, while the other respiratory therapist on respondent's shift was assigned to cover patients on three floors (Tr. 127, 130-32, 135-36).

Respondent's actions were negligent as she failed to adhere to the standard of care for her duties as a respiratory therapist at the Facility, and her negligence constitutes misconduct. *See*

Health & Hospitals Corp. (Jacobi Medical Ctr.) v. Hammond, OATH Index No. 2286/17 at 9-10 (Oct. 26, 2017) ("Misconduct may be premised on carelessness or negligence, as well as willful or intentional conduct.") (citing *McGinigle v. Town of Greenburgh*, 48 N.Y.2d 949, 951 (1979); *Reisig v. Kirby*, 62 Misc. 2d 632, 635 (Sup. Ct. Suffolk Co. 1968), *aff'd*, 31 A.D.2d 1008 (2d Dep't 1969). Notably, a single error may constitute negligence where the agency has a particular interest in accuracy or there is potential for adverse consequences. *Hammond*, OATH No. 2286/17 at 10 (respiratory therapist's failure to notify medical staff that he had removed a respiratory device constitutes negligence). Here, respondent had been trained and reminded in monthly staff meetings of the need to conduct a ventilator check when a patient is transported from dialysis because it is the only way to ensure that the ventilator was taken off standby mode. She did not adhere to this standard.

In sum, this charge is sustained.

Falsifying Medical Records (Specification 2)

Respondent is also charged with having falsified medical records on May 9, 2025, by documenting that Patient A was on a particular ventilator inside the patient's room and that the ventilator produced readings or results at approximately 2:30 p.m., when the patient was not in the room or connected to the ventilator (ALJ Ex. 1). This charge is sustained.

Respondent documented that she performed an assessment of Patient A's ventilator starting at 2:30 p.m. on May 9, and the assessment was locked at 2:57 p.m. (Pet. Ex. 3; Tr. 26-27). The ventilator number shown on the ventilation flow sheet is that of the ventilator in Patient A's room (Tr. 27; Pet. Ex. 3). The assessment does not reflect an oxygen saturation rate or a heart rate, which readings are obtained using a pulse oximeter attached to the patient's finger, meaning that the patient must be present to obtain the readings. However, ventilator settings ordered by the doctor were recorded on the ventilation flow sheet (Wu: Tr. 28; Esan: Tr. 92, 115-16; Pet. Ex. 3). Although the ventilation flow sheet indicates that respondent performed the ventilator assessment between 2:30 and 2:57 p.m., the overwhelming, unrebutted evidence establishes that Patient A was in dialysis during this time; therefore, respondent could not have assessed how the ventilator was functioning when in use by Patient A.

Petitioner did not testify or offer any evidence to explain the discrepancy between the ventilation flow sheet information she entered into the patient's medical records and the evidence that the patient was not connected to the ventilator from which she obtained the information.

In order to prove that respondent falsified medical records, petitioner must establish that respondent intended to knowingly mislead or misrepresent the record. *See Admin. for Children's Services v. King*, OATH Index No. 2284/24 at 9 (Oct. 11, 2024), *adopted*, Comm'r Dec. (Oct. 23, 2024), *aff'd*, NYC Civ. Serv. Comm'n Case No. 2024-0681 (Jan. 31, 2025) ("[P]roof of intentional or knowing falsehood and intent to deceive" is required to establish a false statement charge.). Petitioner has met its burden.

The unrefuted evidence establishes that respondent completed a ventilation flow sheet at 2:57 p.m., reflecting that she assessed Patient A while the patient was attached to the ventilator in the patient's room (Pet. Ex. 3). She "locked" the patient record in the PCC system, meaning that she had to select "save, sign, lock, and exit" on the PCC screen and enter her PCC password (Tr. 52). However, when respondent made this entry, Patient A was in the dialysis unit. Therefore, it was impossible for respondent to have performed a ventilator assessment on Patient A on May 9 between 2:30 and 2:57 p.m. while the patient was connected to the ventilator in the room as respondent indicated in the medical records.

The Facility's Respiratory Care Service Policy and Procedures for Documentation of the Patient's Medical Chart requires that medical documentation be done "as soon as possible after the service is performed but NOT BEFORE" (Pet. Ex. 5) (emphasis in original). In addition, the Policies and Procedures for Ventilator Management provide that the objectives of vent checks include "to evaluate and document the patient's response to mechanical ventilation at the time the check is performed" and "to verify and document that ventilator settings are correct as per the physician's orders" (Pet. Ex. 3). Here, respondent could not have evaluated how Patient A responded to mechanical ventilation as the patient was not present. Her entry of information into the ventilation flow sheet for Patient A did not reflect an evaluation of that patient's response to mechanical ventilation because the patient was not present. Thus, respondent entered information into the PCC system knowing that it misrepresented her activities because she had not assessed Patient A while the patient was connected to the ventilator.

The evidence suggests that respondent took a shortcut as she tried documenting the vent check in the patient's absence, leaving blank values for heart rate and oxygen saturation, which

require that the patient be present. Respondent offered no explanation for her actions. Nevertheless, even absent a clear motive, the record establishes that respondent knowingly opened PCC and entered information in the medical records about her assessment of Patient A's use of the ventilator in the patient's room while the patient was not present. *See Health & Hospitals Corp. (Elmhurst Hospital Ctr.). v. Yao*, OATH Index No. 473/11 at 4 (Dec. 29, 2010) (dietician falsified hospital records by documenting that she conducted a dietary assessment of a patient who had died the day before the purported assessment).

In sum, specification two is sustained.

FINDINGS AND CONCLUSIONS

1. Petitioner established that on May 9, 2025, respondent connected a patient to a ventilator that she left on standby mode so that the patient was deprived of oxygen for approximately 30 minutes and required emergency medical care.

2. Petitioner proved that on May 9, 2025, respondent falsely entered into a patient's medical records that the patient was connected to a ventilator in the patient's room that produced readings at about 2:30 p.m., when the patient was out of the room and not connected to the ventilator.

RECOMMENDATION

Upon making these findings, I requested and reviewed an abstract of respondent's personnel records for purposes of recommending a penalty. Respondent has worked at the Facility since September 2014 and has no record of formal discipline. Her overall performance evaluation from September 2020 to September 2025 rate her performance as "satisfactory," with one rating of "satisfactory plus" for September 2021 to September 2022. For the charges in this proceeding, respondent was placed on a pre-hearing suspension without pay from May 19 to June 18, 2025.

Petitioner seeks termination of respondent's employment (Tr. 198), which is appropriate. The proven misconduct is egregious. As a respiratory therapist, respondent bears significant responsibilities for the life and well-being of her patients, with the potential for catastrophic consequences if she does not properly care for them, including serious injury and death. Respondent's failure to turn on the ventilator that provided oxygen to her patient was a gross breach of her duty to her patient.

Amplifying the seriousness of respondent's misconduct is the compelling, credible testimony of two witnesses that respondent ignored their repeated entreaties for her to provide care for a patient who was in dire medical condition due to respondent's negligence. Although, as respondent's counsel pointed out, respondent is not charged with misconduct for her failure to respond to the PCTs (Tr. 193-94), her inaction in the face of a medical emergency she created is disturbing. Respondent's failure to immediately respond to the emergency suggests that she is ill-suited to the demands of her position.

Even in the face of respondent's unblemished disciplinary record and lengthy tenure, termination of employment is appropriate where her misconduct endangered the life and health of a patient under her care. *See Health & Hospitals Corp. (Henry J. Carter Specialty Hospital & Nursing Facility) v. Williamson*, OATH Index No. 986/16 at 21 (Oct. 7, 2016) (even in the face of an unblemished disciplinary record, "where health or safety concerns are implicated, termination of employment may be the only appropriate remedy"); *Yao*, OATH No. 473/11 at 6 (termination recommended for dietician with no prior disciplinary history for falsifying a patient's record, which could jeopardize patient welfare); *see also Health & Hospitals Corp. (Harlem Hospital Ctr.) v. Triana*, OATH Index No. 282/17 at 26 (May 30, 2017) ("Termination of employment is appropriate where respondent's misconduct and/or incompetence endangered the health and safety of others," even with a minor disciplinary record.); *Health & Hospitals Corp. (Metropolitan Hospital Ctr.) v. Ahmed*, OATH Index No. 567/05 at 5-7 (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 Hospital) v. Doxen*, OATH Index No. 1577/01 at 8 (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").

That respondent engaged in another serious form of misconduct earlier on the same day that she left a patient on a ventilator that was not turned on is particularly troubling. Her entry of false information into the same patient's medical records on the same day that her negligence occurred indicates that she cannot be trusted to fulfill her critical medical duties with integrity. Respondent's counsel argued that this tribunal has recommended penalties short of termination for falsification of official records, citing *Human Resources Admin. v. Li*, OATH Index No. 1497/14 (July 17, 2014) (Tr. 198). However, that case is readily distinguishable as it involved falsification

of a daily productivity report to increase the appearance of productivity, not a patient's medical record, upon which their medical care is based.

Petitioner has a compelling interest in ensuring that its patients are provided with competent care and that its employees can be trusted to make accurate, timely, complete entries into patient medical records to ensure patient records are a reliable basis for treating patients. As a respiratory therapist for patients who depend on a ventilator to breathe, respondent's misconduct has life and death implications. She offered no explanation for the proven misconduct. Accordingly, termination of respondent's employment is appropriate, and I so recommend.

Astrid B. Gloade
Administrative Law Judge

February 6, 2026

SUBMITTED TO:

FLOYD R. LONG
Chief Executive Officer

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