STATE OF NEW JERSEY

In the Matter of A.O., Department of Human Services, Hunterdon Developmental Center	:	**DECISION OF THE CIVIL SERVICE COMMISSION**
CSC Docket No. 2025-2796 OAL Docken No. CSV 11632-25	:	

ISSUED: JULY 15, 2026

The appeal of A.O., a Human Services Assistant with the Department of Human Services, Hunterdon Developmental Center, of his removal, effective March 25, 2025, on charges, was heard by Administrative Law Judge Allison Friedman (ALJ), who rendered her initial decision on May 18, 2026. Exceptions were filed on behalf of the appointing authority and a reply to exceptions was filed on behalf of the appellant.

Having considered the record and the ALJ's initial decision, and having made an independent evaluation of the record, including a thorough review of the exceptions, the Civil Service Commission (Commission), at its meeting on July 1, 2026, accepted and adopted the Findings of Fact and Conclusions as contained in the attached ALJ's initial decision and her recommendation to reverse the removal.

In its exceptions, the appointing authority argues that the ALJ erred in dismissing the charges against A.O. and reversing the penalty of removal because the video footage in the record evidenced that A.O.'s conduct constituted abuse under departmental policies and the underlying circumstances did not otherwise constitute an emergency situation that otherwise excused or justified A.O.'s actions.

As indicated above, the Commission has thoroughly reviewed the exceptions filed by the appointing authority in this matter and finds them unpersuasive. The ALJ's initial decision was well-reasoned and her findings and conclusions were based

predominately on her assessment of the credible evidence in the record, including video footage of the incident. The Commission wholly agrees with the ALJ's analysis of the charges. Notably, the ALJ ultimately found:

> [W]hen human services specialists position themselves at either side of a client, with "each person grabbing a side of the patient under the armpit, a light lift of the patient with their buttock off the ground a little bit, and pulling the patient by the armpits," the technique is best described as a "fireman's carry" and not a drag. *Pendergrass v. Dept. of Human Servs.*, CSV 7328-98, Initial Decision (March 20, 2000), *adopted,* [(MSB, decided July 25, 2000)].
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> * * *
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> In this case, [A.O.] placed his hand under M.T.'s armpit and his arm under M.T.'s arm, as [another employee] did the same on the other side of M.T. while under the watchful eye and direction of their supervisor. Together, they gently raised M.T.'s buttocks from the floor and scooted him into the secure living space. The technique had not been taught to them in training[,] but did not cause any physical or psychological injury to M.T.
>
> The escort is consistent with a "fireman's carry." [A.O.] did not drag or push M.T. [A.O.'s] actions and decisions were based on his knowledge of M.T.'s impulsive, defiant, cunning, and sometimes violent behaviors, as seen in the video and documented in the [behavioral support plan (BSP)].
>
> Here, similar to a Fireman's need for that type of carry, the circumstances were exigent. Based on his prior knowledge that is well documented in M.T.'s BSP[, A.O.] had good reason to believe M.T. would, without warning, try to elope, creating a risk of injury to both M.T. and [A.O.]. Further, [A.O.] used the least invasive lift or escort to move M.T. to a safe location removing the threat of danger.

The Commission acknowledges that the ALJ, who has the benefit of hearing and seeing the witnesses, is generally in a better position to determine the credibility and veracity of the witnesses. *See Matter of J.W.D.,* 149 *N.J.* 108 (1997). "[T]rial courts' credibility findings . . . are often influenced by matters such as observations of the character and demeanor of the witnesses and common human experience that are not transmitted by the record." *See also, In re Taylor,* 158 *N.J.* 644 (1999) (quoting *State v. Locurto,* 157 *N.J.* 463, 474 (1999)). Additionally, such credibility findings need not be explicitly enunciated if the record as a whole makes the findings clear. *Id.* at 659 (citing *Locurto, supra).* The Commission appropriately gives due deference

to such determinations. However, in its *de novo* review of the record, the Commission has the authority to reverse or modify an ALJ's decision if it is not supported by sufficient credible evidence or was otherwise arbitrary. *See N.J.S.A.* 52:14B-10(c); *Cavalieri u. Public Employees Retirement System,* 368 *N.J. Super.* 527 (App. Div. 2004). In this matter, the exceptions filed are not persuasive in demonstrating that the ALJ's determinations, or her findings and conclusions based on those determinations, were arbitrary, capricious or unreasonable. As such, the Commission has no reason to question those determinations, or the findings and conclusions made therefrom. Accordingly, the Commission finds that the charges were properly dismissed and the appellant's removal should be reversed.

Since the removal has been reversed, the appellant is entitled to be reinstated with mitigated back pay, benefits, and seniority pursuant to *N.J.A.C.* 4A:2-2.10 from the first date of separation without pay until the date of actual reinstatement. Moreover, as the appellant has prevailed, he is entitled to reasonable counsel fees pursuant to *N.J.A.C.* 4A:2-2.12.

This decision resolves the merits of the dispute between the parties concerning the disciplinary charges and the penalty imposed by the appointing authority. However, per the Appellate Division's decision, *Dolores Phillips v. Department of Corrections*, Docket No. A-5581-01T2F (App. Div. Feb. 26, 2003), the Commission's decision will not become final until any outstanding issues concerning back pay are finally resolved. In the interim, as the court states in *Phillips, supra*, if it has not already done so, upon receipt of this decision, the appointing authority shall immediately reinstate the appellant to his permanent position.

ORDER

The Civil Service Commission finds that the action of the appointing authority in removing the appellant was not justified. The Commission therefore reverses the removal and grants the appeal of A.O.

The Commission orders that the appellant be granted back pay, benefits, and seniority from the appellant's first date of separation without pay to the actual date of reinstatement. The amount of back pay awarded is to be reduced and mitigated as provided for in *N.J.A.C.* 4A:2-2.10. Proof of income earned, and an affidavit of mitigation shall be submitted by or on behalf of the appellant to the appointing authority within 30 days of issuance of this decision.

Additionally, the Commission orders that counsel fees be awarded to the attorney for the appellant pursuant to *N.J.A.C.* 4A:2-2.12. An affidavit of services in support of reasonable counsel fees shall be submitted by or on behalf of the appellant to the appointing authority within 30 days of issuance of this decision.

Pursuant to *N.J.A.C.* 4A:2-2.10 and *N.J.A.C.* 4A:2-2.12 the parties shall make a good faith effort to resolve any dispute as to the amount of back pay or counsel fees. However, under no circumstances should the appellant's reinstatement be delayed pending resolution of any potential back pay or counsel fees dispute.

The parties must inform the Commission, in writing, if there is any dispute as to back pay or counsel fees within 60 days of issuance of this decision. In the absence of such notice, the Commission will assume that all outstanding issues have been amicably resolved by the parties and this decision shall become a final administrative determination pursuant to R. 2:2-3(a)(2). After such time, any further review of this matter shall be pursued in the Superior Court of New Jersey, Appellate Division.

DECISION RENDERED BY THE
CIVIL SERVICE COMMISSION ON
THE 1ST DAY OF JULY, 2026

_____

Mary Cruz
Acting Chairperson
Civil Service Commission

Inquiries
and
Correspondence

Shannon L. Dalton
Director
Division of Appeals and Regulatory Affairs
Civil Service Commission
Written Record Appeals Unit
P.O. Box 312
Trenton, New Jersey 08625-0312

Attachment

State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION
OAL DKT. NO. CSV 11632-25
AGENCY DKT. NO. 2025-2796

IN THE MATTER OF A[redacted] O[redacted],
DEPARTMENT OF HUMAN SERVICES,
HUNTERDON DEVELOPMENTAL CENTER.

John F. McDonnell, Esq., for appellant A[redacted] O[redacted] (Artigliere & McDonnell, attorneys)

Kevin Sangster, Deputy Attorney General, for respondent (Jennifer Davenport, Attorney General of New Jersey, attorney)

Record Closed: April 3, 2026 Decided: May 18, 2026

BEFORE **ALLISON FRIEDMAN**, ALJ:

STATEMENT OF THE CASE

On June 25, 2025, the Hunterdon Developmental Center (HDC) terminated A[redacted] O[redacted], a human services assistant, after he safely escorted resident M.T. from an emergent situation and location to a secure one. Did C[redacted] abuse or neglect M.T.? No. Physical abuse is the type when a physical act is directed at a patient or resident of

a type that could tend to cause pain, injury, anguish, or suffering. Administrative Order 4:08, Supplement S 1 (R-15), *see also*, 42 C.F.R. § 488.301 (2025).

PROCEDURAL HISTORY

On March 25, 2025, the Department of Human Services served C[redacted] with a Preliminary Notice of Disciplinary Action (PNDA) for an incident that occurred at the HDC on February 4, 2025. The charges were neglect of duty, loafing or willful failure to devote attention to tasks, physical or mental abuse of a patient, inappropriate physical contact or mistreatment of a patient, improper conduct, violation of a rule, incompetency, conduct unbecoming, and other sufficient cause. On that same date the HDC suspended C[redacted]. On June 25, 2025, the Center issued and served a Final Notice of Disciplinary Action (FNDA). HDC terminated C[redacted] on that same date for the same charges as listed in the PNDA. On June 11, 2025, C[redacted] filed his request for appeal. On July 1, 2025, the Civil Service Commission transmitted the matter to the Office of Administrative Law (OAL) under the Administrative Procedure Act, N.J.S.A. 52:14B-1 to -15, and the act establishing the OAL, N.J.S.A. 52:14F-1 to -23, for a hearing under the Uniform Administrative Procedure Rules, N.J.A.C. 1:1-1.1 to -21.6. I held a testimonial hearing on December 3, 2025. Closing briefs were received on April 2, 2026. I closed the record on April 3, 2026.

DISCUSSION AND FINDINGS OF FACT

To understand the event of February 4, 2025, that led to A[redacted] C[redacted]'s termination, one must first understand the complete background and circumstances surrounding the event. C[redacted] testified that he had worked for HDC for the prior five years as a human services assistant. During those five years, C[redacted] was assigned to care for resident M.T. at least a few times per week and was always assigned to work in the cottage where M.T. resided. M.T. is a twenty-four-year-old male who is nonverbal, autistic, and heavyset. C[redacted] knows M.T. well and described him as "his guy." C[redacted] knew M.T. to be cunning and unpredictable and knew that out of frustration and desire M.T. would attempt to get what he wanted without regard to hurting himself or others in

his path. M.T.'s potentially dangerous and forceful behavior is on display in the video of February 4, 2025. R-19.

At the hearing Colleen Schanstine, the investigator assigned to this case, testified that she had never been shown the entire video. Schanstine's first viewing of the complete video was at the hearing. Schanstine described the features that were seen in the video and identified the individuals in the video. Schanstine testified having not been shown the entire video she did not know that M.T. had tried to leave the cottage earlier that evening. She also testified not knowing that M.T. had to be forcibly stopped from exiting the cottage or that he had been pushed by another caregiver earlier. The video begins with a view of a glass door and the outdoors beyond the door is visible. There is a garbage can mounted on the wall within inches of the glass door inside the hallway. There is one steel door on the right side of the hallway (the day space) and two steel doors on the left side of the hallway (bathrooms). The hallway walls are concrete. At the opposite side of the glass exit door is the steel door that leads to the living space, which is visible on the video when the door is open. Schanstine confirmed that M.T. did not have any injuries as a result of the actions of C[redacted].

Less than a minute into the video, M.T. is seen exiting the day space then walks across the hallway toward the bathroom doors. M.T. then bends down and seemingly picks up a piece of garbage. The caregiver, not appreciating the potential danger with M.T., allows a couple of feet to be created between M.T. and himself. As a result, when M.T. threw out the garbage he bolted toward the glass door, opening it gaining access to the outdoors. The caregiver immediately grabbed M.T. around the shoulders and neck area to stop him. Then he physically turned M.T. around toward the day-space doors. As M.T. is already heading back to the day space, another caregiver pushes M.T. from behind with both hands. The force of the push causes M.T. to slightly trip on his way back to the day-space door.

These actions of M.T. seen on the video corroborate and support C[redacted]'s testimony and his assessment of M.T. This enables O[redacted] to see danger when others who do not know M.T. as well cannot. O[redacted] described MT. as someone who when he wants something can be cunning, deliberate, forceful, and determined. The correctness

of O[redacted]'s behavior assessment of M.T. is pivotal to placing his actions of February 4, 2025, into their proper context.

Further supporting O[redacted]'s correct and insightful description of M.T. is M.T.'s Behavior Support Plan (BSP). R-9. Specifically, the data in M.T.'s BSP concludes that M.T. was known to be aggressive 178.6 times per month, self-injurious behavior averaged 198.8 times per month, elopement averaged 24.2 times per month, and property destruction averaged 7 times per month. Id. at 046. M.T.'s negative behaviors varied in intensity and severity. Ibid.

Additionally important to determining the appropriateness of O[redacted]'s actions with M.T. on February 4, 2025, is the fact that the clients who were normally housed in Cottage 20 were relocated to Cottage 11 along with the staff. This is important because of the significant security differences and physical differences between the cottages. Specifically, the door in Cottage 11 is glass surrounded by windows with a clear view of the outside providing a temptation to M.T. to leave. Cottage 20, the cottage M.T. was accustomed to, had a steel door with no view of the outdoors, thus no temptation for him to run out existed.

The video continues, and a half hour later M.T. is seen leaving the secure day space, a caregiver following. O[redacted] is then seen returning from his break. His supervisor, S[redacted] A[redacted], is seen asking O[redacted] to help get M.T. to return to the secure living area. O[redacted] testified that since M.T. is "his guy," when he tells M.T. to come with him M.T. goes willingly. However, on the video, M.T. exits the day space, and when he recognizes he is being taken to the living space and not outside he begins to resist. First, in accordance with the BSP, M.T.'s iPad is used to entice him back to the secure living space in accordance with his behavior plan. R-9. This enticement did not work. At this time the human service assistant assigned to M.T., [redacted], returns from his break and assists O[redacted]. M.T. having placed his back against the concrete wall sliding down until his buttocks reached the floor, with his legs outstretched forward, refused to move. R-19. [redacted] retrieved M.T.'s coat, which M.T. likes, and tried to entice him back into the secure living space with that. This enticement also fails to get M.T. into the secure living space.

O[redacted], aware of M.T.'s behaviors and concerned about his tendency to suddenly bolt for the exit, stood in very close proximity to M.T. while actively distracting him from the glass-door exit. O[redacted] is seen using his hands to play with M.T. and patting his back to prevent the situation from escalating. R-19. All the while, Akpor-Mensah, the supervisor, is on the video holding the door open to the secure living space, motioning to get M.T. into the living space. O[redacted] and [redacted] both explained that A[redacted] verbally instructed them to escort M.T. inside but to be careful not to hurt him.

O[redacted] and[redacted] are then seen trying to get M.T. to his feet by using their strength and encouragement. When they are unable to get M.T. to his feet, C[redacted] places his hand under M.T.'s armpit and his arm under M.T.'s arm. When [redacted] holds M.T.'s arm outstretched, C[redacted] redirects him to mirror the under-arm carry he is doing. With C[redacted] on one side of M.T. and the other caregiver on the opposite side of M.T., the two seem to lift M.T. slightly and proceed to gently scoot him a short distance into the secure living space. R-19. During this scoot, the bottom of M.T.'s legs and buttocks are possibly in continual contact with the floor.

O[redacted] testified that he believed that the situation to be emergent. The supervisor's directions supported O[redacted]'s belief. For those reasons C[redacted] followed his supervisor's direction and lifted or escorted M.T. in the safest and gentlest manner he knew how. O[redacted]s top concern being that if M.T. were not placed in a secure location, he would try again to get through the glass exit door with no consideration of the harm he may cause himself or others. The distance from where O[redacted] moves M.T. appears to be about ten feet. Ibid. There is no evidence that M.T. suffered any physical or psychological injury resulting from the escort.

O[redacted] acknowledged that this was not a hold that he was taught. However, C[redacted] also testified that he had never been taught to hold, carry, or escort that should have been used under these circumstances. This is corroborated by the testimony of Enock Berluche, the director of professional services. Berluche testified regarding the training O[redacted] received with Handle with Care, a training program to teach how to properly perform restraint holds and escorts for different scenarios. However, he acknowledged that he did not train and that there is no different way to escort, lift or hold

a 170 pound man or a man the size of M.T. C admitted that the escort or lift he and used with M.T. had not been taught in training. However, C used the safest and gentlest way to move M.T. to safety. Berluche testified to the escalations O is trained to follow. The first is re-direction in accordance with the patient's support plan, then a safe hold or escort, and when that does not work a Code Green should be called. He described a Code Green as when a caregiver tells someone to call make a call that then triggers a page to be sent out through the facility. Following the page, other staff members respond to help with the situation. The caregiver on scene is expected to hold the patient in place until help arrives. Tr. of December 3, 2025, at 121–22.

O testified that in the years he has worked at the Center he has never called a Code Green, and he thought that a supervisor would make that call, not him. O 's rationale and testimony is supported by Berluche. Berluce testified that if a supervisor were present he would expect the supervisor to call the Code Green. Perhaps most importantly, there is no phone in the hallway to use. R-19 Further since there is no phone in the hallway C would have had to leave M.T. to make the call. O is the person in the video who is distracting M.T. from the glass exit door. was also located next to M.T. and in a position to stop M.T. from running through the glass door exit or hurting himself. However, the supervisor, Akpor-Mensah, holding open the door to the residential area, is in the best position to have called the Code Green, not just in location but in authority. Had O left to make the call that would clear a path for M.T. to head through the exit door. Expecting O to leave M.T. and make that call under these circumstances is unreasonable.

No event happens in a vacuum. That could not be truer than in this case. Only through review of the entire video, review of M.T.'s BSP, and consideration of C 's knowledge of M.T.'s behaviors, as well as the supervisor's action or inaction, can the facts be determined.

Based on all the factors to be considered, I **FIND** that there existed an emergent dangerous situation with M.T. that could have resulted in physical injury to M.T. or others. I further **FIND** that no hold, technique, or procedure taught to remove M.T. from the

dangerous situation. Further, I **FIND** that O[redacted] used a minimal amount of force in the gentlest manner possible to ensure M.T.'s safety. Additionally, I **FIND** that if O[redacted] had left M.T. to call a Code Green, it would have increased the risk of harm to M.T. Lastly, I **FIND** that O[redacted] followed the direction of his supervisor.

DISCUSSION AND CONCLUSIONS OF LAW

O[redacted] is charged with seven different disciplinary violations. The first and most serious of which is physical abuse. Physical abuse is a physical act directed at a client, patient, or resident of a type that could tend to cause pain, injury, anguish, and/or suffering. Such acts include but are not limited to the client, patient, or resident being kicked, pushed, or dragged. Additionally abuse includes a physical action directed at a client that could tend to cause pain, injury, anguish or suffering. Department of Human Services Order 4:08, Supplement 1 (R-15).

Here, HDC is alleges that O[redacted] abused M.T. when he and [redacted] "scooted" M.T. into the living space, likening it to a drag. However, when human services specialists position themselves at either side of a client, with "each person grabbing a side of the patient under the armpit, a light lift of the patient with their buttock off the ground a little bit, and pulling the patient by the armpits," the technique is best described as a "fireman's carry" and not a drag. Pendergrass v. Dep't of Human Servs., CSV 7328-98, Initial Decision (March 20, 2000), adopted, MSB (September 5, 2000), https://njlaw.rutgers.edu/OAL/index.php.

The second violation charged is inappropriate conduct and inappropriate physical contact or mistreatment of a patient. This violation occurs when physical contact violates common decency. R-18 at 153, 154, Administrative Order 4:08 C11. The third violation charged is neglect of duty. Generally, the term 'neglect' connotes a deviation from normal standards of conduct." In re Holder, 2021 N.J. AGEN LEXIS 217, *69 (July 2, 2021) (citing In re Kerlin, 151 N.J. Super. 179, 186 (App. Div. 1977). The fourth violation charged is violation of a rule, regulation, policy, order, or administrative decision. R-18 at 158, Administrative Order 4:08 E1. The fifth violation charged is incompetency and failure to perform duties. Caselaw has determined incompetence to be "lack of the ability or

qualifications necessary to perform the duties required of an individual [and]a consistent failure by an individual to perform their prescribed duties in a manner that is minimally acceptable for his/her position." Steinel v. City of Jersey City, 7 N.J.A.R. 91 (1983); Clark v. New Jersey Dep't of Agric., 1 N.J.A.R. 315 (1980). A violation of this nature is committed when an employee has been disciplined for incompetency, inefficiency, or failure to perform duties. N.J.A.C. 4A:2-2.3(a)(1). The sixth violation charged is conduct unbecoming. Conduct unbecoming can be a violation of the implicit standard of good behavior that devolves upon one who stands in the public eye as an upholder of that which is morally and legally correct, or inappropriate actions on the part of the public employee. In re Emmons, 63 N.J. Super. 136, 140 (App. Div. 1960) see also Ferrogine v. State Dep't of Human Servs., Trenton Psychiatric Hosp., CSV 2441-98, Initial Decision (April 17, 1998), https://njlaw.rutgers.edu/OAL/index.php, modified, Merit System Board (July 6, 1998). The seventh violation charged is "other sufficient cause." Other sufficient cause is an action or behavior that violates the standards of good behavior that when viewed in the public eye is morally and legally correct. In re MacDonald, CSR 9803-13, Initial Decision (May 19, 2014), adopted, Civil Service Commission, (September 3, 2014), https:/njlaw.rutgers.edu/collections/OAL/index.php.

In this case, C[redacted] placed his hand under M.T.'s armpit and his arm under M.T.'s arm, as [redacted] did the same on the other side of M.T. while under the watchful eye and direction of their supervisor. Together, they gently raised M.T.'s buttocks from the floor and scooted him into the secure living space. This technique had not been taught to them in training but did not cause any physical or psychological injury to M.T..

This escort is consistent with a "fireman's carry." C[redacted] did not drag or push M.T. O[redacted]'s actions and decisions were based on his knowledge of M.T.'s impulsive, defiant, cunning, and sometimes violent behaviors, as seen in the video and documented in the BSP.

Here, similar to a Fireman's need for that type of carry, the circumstances were exigent. Based on his prior knowledge that is well documented in M.T.'s BSP C[redacted] had good reason to believe M.T. would, without warning, try to elope, creating a risk of injury to both M.T. and C[redacted]. Further, C[redacted] used the least invasive lift or escort to

move M.T. to a safe location removing the threat of danger. Therefore, I **CONCLUDE** that C[redacted]'s actions of February 4, 2025, do not constitute physical abuse or improper physical contact. Based on the same application of the facts I further **CONCLUDE** that O[redacted] did not neglect his duty, that he did not violate a rule or regulation, that he did not fail to perform his duties, that his conduct was not unbecoming, and that there is no "other sufficient cause" for disciplinary action, and thus he is not subject to discipline.

ORDER

Given my findings of fact and conclusions of law, I **ORDER** that A[redacted] C[redacted] be reinstated to his position.

I further **ORDER** that A[redacted] O[redacted] be awarded back pay for any period he has been out of work without pay due to this disciplinary action.

I hereby **FILE** my initial decision with the **CIVIL SERVICE COMMISSION** for consideration.

This recommended decision may be adopted, modified or rejected by the **CIVIL SERVICE COMMISSION**, which by law is authorized to make a final decision in this matter. If the Civil Service Commission does not adopt, modify or reject this decision within forty-five days and unless such time limit is otherwise extended, this recommended decision shall become a final decision in accordance with N.J.S.A. 52:14B-10.

Within thirteen days from the date on which this recommended decision was mailed to the parties, any party may file written exceptions with the **DIRECTOR, DIVISION OF APPEALS AND REGULATORY AFFAIRS, UNIT H, CIVIL SERVICE COMMISSION, 44 South Clinton Avenue, PO Box 312, Trenton, New Jersey 08625-0312**, marked "Attention: Exceptions." A copy of any exceptions must be sent to the judge and to the other parties.

May 18, 2026
DATE

ALLISON FRIEDMAN, ALJ

Date Received at Agency: May 18, 2026

Date Mailed to Parties: May 18, 2026

AF/ml

APPENDIX

Witnesses

For petitioner

[redacted]
A[redacted] O[redacted]

For respondent

Colleen Schanstine
Enock Berluche

Exhibits

For petitioner

A-1 Amended PNDA dated March 25, 2025
A-2 FNDA dated June 25, 2025
A-3 Confidential Incident Report dated February 4, 2025 (admitted December 3, 2025)
A-4 Susan Fair's statement (admitted December 3, 2025)
A-5 A[redacted] O[redacted]'s statement (admitted December 3, 2025)
A-6 [redacted] statement (admitted December 3, 2025)
A-7 Previously marked document (admitted December 3, 2025)
A-8 Assignment sheet (admitted December 3, 2025)
A-9 Investigation Report
A-10 Patient's Behavior Support Plan
A-11 July 12, 2024, Memorandum to all employees
A-12 Clinical Services re: Code Green Policy

For Respondent

R-1 PNDA dated March 25, 2025, HDC004-005
R-2 Amended PNDA dated March 25, 2025, HDC006-007
R-3 FNDA dated June 2, 2025, HDC008-009

R-4 Confidential Incident Report HDC010-015

R-5 O[redacted]'s Witness Statement HDC019

R-6 [redacted] Witness Statement HDC020-021

R-7 Investigation Report HDC035-043

R-8 O[redacted]'s Acknowledgment of Behavior Support Program HDC044

R-9 Patient's Behavior Support Program HDC045-054

R-10 O[redacted]'s Defensive and Physical Control Techniques Test Report HDC055-089

R-11 Mistreatment of Individuals Training Acknowledgment HDC101-103

R-12 Preventing Abuse and Neglect Training Acknowledgment HDC104

R-13 The Stephen Komnino's Law Training Acknowledgment Form HDC105

R-14 Administrative Decision HDC091a-099

R-15 Administrative Order No. 030 HDC106-112

R-16 Administrative Order 2:05 HDC113-129

R-17 Clinical Services (Code Green) Policy HDC130-144

R-18 DHS Disciplinary Action

R-19 Closed Circuit Video of the Hallway of Cottage 11