State of New Jersey
DEPARTMENT OF HUMAN SERVICES
PO Box 700
TRENTON, NJ 08625-0700

CHRIS CHRISTIE
GOVERNOR

KIM GUADAGNO
LT. GOVERNOR

ELIZABETH CONNOLLY
ACTING COMMISSIONER

FINAL DECISION

OAL DKT. NO. HSL 00505-15

AGENCY DKT. NO. DHU# 15-001

DEPARTMENT OF HUMAN SERVICES

OFFICE OF LICENSING,

OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY,

Petitioner,

v.

MARGARET VANN,

Respondent.

A. INTRODUCTION

Margaret Vann brought an appeal of the revocation of her license to operate a Community Care Residence (CCR) by the Department of Human Services. Originally, the Office of Licensing, based upon investigations by the Office of Investigations (OI) of the Department of Human Services, had suspended her license and she had appealed that action (in an earlier suspension case HSL-01987-14/DHU14-002). Subsequent investigations by OI substantiated acts of neglect by Ms. Vann. After reviewing the findings, the Office of Licensing revoked Ms. Vann's license. Ms. Vann appealed the revocation and the revocation matter was transmitted to the Office of Administrative Law (OAL). There, the suspension was considered moot, having been superseded by the revocation, and the only contested matter to be decided was the revocation of the CCR license.

The OI investigations substantiated Vann's neglect of two individuals with developmental disabilities (Service Recipients) who had been entrusted to her care. The OI investigation found that the individuals under her care were neglected based upon a negative home inspection. The inspection revealed holes in the Service Recipients' mattresses, standing water and likely mold present in the basement, an inadequate food supply in the home, inadequate clothing for the Service Recipients, and a potentially dangerous overloaded power outlet.

Ms. Vann disputed the revocation of her license and requested an OAL hearing to appeal the decision. Her appeal was transmitted to the OAL and filed on January 5, 2015. (The suspension appeal had been transmitted on February 14, 2014 and was returned to OPIA on April 23, 2015.) A hearing was held on April 14, April 23, and May 22, 2015. The record was closed on May 22, 2015. The Administrative Law Judge (ALJ) requested an extension of time to file the Initial Decision. The Initial Decision was emailed to the parties on August 21, 2015.

B. THE INITIAL DECISION

During the hearing, Joseph A. Ascione, the ALJ, heard testimony and reviewed evidence. The Initial Decision incorporated the testimony of seven witnesses for the Department and two witnesses for the licensee, as well as forty-two documents submitted by the parties. The ALJ cited the following as findings of fact in the initial decision (the initials D.T. and H.D. are those of the Service Recipients):

1. "On January 6, 2014, the OI instituted an investigation based upon a report from Jose Torres at the CCR premises operated by Vann. Two clients of DDD were housed at that location.
2. On January 6, 2014, OOL, DDD (sic) conducted an initial risk assessment.
3. The initial risk inspection discovered dampness and mustiness in the basement, including flooding.
4. The initial risk inspection discovered a large hole in D.T.'s mattress.
5. The initial risk inspection discovered a small hole in H.D.'s mattress.
6. The initial risk inspection discovered a minimum food supply on hand.
7. The initial risk inspection discovered there to be clutter, which could have been a fire hazard.
8. The initial risk inspection determined that an overloaded power strip had numerous electrical devices attached.
9. The initial risk inspection determined that the clients' rooms did not meet required CCR standards because of the absence of doors on the closets.
10. The initial risk inspection determined that the allegations of the Torres's report were supported by other information.
11. As a result of the initial risk assessment [by] the OOL, DDD removed the two clients from Vann's premises and placed them at a respite location. The medical records of the clients were removed from the Vann premises.
12. Vann failed to note medical conditions of D.T. and/or failed to open medical mail addressed to D.T.
13. The investigation continued and the medical records revealed that one of the client's, D.T., had on two occasions attempted to have a mammogram performed only to be inconclusive. The medical recommendation required conducting a breast biopsy.
14. An appointment with the surgeon resulted in a notation that the patient had refused the biopsy. Vann characterized the appointment as only consultive (sic). Regardless of that factual finding, Vann made no notation in the client's medical records, nor did she consult with the known medical guardian of D.T.
15. As a result of the unusual incident inspection, the OI determined from the record and testimony that the clients' clothing was seasonally insufficient.

16. As a result of the unusual incident inspection, the OI determined from the record and testimony that the power strip had been overloaded. This determination cannot be supported on the record.
17. The OOL, DDD initial risk assessment reasonably found that the clients were at imminent risk of injury and properly took the action to remove them from the Vann premises.
18. Vann became licensed as a CCR in 2009 and has continued to be renewed annually, at times addressing corrective actions requested by OOL, DDD (sic).
19. On January 9, 2014, the OOL suspended Vann's CCR license based upon neglect of her clients.
20. On February 12, 2014, the OOL amended the suspension of Vann's CCR license to include additional allegations of neglect.
21. On September 23, 2014, the OI issued the results of its investigations finding that Vann neglected the clients. However, the finding of neglect did not trigger placement on the Central Registry. Vann received notice that it could affect her license.
22. On December 2, 2014, the OI revoked the license of Vann as a CCR."

The ALJ concluded that Ms. Vann's actions rose to the level of neglect; concluding that:

1. Vann breached her responsibility to comply with the minimum standards of N.J.A.C. 10:44B-1.6(a).
2. Vann breached her responsibility by allowing a substantiation of neglect, N.J.A.C. 10:44B-2.1(i) states neglect shall be prohibited
3. Vann's mistreatment of H.D. and D.T. is sufficient cause for immediate licensure revocation in accordance with N.J.A.C. 10:44B-2.1(i)(1).
4. Vann's conduct was neglect, placed H.D. and D.T. in an unsafe environment, and constituted sufficient grounds for the revocation of Vann's CCR license.

The ALJ ordered that the revocation of Margaret Vann's CCR licensure should be affirmed. The ALJ went on to state that, "Vann is left with the ability to reapply for her license after December 2, 2015, as one year will have expired from the initial date of the revocation. This may allow Vann to continue to provide CCR services in the future." The ALJ filed the initial decision with the Director of the Office of Program Integrity and Accountability for consideration.

C. EXCEPTIONS

No exceptions were filed.

D. ANALYSIS OF INITIAL DECISION

The Office of Program Integrity and Accountability, on behalf of the Department of Human Services, gave careful consideration to the ALJ's Initial Decision and the entirety of the OAL file. Because the ALJ has had the opportunity to personally view and interact with the witnesses to gauge their credibility and because the findings of fact are reasonable inferences from the cited testimony, I accept and affirm the ALJ's findings of fact. In reviewing the decision of the ALJ, I must modify the applicable choice of law and

the comments concerning the reapplication for a CCR license. The Initial Decision cites both N.J.A.C. 10:44A and N.J.A.C. 10:44B in applying the facts to the law. N.J.A.C. 10:44A is a Chapter devoted to "The Standards for Community Residences for Individuals with Developmental Disabilities;" these types of residences are run by agencies that generally operate a number of group homes and hire employees to do so. N.J.A.C. 10:44B is a Chapter identified as the "Manual of Standards for Community Care Residences;" these types of residences are operated by individual homeowners within their own homes. Margaret Vann's licensure was for a CCR regulated under N.J.A.C. 10:44B and NOT under N.J.A.C. 10:44A. Pursuant to N.J.S.A. 52:14B-10 (c), and upon a review of the record submitted by the ALJ, I must modify the recommended decision.

1. **WEIGHT OF TESTIMONY**
   The ALJ found all of Department's witnesses credible and their testimony was accepted as to the factual information they witnessed. Each witness's understanding of reports filed or information related to them by other employees of the DDD was accepted by the ALJ. The ALJ found Vann's testimony less than credible and her statements self-serving. As previously stated in the analysis of the initial decision (above, at D.), I affirm the ALJ's determination of credibility.

2. **NEGLECT**
   The testimony at court clearly establishes that the Service Recipients were neglected by Ms. Vann. I affirm the findings of the ALJ cited above and modify the decision to clearly state that Margaret Vann's actions or inactions constitute neglect, as defined at N.J.A.C. 10:44B. N.J.A.C. 10:44B states that a violation of New Jersey laws pertaining to CCRs and a failure to comply with minimum standards warrants a revocation of a CCR license. Substantiation of neglect - a violation of the New Jersey Administrative Code and a clear failure to meet minimum CCR standards - is sufficient reason to revoke a CCR license.

3. **CHOICE OF LAW**
   The ALJ incorrectly used the definition of neglect from N.J.A.C. 1044A-1.3 ("The Standards for Community Residences for Individuals with Developmental Disabilities," run by agencies) in his Initial Decision concerning neglect within a CCR. The correct definition is found at: N.J.A.C. 10:44B-1.3 – "The Manual of Standards for Community Care Residences," run by individual homeowners. The correct definition is: "'Neglect' means the failure of any person responsible for the welfare of an individual to provide the needed supports and services to ensure the health, safety, and welfare of the individual. These supports and services may or may not be defined in a plan of care for the individual, or otherwise required by law or rule. Neglect includes acts that are intentional, unintentional, or careless, regardless of the incidence of harm inflicted on the individual. Examples include, but are not limited to, the failure to provide needed care such as shelter, food, clothing, supervision, attention to personal hygiene, medical care, and protection from health and safety hazards." The correct definition, when applied to the ALJ's findings of fact cited above overwhelmingly and beyond a preponderance of the evidence mandate a finding of neglect. There was a failure to provide needed care in the named matters of:

   a. Shelter – the house was cluttered and lacking doors. There was standing water in the basement.

b. Food – there was insufficient food in the house.
c. Clothing – the Service Recipients' clothing was inappropriate for winter.
d. Safety – an overloaded power strip.
e. Medical Care – a needed biopsy was allowed to go unscheduled for two years.

By either measure, but most certainly under the proper code section - N.J.A.C. 10:44B - Ms. Vann neglected the care of the individuals with developmental disabilities that she had been trained and paid to care for.

The ALJ incorrectly used a reference from N.J.A.C. 1044A-1.6 (The Standards for Community Residences for Individuals with Developmental Disabilities, run by agencies) in his Initial Decision to justify the immediate licensing revocation of a CCR. The correct authority is found at: N.J.A.C. 10:44B-1.6(a) Options on non-compliance with standard in "The Manual of Standards for Community Care Residences," run by individual homeowners. There, the CCR regulations state, "The Department may revoke a license whenever the licensee shall be found to be violating any State or Federal law pertaining to CCR, or whenever such residence shall fail to comply with the minimum standards established by the Department." As described above, Ms. Vann clearly violated the New Jersey Administrative Code when she was substantiated as having committed neglect against the Service Recipients – all of the ALJ's factual findings support the existing Office of Investigation substantiation of neglect. Further, the insufficient provision of food, shelter, care, and clothing by Ms. Vann is a failure to meet minimum CCR standards. The correct code section, N.J.A.C. 10:44B, justifies the revocation of her CCR license.

N.J.A.C. 10:44B (Manual of Standards for Community Care Residences) defines the licensing of CCRs. The standards for licensure are listed at N.J.A.C. 10:44B-1.4. The ALJ's decision cannot alter or modify the statutory (N.J.S.A. 30:1-12) delegation to DHS's Office of Licensing to be the sole decision-making entity, with the authority to grant CCR licensure. I must modify the Initial Decision by deleting the paragraph pertaining to Ms. Vann's reapplying for licensure from one year after a certain date (Page 18). There is absolutely no basis at law for such a provision.

4. APPLICATION OF LAW

I modify the ALJ's references to N.J.A.C. 1044A (The Standards for Community Residences for Individuals with Developmental Disabilities) and change them to citations within the rules of N.J.A.C. 10:44B (Manual of Standards for Community Care Residences). The regulation of CCR operated by individual homeowners is governed by N.J.A.C. 10:44B. The ALJ's recitation of the case's findings of facts clearly and beyond a preponderance of the evidence prove that Ms. Vann neglected the two service recipients with developmental disabilities under her care according to the definition of neglect as found at N.J.A.C. 1044B-1.3. In addition, N.J.A.C. 10:44B-1.6(a) permits the Office of Licensing to revoke a CCR license for the actions described by the ALJ in his finding of facts. The application of the rules found in N.J.A.C. 10:44B (Manual of Standards for Community Care Residences) to the facts of this case, as ascertained by the ALJ,

reasonably and by a preponderance of the evidence mandate a revocation of Ms. Vann's CCR license.

E. FINAL AGENCY DECISION

1. The New Jersey Legislature has given the Department of Human Services the authority to license and regulate Community Care Residences, under N.J.S.A. 30:6D -1 et seq. Pursuant to those statutes, the Department has promulgated rules and regulations (N.J.A.C. 10:44B) that regulate Community Care Residences. These rules define and forbid neglect of residents. These rules mandate that a licensee who has committed a substantiated act of neglect may have his or her license revoked by the Department. The definition of neglect has previously been discussed under the Analysis of the Initial Decision. The rules delegate to the Office of Licensing the sole authority for granting licensure.

2. To be substantiated, neglect must be shown to have occurred by a preponderance of the evidence. I find that the preponderance of the evidence presented during the hearing substantiates that Margaret Vann neglected two individuals with developmental disabilities under her care. I find that the licensure allowing Margaret Vann to operate a Community Care Residence should be revoked for failure to meet the minimum requirements of licensure and her having been substantiated for neglect.

F. CONCLUSIONS AND ORDER

I **CONCLUDE** that the Department has met its burden of proving neglect of an individual with developmental disabilities by Margaret Vann with a showing of a preponderance of the credible evidence in the record. I further **CONCLUDE** that the substantiation of neglect is sufficient cause for the revocation of Margaret Vann's license to operate a Community Care Residence.

Having given careful consideration to ALJ's Initial Decision and the entirety of the OAL file, as noted above, it was necessary to modify the initial decision due to the application of law in the decision. Therefore, pursuant to N.J.A.C. 1:1-18.6(d), it is the Final Decision of the Department of Human Services that I **ORDER** Margaret Vann's license to operate a Community Care Residence be revoked.

Date: 10/8/15

Lauri Woodward, Director
Office of Program Integrity and Accountability