State of New Jersey

PHILIP D. MURPHY
GOVERNOR

SHEILA Y. OLIVER
LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY
PO BOX 700
TRENTON, NJ 08625-0700

CAROLE JOHNSON
COMMISSIONER

LAURI WOODWARD
DIRECTOR

FINAL AGENCY DECISION

OAL DKT. NO. HSL 01110-18
AGENCY DKT. DRA #18-001

M.G.,

Petitioner,

v.

NEW JERSEY DEPARTMENT OF HUMAN SERVICES,

Respondent.

PROCEDURAL HISTORY

The Department of Human Services' (DHS), Office of Program Integrity and Accountability, investigated a report of an unusual incident involving petitioner and D.B., an individual who receives services from the Division of Developmental Disabilities. By letter dated August 16, 2017, DHS notified petitioner that the investigation had substantiated an allegation of abuse against her and that her name would be placed on the Central Registry. On March 12, 2018, petitioner filed an appeal and DHS transmitted this matter to the Office of Administrative Law (OAL), where it was filed as a contested case on January 22, 2018. A Consent Confidentiality and Protective Order was entered on September 7, 2018, covering any DHS records would be provided by DHS. A hearing was conducted on March 21, 2019 and the record remained open to allow for closing submissions. The record closed on October 9, 2019 following receipt of post-hearing briefs. On December 19, 2019 the Administrative Law Judge (ALJ) issued an Initial Decision on the matter. The Initial Decision, issued by the ALJ, precisely details the evidence considered and is particularly illustrative of the Central Registry placement procedures (as defined by the statute and its regulations) explaining the reporting of an incident, its investigation, the evaluation of evidence, the findings determination, the standards and levels of review for Central Registry placement, as well as the appeal processes. In order to bring more attention to the Central Registry practices of the Department, a great deal of the testimony and analysis in the initial decision is quoted or paraphrased below.

EXCEPTIONS

No exceptions were received by the Office of Program Integrity and Accountability from the Petitioner. The Respondent entered comments, not to anything substantive presented in the Initial Decision, which affirmed M.G.'s placement on the Central Registry, but to the placement of the "(Record Sealed)" notation on the Initial Decision. The Respondent correctly states that the initial and final agency decisions concerning the Central Registry were never intended to be sealed from the public. Compliance with the Consent Confidentiality and Protective Order, issued by the ALJ on September 7, 2018 is sufficient to protect privacy interests of all affected by this case – particularly the use of initials, rather than the full names of service recipients and the Respondent. The initial and final decisions with their proper redactions should not be under seal and should be available for public review.

The availability of Central Registry initial and final decisions to the public increases transparency in the judicial process, educates the agency, its constituents, and members of the bar as this area of the law develops. The availability of these decisions serves as a precedential resource for all who may, in the future, become involved with the Office of Administrative Law. The Order to Seal, however it came to be placed on this initial decision, was improvidently attached. The existing Confidentiality and Protective Order is sufficient. The Initial Decision and Final Agency Decisions should not be under seal.

TESTIMONY AT THE HEARING

Deborah Robinson, the Director of Performance Management within the DHS Office of Program Integrity and Accountability, testified on behalf of the respondent. She oversees the Central Registry of Offenders. The Central Registry is a confidential list of former paid employee caregivers who have been substantiated for abuse, neglect or exploitation of individuals with developmental disabilities following an investigation by the DHS Office of Investigations. The law was enacted in 2010, designed by the Legislature to protect individuals with developmental disabilities. Persons with developmental disabilities are particularly vulnerable because of the amount of care they require and the extent to which they depend on others to provide self-care, including feeding, showering, bathing, transferring and mobility. The amount of care they require makes them susceptible to abuse and neglect.

The Director of the DHS Office of Investigation reviews the investigation of all substantiated cases; and if an incident meets the prongs for the registry, the file is referred to her office. The criteria for being put on the Central Registry is that the abuse has to be intentional, reckless or show careless disregard for the person with developmental disabilities. The caregivers are specifically trained on how to care for the individuals. When someone is placed on the Central Registry, they are sent a letter advising them of same and giving them their appeal rights to either the OAL or a departmental hearing.

Ms. Robinson was familiar with M.G. from reading the investigation report. The incident was that M.G. and another caretaker at the Dungarvin Group Home neglected and abused the service recipient D.B. by dragging her across the floor and then leaving her in her urine and feces in her room for approximately three hours. After reviewing the investigation report, the Office of Investigations determined that the substantiated allegations of abuse and neglect warranted placing M.G. on the Central Registry of offenders and referred the matter to designees of the Commissioner of the Department of Human Services for consideration.

Ms. Robinson reviewed the report and consulted with one of the Department's legal advisors. The recommendation for placement was then sent for a second level of review by the Director of the Office of Program Integrity and Accountability. The evidence considered for placement was that M.G. and another caretaker dragged D.B. from one place to another causing minor injury to D.B.'s back. It looked like a scrape or rug burn in that it was very red and it did not appear to be old. D.B. was left in her room with the door closed. Without D.B. being able to get up or move on her own was abuse. Leaving D.B. sitting in her urine and feces for that amount of time showed a lack of dignity and respect. The investigation report

indicated that D.B. was crying out for assistance and nobody attended to her. The combined physical and emotional abuse convinced them that M.G. should be placed on the Central Registry.

M.G. was notified of respondent's intention to place her on the Central Registry by letter dated August 16, 2017, which also set forth her right to appeal. Of approximately one thousand investigations conducted per year by the Office of Investigations pertaining to the developmentally disabled community, Ms. Robinson believed M.G.'s case was particularly egregious because of the fact that D.B. was dragged across the floor, left on the floor in her urine and feces, and M.G. failed to seek additional help or support.

On cross-examination, Ms. Robinson said she is an administrator and is not trained to do investigations and has no medical background. She relied on the investigation report which was prepared by James Balady from the Office of Investigations who was trained by the DHS in investigations. She had not met with the investigator and did not meet with any of the eyewitnesses in this case. She was aware that the victim in this case, D.B., sometimes tells stories and makes things up. However, according to the investigation, D.B. gave a consistent statement three times. D.B. said she was dragged across the floor and her roommate testified that D.B. was dragged across the floor. Ms. Robinson saw a photograph of what looked like a rug burn or scrape on her back. There were feces along the floor in the photograph. D.B. only required one staff member to bathe her.

If a patient is on the floor and cannot physically be lifted, help should be sought. If M.G. requested her supervisor to help and she did not, M.G. should have continued to seek help, by calling the on-call supervisor. Ms. Robinson is aware from reading the investigation report that the other staff member present, C.B., never left the office the entire time that D.B. was on the floor. C.B. was not helpful. The only witnesses to this incident were M.G., C.B., the victim D.B., her roommate, D.E., and subsequently the direct staff members who came on duty for the next shift.

M.G. did not cooperate in the investigation until after it was completed. The investigation was completed in July, 2017. The director of investigations, Maria McGowan reviewed the report on July 12, 2017. After it was reviewed, M.G. gave a statement on July 21, 2017. Ms. Robinson was unaware that M.G. gave a statement before she made the final determination to place M.G. on the Central Registry. M.G.'s lack of cooperation was factored into the determination. The entire investigation was concluded without M.G. ever having been interviewed, and Ms. Robinson never reviewed M.G.'s statement. The Central Registry Determination document was dated July 18, 2017.

By letter dated July 13, 2017, M.G. was advised that the investigation was concluded and that she had been substantiated for abuse and neglect. M.G. then contacted the Office of Investigations to give an interview. Previously, on January 26, 2017 a letter had been sent to M.G. certified and regular mail to contact the investigator. On February 2, 2017 M.G. spoke to the investigator and scheduled an interview for February 3, 2017 at 1:30 p.m. at the Trenton Public Library. M.G. did not appear for the interview at 1:30 p.m. The investigator spoke to M.G. and she said she would be there by 2:00 p.m. By 3:00 p.m. M.G. still had not arrived and the investigator attempted to contact her, but she did not answer her phone. On February 6, 2017 the Office of Investigations received a receipt for a certified letter that was signed by M.G. dated February 2, 2017.

Matthew Cook testified on behalf of the respondent. He works in the Office of Investigations for the Department of Health. His current job title is Chief of Investigations. He oversees the investigations of abuse and neglect in the four state psychiatric hospitals. He previously worked in the Office of Investigations for the Department of Human Services as the Supervisor of Investigations for eight years where he supervised investigators doing abuse, neglect and exploitation investigations in the developmental centers or any community residences or group homes that provided care to people with developmental disabilities. He has received training from the Department of Human Services, but his formal, nationally recognized training is from a company called Labor Relations Alternatives.

The Office of Investigations is an outside entity that investigates abuse, neglect and exploitation in group homes and developmental centers. The results of an investigation are that allegations are either substantiated or unsubstantiated. An allegation is substantiated if, based upon the preponderance of the evidence, it is more likely than not that the event occurred in the way it was reported. If there is a

substantiated case of abuse, neglect, or exploitation of someone with a developmental disability, the case is forwarded to a panel that makes a determination, based on the Central Registry law, as to whether that person should be placed on the Central Registry. Abuse is any action by a caregiver that causes or has the potential to cause injury or anguish. Verbal abuse is making demeaning statements to someone receiving services. Examples of physical abuse are kicking, punching, slapping and/or dragging someone that could cause injury. Verbal or psychological abuse could be anything from calling someone names to threatening them or demeaning them to make them feel less than human. Neglect is any action or failure to provide for the health, safety and well-being of the person.

Mr. Cook did not personally conduct the investigation into the incident at the Dungarvin Group Home involving M.G. He reviewed the investigation and was present when M.G. was interviewed by Mr. James Balady, the investigator in this case who has retired. Mr. Cook was Mr. Balady's supervisor for eight years. He reviewed Mr. Balady's investigation report and approved it. He is familiar with all of the documentary, photographic and testimonial evidence relied upon by Mr. Balady in completing his investigation report.

Any event that is considered potential abuse, neglect or exploitation occurring in a state-run developmental center or group home comes to the Office of Investigations as an Unusual Incident Report (UIR) from the Critical Incident Management Unit after having been received from the reporting agency. Mr. Cook reviews the UIR and, if it meets the definition, assigns it to an investigator. Once the investigation is started, he meets with the investigator weekly to discuss its status. Mr. Cook was familiar with the investigation.

The incident occurred on November 4, 2016 and identified the alleged perpetrators as M.G. and C.B. and the victim as D.B., an individual with developmental disabilities who resided at the Dungarvin Group Home. On November 4, 2016 at 11:00 p.m., two staff members from the next shift, Mr. Valery Jean and Ms. Lynnette George discovered D.B. covered in feces in her room and with a bruise on her back. When they asked D.B. what occurred, D.B. said she was dragged to her room and left there in her feces. The UIR commenced the investigation and came from the Agency. The Agency contacted the Critical Incident Management Unit, who referred it to the Office of Investigations. Mr. Cook received the UIR and assigned it to Mr. Balady for an investigation.

According to the Incident/Allegation Summary of the Investigation Report, the UIR reflected that on November 4, 2016 at 11:00 p.m., overnight staff members Mr. Valery Jean and Ms. Lynette George discovered D.B. sitting on the floor of her bedroom covered with feces. Mr. Jean and Ms. George were able to get her up from the floor and shower her within twenty minutes. Ms. George discovered a bruise on D.B.'s back while showering her and documented it. The administrative staff at Dungarvin gathered more information and found that M.G. and C.B. were the two staff members working the previous shift. Mr. Jean and Ms. George asked D.B. what happened, and she stated that the previous staff were tired of cleaning her up, so they dragged her to her bedroom and locked the door and left her there. The UIR indicated that C.B. and M.G. stated that D.B. was left alone in her room with soiled clothing for approximately three hours. C.B. stated that between 8:00 p.m. and 11:00 p.m., she completed T-logs and administered medication to the other individuals in the group home. T-logs are running logs documenting what was going on in the group home. C.B. stated that she was not feeling well and did not check on D.B. C.B. stated that she heard D.B. calling from her bedroom for M.G. throughout the evening for approximately three hours.

D.B. stated that she was initially in the living room watching TV and had a bladder accident and that staff changed her. D.B. had another bladder accident and the staff members got mad and dragged her from her chair in the living room to her bedroom. While she was in her bedroom, she needed to use the bathroom and called for staff members to help. When no one came, she had no choice but to defecate on herself. D.B. said the staff members pushed her back into her bedroom and closed the door. The Dungarvin UIR indicates that M.G. and C.B. were terminated November 5, 2016.

Based on the allegations relayed in the UIR, this is the type of case that the Office of Investigations would investigate. Mr. Balady conducted an investigation and interviewed numerous witnesses. He made multiple attempts to contact C.B. for an interview, but she never responded. Mr. Balady conducted a

telephone interview of Bukola Alonge, the former program director at Dungarvin. He also conducted two interviews of the victim D.B. and also interviewed her housemate D.E., who was not able to provide any information. Mr. Balady interviewed Ms. George and Mr. Jean, the staff members who came on duty following the incident. He also interviewed Tim Kirschbaum, the area director of the central and southern regions for Dungarvin's Group Homes. He interviewed D.R., another housemate of the victim. These were the interviews conducted and reflected in the incident report.

Mr. Balady interviewed D.R., a housemate of D.B. This investigation report was compiled in the normal course of business. Based on Mr. Cook's conversations with Mr. Balady the investigation report introduced into evidence accurately reflected the statements made by D.R. during her January 25, 2017 interview with Mr. Balady. According to D.R., on November 4, 2016 she was in the living room with two female staff members who were later identified as M.G. and C.B. D.R. stated that D.B. was sitting in her lounge chair when one of the staff dragged her from the chair to the floor and then both staff dragged her from the floor to her bedroom. D.R. stated that at this point she went to her own bedroom, closed the door and went to sleep.

Mr. Balady obtained a statement from Tim Kirschbaum, the Area Director of the Central and Southern Regions of New Jersey for the Dungarvin Group Homes. Based on Mr. Cook's conversations with Mr. Balady, the statement accurately reflects the statements made by Mr. Kirschbaum during his January 25, 2017 interview with Mr. Balady. Mr. Kirschbaum received a telephone call from Mr. Jean sometime after 11:00 p.m. on November 4, 2016. Mr. Jean reported that when he arrived at the group home, D.B. was sitting on her bedroom floor and she had had a bowel movement and urinated and needed to be cleaned. Mr. Kirschbaum advised Mr. Jean to attend to her and to call him back. Mr. Jean called him back ten minutes later and stated that he and Ms. George had cleaned and showered D.B. and she was now in bed. Mr. Jean stated that he and Ms. George were upset how they found D.B. at the beginning of their shift. Mr. Kirschbaum read the shift notes that night from remote access. Mr. Kirschbaum went to the group home the next morning and spoke to C.B. and advised her that there was going to be an investigation and that she was not going to be allowed to work. He also contacted M.G. and advised her not to report to work due to the investigation.

Mr. Kirschbaum interviewed D.B. at the group home. D.B. alleged that she had been pulled out of the chair by C.B. onto the living room floor and laid on the floor for a few hours in a diaper soaked with urine and bowel matter. Two hours later, D.B. told Mr. Kirschbaum that she was dragged from the living room to her bedroom by C.B. and sat on the floor in her bedroom for about two hours, until the two night shift staff members came in and cleaned her. An investigator from Dungarvin did an investigation and noted that when the staff members showered D.B., a bruise was discovered on her lower back.

On January 25, 2017, Mr. Balady attempted to interview D.E., another resident of the group home, but no verbal responses were provided in response to his questions.

On January 27, 2017, Mr. Balady took a statement from Lynette George, which coincided with the statements made by Ms. George in his interview with her. Ms. George came in to work on November 4, 2016 at 11:00 p.m. and was one of the staff members who relieved M.G. and C.B. that evening. When Ms. George got to the house, Mr. Jean was already there at the front door of the house with gloves in his hand and he was taking out the trash. Mr. Jean told her that when he arrived the previous shift members were leaving the home. After Mr. Jean checked-in, he started to check the clients and discovered D.B. sitting on the floor of her room with feces all over her. Her bedroom door was closed before he went into her room. He told Ms. George that he then went outside, C.B. was in her car. He asked C.B. why was D.B. on the floor in her room with feces all over her. Mr. Jean said that C.B. said that D.B. had been sitting on her bedroom floor since 6:00 p.m. and had refused to get up from the floor and that C.B. called the program director, Bukola Alonge, and told her that D.B. was on the floor and refused to get up. One of them, either Mr. Jean or Ms. George, made a telephone call to Ms. Alonge, but she did not answer the phone, so they left a message for her describing what they had seen. They then contacted Mr. Kirschbaum who was the area director and spoke to him. Mr. Kirschbaum told them to write an incident report. Mr. Jean took a picture of the feces on the bedroom floor and sent the photo to Mr. Kirschbaum, cleaned the room and showered D.B. At this point, the bruise was discovered on D.B.'s back and Mr. Jean took a photograph

of that as well and included it in the incident report. They cleaned the bruise and put Neosporin on it. Ms. George described the bruise as being the size of a quarter and was red and the skin appeared open.

The next day D.B. told Ms. George that she had an accident and peed herself, so the staff gave her a shower and changed her clothes. She had another accident in the living room while sitting in her chair, and the two staff members got mad and dragged her onto the floor from the living room to her bedroom. D.B. yelled for staff to come because she had to have a bowel movement, but nobody came so she had a bowel movement while sitting on the floor of her room. Staff came to her room and closed the door because of the smell. D.B. told Ms. George she got the bruise on her back when she was dragged by the two staff members to her room. D.R., D.B.'s housemate, was sitting at the kitchen table while D.B. was relaying this to Ms. George. D.R. said that she saw what happened and that the two staff members were "being a bitch," that they did not clean D.B., and dragged her to her room. At that point Mr. Kirschbaum came to the house and Mr. Jean and Ms. George relayed what happened based upon what D.B. told them. He then spoke with D.B.

On January 27, 2017, Mr. Balady interviewed Mr. Valery Jean and prepared a statement. Based on Mr. Cook's conversations with Mr. Balady, this statement accurately reflects the statements made by Mr. Jean during his interview with Mr. Balady. Mr. Jean arrived at the house around 11:00 p.m. and C.B. and M.G. were still there. Mr. Jean said he smelled feces and checked the individuals in the house and discovered that D.B.'s door was open, and he smelled feces. D.B. was sitting on the floor by her bed and she had feces on her lower legs and buttocks. There were feces smeared on the floor. D.B.'s walker was near her in the room. Mr. Jean told C.B. and M.G. to clean D.B. and asked them what happened. C.B. said that D.B. had been sitting on the floor in feces since 7:00 p.m. because she refused to be cleaned and go to the bathroom.

C.B. said that they called Ms. Alonge on the phone and told her that D.B. was misbehaving and that she did not want to go to the bathroom, but she needed to be cleaned. C.B. did not tell Mr. Jean what Ms. Alonge said to her. Mr. Jean told C.B. and M.G. to try to clean D.B. before they left the shift, but they refused to clean her. When Ms. George arrived, she and Mr. Jean cleaned the room of feces and Ms. George showered D.B. and found the bruise on her back. Mr. Jean also saw the bruise but could not recall who photographed it and sent it to Mr. Kirschbaum. Mr. Jean stated that D.B. was tired and she was not talking so he did not ask her how she got the bruise on her back. Mr. Jean and Ms. George spoke to Mr. Kirschbaum and advised them how they found the bruise and that D.B. was sitting in feces in her bedroom. An incident report was written. The next morning D.B. was talking to her housemate D.R. saying she was dragged on the floor by staff from the living room to her room. Mr. Jean asked D.R. who it was, and she would not give any names because she did not want to get herself in trouble.

Mr. Balady conducted a telephone interview of Ms. Bukola Alonge on February 3, 2017. Based on Mr. Cook's conversations with Mr. Balady, the interview statement accurately reflects the statements made by Ms. Alonge during the interview. According to Ms. Alonge, on November 4, 2016 she received a telephone call from C.B. who was working at the group home with a substitute staff member, M.G. C.B. and M.G. were unable to clean and bathe D.B. who was sitting in feces on the floor of her bedroom and refusing to get up and be cleaned. Ms. Alonge stated that she told C.B. to talk softly to D.B. and that after a short while, D.B. would be cooperative in showering and getting cleaned up. C.B. stated that she and M.G. would re-attempt to convince D.B. that she needed to be cleaned up and showered and the call ended.

D.B. provided a statement to Mr. Balady on January 25, 2017 which accurately reflects the statements made by D.B. to Mr. Balady, based on Mr. Cook's conversations with Mr. Balady. D.B. reported that on November 4, 2016, "I was in my chair in the living room. They dragged to the floor and they dragged me to my room. I had crap all over me. I had crap in my hair. They locked me in my room." She stated it was C.B. and M.G. who did this to her. She described one of the staff members as a pregnant lady, C.B. who did not want to clean her. The other was M.G. who did not want to clean her either. D.B. said to Mr. Balady, "I am a human being. I shouldn't be left with shit all over me." D.B. said she was so mad at C.B. and M.G. D.B. was crying in her room and was scared because they were so mean to her. She stated she was asking them to clean her, but she had to wait three hours until the next shift came to clean

her. They gave her a shower and put a nightgown on for her and then she went to bed. D.B. said she got the bruise on her back because C.B. and M.G. dragged her on the floor.

D.B. was interviewed again on May 25, 2017 and the interview accurately reflects what D.B. relayed to Mr. Balady, based on Mr. Cook's conversations with Mr. Balady. D.B.'s statements were consistent in both interviews.

A second statement of D.R., a housemate of D.B., was taken on May 25, 2017 by Mr. Balady, who indicated that she was in the living room playing with her iPad and saw two female staff members drag D.B. from the living room floor to her bedroom and did not recall anything else. Her statement was consistent, but not as detailed as the first statement.

An Individualized Habitation Plan (IHP) for D.B., dated July 22, 2016, was reviewed by Mr. Balady as part of his investigation. Mr. Balady had indicated that D.B. had a legal guardian. It is also documented that she needs to be checked every fifteen minutes when she is in the bedroom and checked hourly overnight, although this was not an overnight shift. She utilized a walker. She required assistance from staff members for bathing, showering, hygiene care and dressing. This is important because it shows she cannot do these things on her own. As part of the investigation, Mr. Balady also reviewed an Adaptive Behavior Health Safety Risk Summary (ABS) for D.B. dated July 22, 2016, which was significant because it indicates that D.B. has episodes of urinary and bowel movements and utilizes adult incontinent aid products and requires assistance from staff members for her hygiene care. Part of staff members' responsibilities are to be familiar with a service recipient's IHP and ABS.

Mr. Balady reviewed several photographs as part of his investigation. The first photograph was of the injury to D.B.'s back. The second photograph shows feces on the floor. The third photograph is of the Dungarvin Group Home living room leading to the hall towards D.B.'s bedroom. The fourth is the hall from the living room to D.B.'s bedroom, which Mr. Balady measured as being approximately ten feet. The fifth photograph is D.B.'s bedroom. The sixth photograph is D.B. pointing to the recliner from which she was dragged. The seventh photograph shows D.B. with her walker standing in the living room. The significance of the photograph of the injury supports D.B.'s claims she was dragged and was injured.

As part of the investigation, Mr. Balady reviewed M.G.'s training records. The Dungarvin training records for M.G. indicate that on May 19, 2016 she received training on the prevention of abuse and neglect. The significance of the training records is that on May19, 2016, M.G. demonstrated an understanding of what abuse and neglect were and understood relevant agency policy.

Mr. Balady reviewed the Dungarvin time sheets for November 4, 2016 which showed that C.B. worked from 3:04 p.m. to 11:07 p.m. and M.G. worked from 3:01 p.m. to 11:04 p.m. Ms. George worked from 11:15 p.m. on November 4 until 7:11 a.m. on November 5, 2016. Mr. Jean worked from 11:06 p.m. on November 4, 2016 until 7:04 a.m. on November 5, 2016.

M.G. and C.B.'s employment with Dungarvin Group Home terminated on November 4, 2016. The investigation report found that the allegation of physical abuse with minor injury to a service recipient was substantiated as to M.G. and C.B. M.G. was also substantiated for neglect. Mr. Balady's findings were set forth in his investigation report. Mr. Cook agreed with Mr. Balady's findings and conclusions. He would not have approved the report if he did not.

By letter dated July 13, 2017, Martin Temple, Chief of Investigations, advised M.G. that she was substantiated for abuse and neglect charges and that a determination of placement on the Central Registry of Offenders against Individuals with Disabilities was pending administrative review. M.G. contacted the respondent after receiving this letter and arranged to be interviewed by Mr. Balady. Mr. Cook was also present for this interview which took place on July 21, 2017. Mr. Cook stated that M.G.'s statement was not consistent with everything else they had gathered in the investigation report. M.G.'s answers were not consistent with how people are trained to handle people with development disabilities as to moving people. Nothing stated by M.G. in her July 21, 2017 interview altered the findings of the investigation report. The preponderance of evidence supported the findings and, in fact, some of the statements M.G. made confirmed that the abuse had taken place. The report was completed, sent to the regional chief, through the director, to the Central Registry panel, where a determination was made that the findings rose to the level for being placed on the Central Registry.

On cross-examination, Mr. Cook stated that M.G.'s interview, even though it was completed after the investigation was concluded, should have been forwarded with the investigation to the Central Registry panel.

M.G. and C.B. were terminated from their employment on November 4, 2016, the day of the event by their employer, the Dungarvin Group Home. They did not work for the State of New Jersey and respondent did not have anything to do with their termination. Dungarvin conducted their own investigation.

Prior to this incident, C.B. had been substantiated for neglect of the same client, D.B. C.B. was M.G.'s supervisor at the group home on November 4, 2016. Mr. Cook did not know how C.B. became employed at Dungarvin with the previous substantiation finding. C.B. did not cooperate with the State's investigation and is currently on the Central Registry. In Mr. Kirschbaum's first interview of D.B., she indicated that C.B. pulled her out of her chair onto the living room floor and was dragged from the living room floor to her bedroom by C.B. This was the first statement given by the victim, the very next morning. This statement is inconsistent with her later statement that two people dragged her. D.B. had a history of falling out of chairs that resulted in hospitalizations according to her IHP. Therefore, it would not be unusual that she could fall out of her chair on her own without being dragged out of her chair. D.B. never stated that she was pulled out of her chair by M.G. Mr. Cook indicated that being pulled out of the chair was not what constituted the abuse to be substantiated. It was how she got from the floor to her room. C.B. said D.B. was crying for help and being ignored by staff but D.B.'s housemate who was in the next room said she did not hear anything. C.B. was pregnant at the time and did not want to help. D.B. also had a history of making things up according to Mr. Kirschbaum. Mr. Cook explained that the investigator cannot take into account the clients' past statements or that they previously embellished stories and must treat all the allegations as true for purposes of conducting the investigation. The Center for Medicaid Services guidelines require this. A lot of people that make up stories are the ones that are abused the most.

Mr. Cook stated that he believed the victim D.B.'s story in this case because she was consistent in her statements. She openly admitted to having urinated the first time and got cleaned up and then she urinated the second time and that is when the staff got mad. Mr. Cook was present for M.G.'s interview. The Director of Investigations was Maria McGowan who directed them to interview M.G. They determine if an allegation is substantiated or not. What gets sent to the Central Registry panel is something that Mr. Cook has never been involved with.

Mr. Jean's time card indicated he checked in at 11:06 p.m. after M.G. checked out at 11:04 p.m. M.G. denied having a conversation with Mr. Jean, yet Mr. Jean indicated that he told both M.G. and C.B. to clean up D.B.

Mr. Balady's investigation report notes "related concerns" including the fact that C.B. was substantiated for neglect of D.B. in an incident on August 9, 2016; that C.B. and M.G. were identified as alleged perpetrators in a similar incident on October 27, 2016 involving placing D.B. in her room and closing the door; that C.B. and M.G. failed to cooperate and be interviewed; that the Dungarvin investigation report did not address the allegation of physical abuse; and that Ms. Alonge did not answer her phone at 11:00 p.m. Mr. Cook did not know if his office investigated the incident of October 27, 2016. M.G. did eventually consent to be interviewed but not before this report was written and she was advised she was substantiated. At 8:00 p.m., C.B. made a call up the chain of command to Ms. Alonge, who told her to leave her and try to convince her to take a shower. She told her to leave her there. At the time the call was made, D.B. was still in the living room. After knowing there was a problem at 8:00 p.m., she did not answer her phone and did not check back with staff to follow up. Ms. Alonge was no longer an employee of Dungarvin when they commenced the investigation. Mr. Cook did not know what Ms. Alonge said to C.B., or what C.B. told M.G. she was to do that day, because he did not hear it. It was easy to substantiate charges against C.B. because she admitted hearing D.B. calling for help yet did nothing.

M.G. said she 'crab-walked' the patient by herself to the bedroom, which is abusive since it had the potential to cause injury. M.G. admitted that D.B. was too big to move by herself and she could have hurt D.B. There is no training in the world that says get behind someone and crab walk them down the hallway as far as you can. She should have left her on the living room floor in her feces and stayed with

her and continue to talk to her every fifteen minutes. The neglect part came into play with the statements from D.B. that she was left in her room by herself and she was calling for help. You would not be calling for help if the staff member is standing there with you. D.B. should never have been moved from the living room to the bedroom; that is how the injury took place. D.B. should have been left in the living room. Also, based on the other information gathered in the investigation, Mr. Cook did not believe that M.G. stayed with D.B. for three hours talking to her while she was on the floor in her bedroom. Mr. Cook did not believe that M.G. 'crabbed walked' D.B. into her room. He believes she was dragged by C.B. and M.G. which is how the injury occurred. Mr. Cook did not know what D.B. was wearing at the time, only that the red mark on D.B.'s back appeared to be a fresh injury and Mr. Jean took a photograph of it that night. The floors in the house are all hardwood floors.

The first photograph in evidence was a photograph of the injury to D.B. Mr. Cook does not know if the mark was already on D.B. before M.G. came on duty. This incident happened on November 4, 2016 and was known to staff November 5, 2016. The Agency did their own report which went to the reporting authority on November 14, 2016. The Office of Investigations did not commence their investigation until January 20, 2017. Ms. Alonge was never brought up on any charges in connection with this incident.

On re-direct examination, Mr. Cook stated that it is not unusual for individuals with developmental disabilities to have difficulties remembering details. Nothing said by M.G. in her July 21, 2017 interview altered the investigation's findings.

On re-cross examination, Mr. Cook admitted that any investigation and interview of witnesses would be better if conducted sooner than before two months had passed.

M.G. testified on her own behalf. She is twenty-four years old and recently graduated from EMS Academy in Lawrenceville, which is a nursing school and has obtained her CAN certification.

On November 4, 2016, she was working at the Dungarvin Group Home as a substitute caregiver. She had been employed by the Agency for three or four months and had been at this specific Dungarvin group home for about two weeks. Her title was Direct Support Staff. She received two weeks of training when she first started the job including medical training and training regarding abuse and neglect. She had never been substantiated for abuse and neglect and never had any charges leveled against her prior to this. M.G. has never abused a patient. She did not abuse D.B.

She knew D.B. on November 4, 2016 and had a good relationship with her. She likes being a caregiver and although she can no longer work with developmentally disabled individuals because of this matter, she is currently working with seniors because she likes what she does. She had been working with people with disabilities for about five years before she got the Dungarvin job. M.G. worked at Community Options for four months after she was terminated from Dungarvin, which still involved persons with developmental disabilities. She had obtained a job at Eden Autism but was terminated when she was placed on the list.

On November 4, 2016 she worked from 3:00 p.m. to 11:00 p.m. She worked with C.B. who was the house manager. M.G. had only met her the two weeks prior when she started substituting at this group home. C.B. was considered her supervisor. There were no other staff working that shift. M.G. did not have any contact with the supervisor, Ms. Alonge. She heard C.B. speak to Ms. Alonge on the telephone but did not hear what Ms. Alonge said to her. When C.B. called Ms. Alonge, D.B. was already in her bedroom. M.G. observed D.B. on the floor in the living room after D.B. had slid out of her chair. No one dragged D.B. out of her chair. Neither C.B. nor M.G. had changed D.B. from the time they came on the shift at 3:00 p.m. until she slid out of her chair at 7:00 p.m. M.G. was not frustrated at D.B. for urinating, that is part of her job. When D.B. was on the floor in the living room, M.G. attempted to get C.B. to help her but she was aware that she had been involved in a previous incident with D.B. and did not want to help. C.B. was eight months pregnant at the time.

D.B. could walk by herself with a walker. If she did not want to walk, she would throw herself on the ground sometimes. D.B. was on the living room floor for forty-five minutes before M.G. tried to move her. M.G. was trying to speak to her to convince her to get up, but she would not cooperate. M.G. decided to get her up without assistance because she was beginning to make a mess on the living room floor and

there were three other residents there. M.G. hooked her arms under D.B.'s arms from the back and D.B. walked her feet while M.G. was walking her backwards. D.B. did assist M.G. in getting herself to her room. M.G. cannot physically drag D.B. and it was hard just walking her to her room with M.G. using her feet. At no time did D.B.'s back touch the floor. M.G. was talking to D.B. telling her that they were going to her room and even if D.B. did not want to get up of the floor, M.G. would change her on the floor. C.B. did not physically help M.G. move D.B. from the living room to the bedroom. If the witnesses said two individuals dragged D.B. from the living room to the bedroom or off the chair, they are incorrect. It took M.G. two seconds to walk D.B. from the living room to the bedroom. She mopped the living room floor. When they got D.B. in her room, M.G. took off her shirt and saw the bruise. It was red and discolored and she thought it was old. M.G. told C.B. to call Ms. Alonge. M.G. did not feel comfortable touching D.B. C.B. looked in the book and no one had reported it so that would make M.G. a first responder and she would have to file a report. M.G. reported the bruise on D.B.'s back to C.B. who reported it to Ms. Alonge. She heard C.B. say that on the phone. M.G. said they were told to wait until another guy came on board. D.B. was in the bedroom from about 8:00 p.m. until 11:00 p.m. During these three hours M.G. was in D.B.'s room and by her door trying to convince her to get up but she would not cooperate. They were told by the supervisor not to move D.B. again so M.G. just waited as instructed.

Nobody asked her to stay late and help with D.B. At 11:00 p.m. when her shift was over, Mr. Jean came on and C.B. told him what had happened and how they were waiting for a male to come on shift. Mr. Jean said even he could not lift her on his own and he still would need help from a female staff member. M.G. did not have any conversation with Mr. Jean. She asked C.B. if she could leave and C.B. told her yes that it was fine. If they had asked her to stay, she would have. During the time M.G. was on the floor she was not screaming out in pain or screaming for assistance. M.G. did leave D.B. to give another resident a shower for approximately twenty minutes, but she was still right next to D.B.'s room.

M.G. said she missed the interview with Mr. Balady at the library because she had finals at Mercer County College and never made it to the library next door for the interview. When she received the letter from Mr. Temple, she immediately contacted him to set up the interview. She also requested an informal and OAL hearing at the same time.

M.G. does not believe that she abused D.B. by walking her from the living room to the bedroom. She heard the testimony of Mr. Cook that said the abuse was that she dragged D.B. M.G. felt it would have been neglect to leave her sitting soiled and soaked in the living room. Granted, she just moved her to another place in the same situation, but that was her attempt to help D.B. M.G. did not let her fall out of her chair and leave her in front of the chair, full of urine and feces the whole time. M.G. states that before she saw the mark on her back, she would have changed her. She did not need her to stand up to change her. However, once she saw the bruise, she stopped. M.G.'s actions did not cause the bruise. She did not drag D.B. The statement she gave to the investigator was truthful and accurate. She was the person who discovered the bruise and reported it to her direct supervisor, who reported it to her supervisor.

It does not make her mad when someone defecates or urinates on themselves since she is used to this happening and is part of the job. She was not mad at D.B. that day. She tried to help her and did not abuse or neglect her.

On cross-examination, M.G. had indicated in her statement that D.B. had a bad attitude. D.B. would soil herself even though she could physically use the bathroom. She could physically stand up, use her walker and go the bathroom. M.G. would just make sure she had wiped herself well. She needs assistance once in the bathroom. M.G. admits that she stood behind D.B. bent over her and put her arms underneath D.B.'s arms and moved her from the living room to the bedroom. M.G. never received training to the effect that she should not have moved D.B. She was not trained to leave someone on the floor. If someone fell, she was trained to pick them up. D.B. was not too heavy to move with M.G. helping. M.G. moved D.B. from the living room to her bedroom, but she remained in her soiled clothes. She did not clean up the feces in the bedroom around D.B., just in the living room. The pictures that were taken of feces on the floor in the bedroom had to have been taken after they lifted D.B. off the bedroom floor because it was not around her as she was sitting on the floor in the bedroom. C.B. did not help M.G. She did not call anyone else for help. M.G. did not call Ms. Alonge or Mr. Kirschbaum. No one asked M.G. to stay late although she

offered. She did not explain to Mr. Jean what happened, she heard C.B. explaining the situation to Mr. Jean. M.G. just said hello and goodbye to Mr. Jean. Ms. George did not arrive until after M.G. was gone. She did not feel the need to tell the people, coming onto the next shift to relieve her, what the situation was - even though M.G. said she stayed with M.G. during the three hours. M.G. was only a substitute, but she reported to her supervisor, C.B. M.G. admits that it was neglectful for D.B. to be left in her soiled clothing, but she tried. She was there with a supervisor who did nothing, and it was not her group home; she worked in a Trenton group home and her contacts were different people. M.G. said her responsibility was to tell her group manager and C.B. called her supervisor.

M.G. admitted that leaving D.B. on the floor in her bedroom for over three hours in her own urine and feces was neglectful, but she did not leave her there, she tried to assist her. M.G. stated that she was the one who originally saw the bruise on D.B.'s lower back, yet she did not report this in writing. She took a picture and sent it to C.B.'s phone and does not know what happened to it.

M.G. testified that she did not change D.B. when she was sitting in her urine and feces because she found a bruise and reported it to C.B. When asked why she did not change D.B. after reporting the bruise, M.G. stated that C.B. said Ms. Alonge said to not touch D.B., someone will come in to help.

M.G. indicated that D.B. was cooperating with her by doing the crab walk to her room and was cooperating with letting her change her, until M.G. stopped because she saw the bruise. D.B. was not being difficult.

ALJ'S DETERMINATIONS OF CREDIBILITY FINDING OF FACT

Credibility contemplates an overall assessment of the story of a witness in light of its rationality, internal consistency, and manner in which it "hangs together" with other evidence. Carbo v. United States, 314 F.2d 718 (9th Cir. 1963). A trier of fact may reject testimony because it is inherently incredible, or because it is inconsistent with other testimony or with common experience, or because it is overborne by other testimony. Congleton v. Pura-Tex Stone Corp., 53 N.J. Super. 282, 287 (App Div. 1958).

Respondent's case in chief offered no direct testimony from any witnesses to the events of November 4, 2016. Ms. Robinson had no first-hand knowledge. Mr. Balady, the investigator who conducted the investigation and interviewed the witnesses, retired, and his supervisor, Mr. Cook, testified as to the contents of the investigation report, based on what he knew of the investigation from his conversations with Mr. Balady as his supervisor. Mr. Cook was present when Mr. Balady interviewed petitioner, M.G. and was familiar with her statement.

There was a continuing objection lodged by petitioner's counsel as to the hearsay nature of the investigation report and the witnesses' statements and his inability to cross-examine any witnesses. Although the OPIA Investigation Report is a business record maintained in the ordinary course of business, it is replete with hearsay. Although hearsay evidence is admissible in OAL hearings N.J.S.A. 52:14B-10(a), it should be accorded whatever weight the tribunal deems appropriate taking into account the nature, character and scope of the evidence, the circumstances of its creation and production, and, generally, its reliability. Under the residuum rule, hearsay "may be employed to corroborate competent proof, or competent proof may be supported or given added probative force by hearsay testimony. But in the final analysis, for a court to sustain an administrative decision, which affects the substantial rights of a party, there must be a residuum of legal and competent evidence in the record to support it." Weston v. State, 60 N.J. 36, 51 (1972).

Petitioner's own testimony provided the residuum of legal and competent evidence necessary to sustain the allegations in this case. Although M.G. denied dragging D.B. from the living room to her bedroom, she admitted moving her from the living room to the bedroom. She described that she put her arms under D.B.'s arms and 'crabbed walked' D.B. to her room. Even if this were to be believed, it is not credible that D.B.'s lower back would not have come into contact with the wooden floor during this maneuver and causing the brush burn type bruise of D.B.'s lower back. There was no evidence in the record of an injury to D.B. before this incident and there was an injury to D.B.'s lower back after M.G. moved her.

M.G. should not have moved her at all without assistance since there was evidence that D.B. was a big woman. M.G. admitted that it was neglectful of her to leave D.B. sitting in her room for three hours in her urine and feces, but she was following her supervisor's directions and was waiting for help to arrive. However, when the new shift came on duty, M.G. did not advise them of D.B.'s condition and she did not stay to help D.B. get cleaned up. This is not credible or acceptable behavior for a caregiver. M.G. was also inconsistent in her testimony that she could have changed D.B. on the floor herself, but once she saw the bruise, she did not do anything but tell C.B. about it. It is not credible that once she reported the bruise, she did not then continue to clean D.B. up. M.G. testified that she stayed with D.B. and kept checking on her throughout the time she was in her bedroom, but this is not credible since the investigation report indicated that D.B. was calling for assistance. D.B. would not be calling for help if M.G. was with her. Furthermore, M.G. testified that she did give another resident a shower during this time, so it is not credible that M.G. remained with D.B. throughout the time D.B. remained on the floor in her room.

Based upon the ALJ's consideration of the testimonial and documentary evidence presented at the hearing, and having had the opportunity to observe the demeanor of the witnesses and assess their credibility, the **ALJ FOUND** the following as **FACTS**:

- D.B. is a developmentally disabled individual receiving residential services at the Dungarvin Group Home funded by the Division of Developmental Disabilities.

- M.G. was a direct caregiver to D.B. and worked the 3:00 p.m. to 11:00 p.m. shift at the Dungarvin Group Home on November 4, 2016.

- M.G. received training regarding abuse and neglect.

- D.B.'s Individualized Habitation Plan (IHP) dated July 22, 2016, indicated that D.B. utilized a walker and required assistance from staff members for bathing, showering, hygiene care and dressing.

- D.B.'s Adaptive Behavior Health Safety Risk Summary (ABS) dated July 22, 2016 indicated that D.B. has episodes of urinary and bowel movements and utilizes adult incontinent aid products and required assistance from staff members for her hygiene care.

- On November 4, 2016, at approximately 7:00 p.m., D.B. was sitting on the living room floor refusing to get up and go to the bathroom, after having urinated and after having had a bowel movement.

- M.G. physically moved D.B. from the living room floor to her bedroom floor, although D.B. was too big for M.G. to attempt to move by herself, thereby causing D.B. to sustain a bruise to her lower back. There was no record of D.B. having sustained a prior injury to her lower back.

- M.G. left D.B. in her bedroom on the floor, sitting in her urine and feces for more than three hours until the next shift arrived at 11:00 p.m.

- D.B. repeatedly called for assistance throughout this time and M.G. did not assist her but rather left her there on the floor in her bedroom, sitting in her urine and feces for more than three hours until the next shift reported for work at 11:00 p.m.

- M.G. admitted that leaving D.B. on the floor in her bedroom for over three hours in her own urine and feces was neglectful.

- When the next shift reported for work, M.G. did not advise them as to D.B.'s condition.
- M.G. did not call anyone for assistance during the more than three hours D.B. remained on her bedroom floor sitting in her urine and feces.
- M.G. left when her shift ended, and she did not assist the next shift with showering and cleaning D.B.
- M.G. was terminated from the Dungarvin Group Home on November 5, 2016.

INITIAL DECISION'S ANALYSIS AND CONCLUSION

It is the policy of this State to provide for the protection of individuals with developmental disabilities. N.J.S.A. 30:6D-73(a). The New Jersey Legislature created the Central Registry to protect the legal rights and safety of individuals with developmental disabilities by identifying those caregivers who have wrongfully caused them injury, and then preventing such caregivers from again working with individuals with developmental disabilities. N.J.S.A. 30:6D-73; N.J.A.C. 10:44D-1.3. An individual will be listed on the Central Registry if he or she has committed an act of abuse, neglect or exploitation of an individual with a development disability. N.J.S.A. 30:6D-77(b).

"Abuse," defined in N.J.A.C. 10:44D-1.2, means "wrongfully inflicting or allowing to be inflicted physical abuse, sexual abuse or verbal or psychological abuse or mistreatment by a caregiver upon an individual with a developmental disability."

"Physical Abuse," defined in N.J.A.C. 10:44D-1.2, means "a physical act directed at an individual with a developmental disability by a caregiver of a type that causes one or more of the following: pain, injury, anguish or suffering. Such acts include, but are not limited to, the individual with developmental disability being kicked, pinched, bitten, punched, slapped, hit, pushed, dragged or stuck with a thrown or held object."

In order to be included on the Central Registry, it must be determined whether the caregiver acted with intent, recklessness, or careless disregard to cause or potentially cause injury to an individual with a developmental disability. N.J.S.A. 30:6D-77(b)(1), N.J.A.C. 10:44D-4.1(b). The regulation defines each mental state:

> 1. Acting intentionally is the mental resolution or determination to commit an act.
> 2. Acting recklessly is the creation of a substantial and unjustifiable risk of harm, to others by a conscious disregard for that risk.
> 3. Acting with careless disregard is the lack of reasonableness and prudence in doing what a person ought not do or not doing what ought to be done.

In enforcement proceedings, the burden of proof falls on the agency to prove a violation. Cumberland Farms, Inc., v. Moffett, 218 N.J. Super. 331, 341 (App. Div. 1987). In this matter, DHS bears the burden of establishing the truth of the allegations by a preponderance of the credible evidence. Atkinson v. Parsekian, 37 N.J. 143, 149 (1962). Evidence is said to preponderate "if it establishes 'the reasonable probability of the fact.'" Jaeger v. Elizabethtown Consol. Gas Co., 124 N.J.L. 420, 423 (Sup. Ct. 1940) (citation omitted). The evidence must "be such as to lead a reasonably cautious mind to the given conclusion." Bornstein v. Metro. Bottling Co., 26 N.J. 263, 275 (1958). Precisely what is needed to satisfy this burden necessarily must be judged on a case-by-case basis.

The record clearly reflects that petitioner neglected and physically and psychologically abused D.B. by mistreating her, in leaving D.B. sitting on her bedroom floor for more than three hours in her own urine and feces. M.G. acted with careless disregard, in that her actions were unreasonable and imprudent for a caregiver charged with assisting a developmentally disabled individual with her activities of daily living, including her hygiene. M.G. was grossly negligent in failing to attend to D.B.'s needs and her conduct demonstrated a total disrespect for the rights and dignity of D.B.

M.G. should never have left D.B. sitting in her own feces and urine for more than three hours. M.G. should have changed her and cleaned her up, or, at the very least should have called for assistance rather than leave her in that condition for such a long period of time. Particularly egregious is the fact that M.G. did not advise of D.B.'s condition or assist in D.B.'s care once the new shift reported for duty. M.G. just left when her shift ended, which evidences a total and careless disregard for D.B.'s care and well-being.

Furthermore, M.G. caused an injury to D.B.'s lower back by moving her from the living room floor to her bedroom floor, when she should not have moved her at all without assistance.

The ALJ **CONCLUDED** that the DHS has sustained its burden of proving, by a preponderance of the credible evidence, that M.G.'s actions rose to the level of abuse as defined in N.J.A.C. 10:44D-1.2. Further, the ALJ **CONCLUDED** that M.G. had acted with careless disregard for the well-being of D.B., resulting in injury to an individual with a developmental disability, justifying that her name be entered onto the Central Registry.

The ALJ **ORDERED** that the determination of the Office of Program Integrity and Accountability to place M.G. on the Central Registry of Offenders Against Individuals with Developmental Disabilities for the incident on November 4, 2016, was **AFFIRMED** and M.G.'s appeal **DISMISSED**. The ALJ filed the initial decision with the **DIRECTOR OF THE OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY** for consideration.

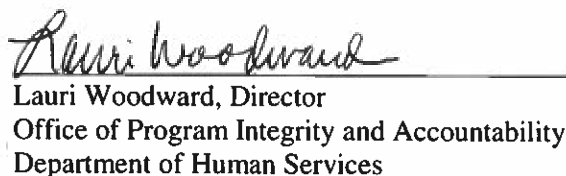
FINAL AGENCY DECISION:

After a careful examination of the entire record generated during the hearing at the Office of Administrative Law – its initial decision, transcripts, exhibits, and accepted evidence, **I FIND**, by a preponderance of the evidence, that the Office of Investigation properly substantiated M.G. committed an act of abuse against D.B., an individual with developmental disabilities.

I FURTHER FIND, that by a preponderance of the evidence, M.G.'s actions rise to the level of abuse as defined in N.J.A.C. 10:44D-2.1, and that that M.G. acted with careless disregard for the well-being of D.B., resulting in injury to an individual protected by N.J.S.A. 30:6D-73, justifying that M.G.'s name should be entered onto the Central Registry.

After a careful consideration of the Initial Decision, a review of all of the evidence, testimony, exhibits, and with deference to the ALJ's having the opportunity to hear testimony and observe witnesses' demeanor to evaluate credibility, **I AFFIRM THAT, M.G.** was properly substantiated for abuse against D.B. **I AFFIRM THAT, M.G.**, in her physical abuse of R.K., acted with careless disregard to the well-being of D.B., an individual protected by N.J.S.A. 30:6D-73, justifying that her name should be entered onto the Central Registry. **M.G. IS THEREFORE ORDERED** to be placed on the Central Registry of Offenders against Individual with Developmental Disabilities.

Date: 1|2|20



Lauri Woodward, Director
Office of Program Integrity and Accountability
Department of Human Services