State of New Jersey
DEPARTMENT OF HUMAN SERVICES
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CHRIS CHRISTIE
GOVERNOR

KIM GUADAGNO
LT. GOVERNOR

ELIZABETH CONNOLLY
ACTING COMMISSIONER

FINAL DECISION
OAL DKT. NO. HSL 08986-14
AGENCY DKT. NO. DHU #14-009

Laura and William Anderson
Petitioners,
v.

Developmental Disabilities Licensing
Respondent.

A. INTRODUCTION

On December 23, 2013, the Office of Licensing notified Laura and William Anderson that an investigation by the Department of Human Services' Office of Investigation had substantiated allegations of neglect of one of the clients under their care, R.W.. The Office of Licensing's notice included a revocation of licensure to operate a Community Care Residence for the developmentally disabled. Petitioners appealed that decision. The Department then transmitted the matter to the Office of Administrative Law (OAL) for a hearing as a contested case pursuant to N.J.S.A. 52:14B-1 to -13 and N.J.S.A. 52:14F-1 to -15 on June 16, 2014. The hearing was held on September 18, 2015, November 10, 2015, and January 26, 2016. Respondent sent a closing brief on February 26, 2016.

B. THE INITIAL DECISION

The Office of Administrative Law hearing included the testimony of five witnesses for the Office of Licensing and the testimony of the Andersons. The matters to be determined in the hearing involved whether or not two instances of neglect had occurred - one for leaving R.W. unsupervised, and one for failure to have R.W.'s tests for placement on the kidney transplant list done in a timely manner. The Administrative Law Judge (ALJ) correctly cited the Community Care Residence Manual definition of neglect:

N.J.A.C. 10:44-B-1.3 defines neglect as follows:

> "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 ALJ then applied the definition of neglect to the circumstances confronted by R.W., the person under the Anderson's care. R.W. needs twenty-four-hour care because she is on dialysis and she has cognitive problems. She can never be left alone in the home. She has congestive heart failure. R.W. needs help with bathing, cueing for brushing her teeth, direction in going from room to room, and at times help with toileting.

The ALJ had the opportunity to observe the witnesses and described the manner in which credibility was weighed and the overall assessment given the witness's story in light of its rationality, internal consistency and the manner in which it comported with the other evidence. Having had an opportunity to observe the demeanor of the witnesses, the ALJ found the Office of Licensing's witnesses, Yurkevicz, Brozon, Butler, Girone, and Carlson, to be credible. The ALJ further found the Andersons to be less credible than the above witnesses.

1) Leaving R.W. unsupervised

The ALJ found that R.W. was unsupervised when the Case Manager visited the Andersons' home on July 13, 2013. The Andersons knew that R.W. needed twenty-four-hour care. The Andersons knew that R.W. was dropped off from her day program at approximately 3:30 p.m. Neither of the Andersons was home when R.W. was dropped off. The Andersons had not made any provision for an alternative caregiver to be home when R.W. arrived; they were both out of the home.

The ALJ concluded that the Andersons neglected R.W. by not being home when she was dropped off by the day program. R.W. and another individual with developmental disabilities under the care of the Andersons were the only ones in the home. The Andersons knew and that R.W. required twenty-four-hour care.

2) Failure to have R.W.'s tests for placement on the kidney transplant list done in a timely manner

The ALJ found that the transplant coordinator for St Barnabas Hospital sent prescriptions for tests for R.W. to L. Anderson on March 27, 2013. By June of 2013, only the chest x-ray and mammogram were done. No testing was done again until December 2013. R.W. was not hospitalized overnight at any hospital after February 2012. The completed tests

for R.W. were not received by the transplant coordinator for St Barnabas Hospital until April 2013, over one year after the initial prescriptions were sent to L. Anderson.

The ALJ concluded that the testing of R.W. to be put on the kidney transplant list was not done in a timely manner, which evidences neglect by L. Anderson.

The ALJ, having decided that the Andersons had neglected R.W. under the definition set forth by the Manual for Community Care Residences in the two instances previously substantiated by the Department of Human Services, maintained the validity of the Office of Licensing's revocation of their Community Care licensure. Based on the totality of the evidence presented during the three day hearing, the ALJ ordered that the revocation of petitioners' license to operate a community care residence for the developmentally disabled was affirmed.

C. EXCEPTIONS

No exceptions to the Initial Decision were received.

D. FINAL DECISION

Careful consideration was given to the entirety of the Initial Decision of the Administrative Law Judge, the testimony of witnesses, the files, applicable law, and the ALJ's determination of credibility. The recommended decision of the ALJ is hereby **AFFIRMED** by the Office of Program Integrity and Accountability.

I **FIND** that the order affirming the revocation of Andersons' Community Care Residence licensure was correct. I further **CONCLUDE** and **ORDER** that the Andersons' license be revoked for the reasons stated above and that order is hereby **AFFIRMED** as the Final Agency Decision of the Department of Human Services in this matter.

Date: 5/3/16

Lauri Woodward

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