State of New Jersey
Department of Human Services
Office of Program Integrity and Accountability
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Governor

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Lt. Governor

SARAH ADELMAN
Acting Commissioner

DEBORAH ROBINSON
Director

FINAL AGENCY DECISION
OAL DKT. NO. HSL 08030-21
AGENCY DKT. NO. DRA 21-013

S.B.,

Petitioner,

v.

NEW JERSEY DEPARTMENT OF HUMAN SERVICES,

Respondent,

AND

S.J.,

Petitioner,

v.

NEW JERSEY DEPARTMENT OF HUMAN SERVICES,

Respondent.

OAL DKT. NO. HSL 08235-21
AGENCY DKT. NO. DRA 21-014
(CONSOLIDATED)

S.B., petitioner, pro se

S.J., petitioner, pro se

Kathleen E. Horton and **Andrew Munger,** Deputy Attorneys General, for respondent Department of Human Services, Office of Program Integrity and Accountability (Matthew J. Platkin, Acting Attorney General of New Jersey, attorney)

Record Closed: September 16, 2022 Decided: September 27, 2022

BEFORE **KATHLEEN M. CALEMMO**, ALJ:

STATEMENT OF THE CASE

Petitioners, S.B. and S.J., appeal their placement on the Central Registry of Offenders Against Individuals with Developmental Disabilities (Central Registry), pursuant to N.J.S.A. 30:6D-73 et seq., on charges that they neglected an individual receiving services from the Division of Developmental Disabilities (DDD) on May 4, 2020, while employed at a group home operated by Heart to Heart Home Care. After an investigation, respondent, Department of Human Services, Office of Program Integrity and Accountability (DHS), substantiated the charges and placed the petitioners' names on the Central Registry. S.B. and S.J. disagreed with the investigation and contested their placement on the Central Registry.

PROCEDURAL HISTORY

By separate letters, each dated October 6, 2020, the Director for DHS notified S.B. and S.J. of its investigative findings and its determination to place their names on the Central Registry. (R-1.) S.B. filed a timely appeal and DHS transmitted the matter to the Office of Administrative Law (OAL), where it was filed as a contested case on September 24, 2021, pursuant to N.J.S.A. 52:14B-1 to -15 and N.J.S.A. 52:14F-1 to -13. S.J. filed a timely appeal and DHS transmitted the matter to the OAL, where it was filed as a contested case on October 1, 2021, pursuant to N.J.S.A. 52:14B-1 to -15 and N.J.S.A. 52:14F-1 to -13.

A Consent Confidentiality and Protective Order was entered on December 8, 2021, in OAL Docket Number HSL 08030-21, and on January 6, 2021, in OAL Docket Number HSL 08235-21, covering any DHS records that may be provided by DHS, in discovery or used as evidence, which may contain protected health information, as defined in 45 CFR Sections 160 and 164, and/or which may contain confidential information pursuant to N.J.S.A. 30:4-24.3 (together, Protected-Confidential Documents).

By letter, dated December 21, 2021, respondent requested that the matters be consolidated. On January 5, 2022, at a telephone conference, The ALJ determined that the consolidation request should proceed by motion to give the pro se petitioners an opportunity to oppose the request due to the possibility of "finger-pointing" at a consolidated hearing. Respondent filed its motion for consolidation on January 31, 2022. When no opposition was received, the ALJ requested confirmation from each petitioner stating their intentions regarding consolidation. S.B. and S.J. confirmed their consent. Accordingly, the ALJ issued an Order of Consolidation on March 2, 2022.

The hearing dates scheduled for May 2, 2022, and May 25, 2022, were adjourned. The hearing was held on July 25, 2022, via Zoom remote platform, by consent of the parties. The

record remained open at the request of respondent for submission of summation briefs. I received respondent's summation brief on September 12, 2022. On September 14, 2022, my assistant sent an email to the parties advising that the record would close on September 16, 2022, unless I received a reasonable request for an extension. No requests were made, and the record closed on September 16, 2022.

EXCEPTIONS

Within thirteen days from the date on which the initial decision was mailed to the parties October 10, 2022), a party could file written exceptions with the Office of Program Integrity and Accountability" (copying the judge and to the other parties). No exceptions to the initial decision were timely received by the Office of Program Integrity and Accountability.

INITIAL DECISION'S FACTUAL DISCUSSIONS AND FINDINGS

The ALJ **FOUND**:

S.B. and S.J. were Community Support Staff (CSS) employed by Heart to Heart Home Care. They were working in a group home managed by their employer. On May 4, 2020, S.B. and S.J. worked the 9:00 a.m. to 3:00 p.m. shift.

The manager of the group home submitted an Unusual Incident Report (UIR) to DDD at 4:20 p.m. on May 4, 2020, that a resident, K.C., had been locked in her room. She reported that K.C. was found with feces on her clothing, hands, and in her mouth. There were feces and urine on the floor, and feces smeared on the bedding and walls. The manager reported the incident to the New Jersey State Police at approximately 4:39 p.m.

Beth Greggs, a Quality Assurance Specialist/Investigator employed by DHS, testified about her investigation of the May 4, 2020, incident involving K.C. She has been an investigator with DHS for ten years. Typically, when DDD receives an UIR, it sends the report to the Central Investigatory Monitoring Unit (CIMU) for further review and processing. CIMU completes its review and forwards any UIR that needs further investigation to DHS. Due to the severity of the May 4, 2020, incident, DDD sent the UIR directly to DHS, where it was assigned to Greggs for investigation. As part of her duties, Greggs prepared the initial investigation report which included her findings and related concerns.

Initially, Greggs only had the information reported by the group home manager contained on the UIR. Through her interviews of staff members and examination of records maintained by the group home, she learned that on May 4, 2020, S.B. and S.J. worked the 9:00 a.m. to 3:00 p.m. shift, and were relieved by S.P. and J.V., who worked the 3:00 p.m. to 11:00 p.m. shift. She also interviewed the staff who worked the 11:00 p.m. to 9:00 a.m. shift the night before, on May 3, 2020. The incident was discovered just after the 3:00 p.m. shift change on May 4, 2020. When J.V. arrived, S.B., who was departing at the end of her shift, reported no concerns and told J.V. that the residents were in their rooms.

According to J.V.'s statement, she went to check on K.C. but she could not open her bedroom door because the doorknob would not turn. J.V. informed her staff partner, S.P., who was preparing medications for administration, about K.C.'s door. When S.P. finished her task, she went with J.V. to K.C.'s bedroom. They were unable to open the door. The supervisor, L.J., arrived at around 3:30 p.m., and the staff members informed her that they were unable to get into K.C.'s room. L.J. tried the door and when it would not open, she retrieved a butter knife from

the kitchen and used it to pry open the door. While the staff members were outside the door, they noticed urine seeping out under the door and into the hall. When they opened the door, the smell was overpowering and K.C. was in a deplorable condition. She was standing in the middle of the room, urine soaked and covered in feces. It was on her clothes, hands, and in her mouth. There was urine and feces on the floor, bedding, and walls. Her adult diaper was so heavy that it hung between her legs. When L.J. was cleaning K.C., she discovered that K.C. was wearing two adult protective diapers that were saturated and filled to the point of disintegration. L.J. advised that putting two adult diapers on a resident is against regulations.

K.C. is a thirty-four-year-old developmentally disabled adult. She is non-verbal and communicates by gestures, sounds, and limited sign language. She has a New Jersey Individualized Service Plan (ISP). One of her disabilities is a PICA disorder.[1] The staff were alerted that K.C. would attempt to eat her feces and pick at her diaper. The most recent notification occurred on May 1, 2020, when K.C.'s behaviors were discussed at a staff meeting, with notes from the meeting as follows: "K.C. eating poop/pampers." Thus, just three days earlier, K.C.'s caregivers were on notice of the problematic behaviors, further necessitating line-of-sight supervision.

During her investigation, Greggs learned that when the shift changed on May 4, 2020, J.V. was alone until her partner, S.P., arrived. S.B. and S.J. were gone before S.P. arrived. Greggs stated that this group home should never be staffed by only one person.

At the start of a new shift, staff is required to check the residents for any complaints or note any concerns. When J.V. attempted to check on K.C., she could not enter the room because the doorknob would not turn. A line-of-sight supervised resident like K.C. should never be left alone in a room with a closed door. If the door needed to be closed, a staff member would be required to be inside the room with K.C. During their interviews, S.B. disclosed that she was sitting in a chair in the hallway and could see K.C.'s bedroom. S.B. and S.J. maintained that K.C.'s bedroom door was open. Greggs stated that the staff members' description of watching from a chair in the hallway would not satisfy the line-of-sight supervision requirement for K.C.

K.C. was wearing two adult diapers when she was discovered after the incident. The group home's records showed that K.C.'s hygiene needs were attended to at 12:30 p.m. on May 4, 2020. This corroborated S.B.'s statement that she showered and toileted K.C. at that time. There is no dispute that the staff members responsible for K.C.'s hygiene, including toileting, were S.B and S.J. until the end of their shift at 3:00 p.m.

At approximately 3:30 p.m., when the staff gained access to K.C.'s room, they discovered that the door handle over the lock on the inside of the door was covered with clear plastic tape. Staff reported to Greggs that K.C. would not have been able to tape the door on her own volition. Staff members, including S.B., admitted seeing the tape, but no one reported it as a violation.

The manager of the group home took a picture of the doorknob that showed tape over the lock and down the sides of the handle. She also photographed the inside of the room to document the feces and puddles of urine on the floor, including a picture of K.C.'s diaper. The group home manager, L.J., took the pictures after she entered the room at approximately 3:30 p.m. on May 4, 2020. She sent the photographs to Greggs by email.

As a result of her investigation, Greggs found that S.B. and S.J. had neglected K.C. by

[1] PICA is an eating disorder in which people compulsively eat non-food items.

allowing her to be left in a deplorable state, although it did not cause injury. K.C. has the right to be kept clean and sanitary for her safety and dignity. Greggs also determined that S.B. and S.J. failed to maintain line-of-sight supervision, which was a violation of K.C.'s rights to be properly supervised for her safety, health, and well-being.

In her defense, S.B. testified that when she arrived on her shift, the night staff member told her that K.C. was not showered because the staff member was alone all night. S.B. decided to wait to shower K.C. until after lunch because K.C. is very messy when she eats. S.B. changed K.C.'s adult diaper when she first arrived at 9:00 a.m. She attended to K.C.'s hygiene needs, including toileting, when she gave her a shower at 12:30 p.m. Afterwards, K.C. went to her room to take a nap. S.B. stated that she saw K.C. at around 2:00 p.m. because she gave her medication. Afterwards, K.C. laid back down on her bed. S.B. also stated the K.C.'s door was open when J.V. arrived for the next shift. She waited a few minutes for the second staff member to arrive but had to leave to pick up her son from school.

S.J. testified in her defense that she stayed until J.V. arrived so she did not leave the home understaffed. She also agreed with everything S.B. stated.

Greggs substantiated neglect despite the conflicting stories. S.B. and S.J. failed to maintain line-of-sight supervision of K.C. They admitted to watching her from a chair stationed in the hallway. S.B. and S.J. had no explanation for the double diapers or for the tape on the door which prevented it from being opened. Three staff members on the relieving shift discovered and documented that the doorknob was taped, K.C. was in a double adult diaper, and she was in a deplorable condition. Based on a preponderance of the evidence from her investigation, Greggs determined that substantiation of neglect against S.B. and S.J. was warranted. Her determination was supported by photographs and interviews with multiple staff members from three shifts. There was no dispute that S.B. and S.J. were the staff members entrusted with K.C.'s care during their 9:00 a.m. to 3:00 p.m. shift on May 4, 2020. Three staff members, with no known animosity against S.B. and S.J., confirmed that K.C. was left inside her room, without supervision, until they were able to open her door at 3:30 p.m. on May 4, 2020.

Greggs completed her investigation and signed her report on September 10, 2020. The report was then circulated for review at three administrative levels. The report was signed by the Supervisor, Regional Chief, and Director. After deliberation, DHS sent S.B. and S.J. each a letter informing them of the results of the DHS investigation which substantiated that S.B. and S.J. neglected K.C., and that their actions met the criteria for placement on the Central Registry.

Greggs had no firsthand knowledge of the incident. She prepared the investigation report based on interviews she conducted with staff members and documents maintained in the ordinary course of business by the Heart to Heart group home. Although the investigation report is a business record maintained in the ordinary course of business, it contains hearsay statements. While 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 after considering the nature, character, and scope of the evidence; the circumstances of its creation and production; and, generally, its reliability. "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).

The ALJ was satisfied that the consistency of the witness statements, with corroboration from documentary evidence recorded at or near the time of the incident, provided sufficient reliability for acceptance of the statements contained in the investigation report as trustworthy.

Greggs conducted interviews and, where possible, confirmed details with the records maintained by Heart to Heart. Moreover, S.B. and S.J. did not dispute Greggs' investigatory findings. They did not deny putting two adult diapers on K.C., seeing tape on the inside door handle, or supervising K.C. from sitting on a chair in the hallway. Their only contradiction was whether the door was open or shut at shift change.

It is the obligation of the fact finder to weigh the credibility of the witnesses, and consider the witness's interest in the outcome, motive, or bias. Credibility is the value that a fact finder gives to a witness's testimony. Credibility is best described as that quality of testimony or evidence that makes it worthy of belief. "Testimony to be believed must not only proceed from the mouth of a credible witness but must be credible in itself. It must be such as the common experience and observations of mankind can approve as probable in the circumstances." In re Estate of Perrone, 5 N.J. 514, 522 (1950).

Greggs is an investigator with over ten years of experience. She expressed no animosity or preconceptions. She conducted interviews and recorded pertinent statements. Accordingly, her investigation report contained reliable and trustworthy information. While S.B. and S.J. may have grievances against their employer, nothing justified placing a vulnerable individual in harm's way or failing to provide the appropriate level of care. In assessing the credibility of S.B. and S.J., they demonstrated a lack of appreciation for the seriousness of the situation and their responsibilities in caring for K.C. While the ALJ accepted S.B.'s testimony that she had a good rapport with K.C. and usually was the staff member who tended her needs, she had no explanation as to why K.C. was found wearing two diapers. Moreover, neither S.B. or S.J. seemed to appreciate the seriousness and danger of the tape being on the inside door handle to K.C.'s room. The tape caused the door to lock even if it was closed accidentally. Moreover, it defies logic for the relieving shift members to lock K.C. in her room, knowing they would be responsible for her cleaning and caring for the next six hours. The only logical explanation of how K.C. ended up in such a deplorable condition was that she was left unsupervised by S.B. and S.J. Whether or not they deliberately locked her in the room is not the issue. Their lack of supervision and reasonable care allowed K.C. to engage in dangerous and unsanitary behaviors that jeopardized her health and safety.

INITIAL DECISION'S ANALYSIS AND CONCLUSIONS OF LAW

DHS asserts petitioners' actions resulted in neglect of an individual with developmental disabilities. Petitioners contended, without proof, that they were not the only staff members to put two adult diapers on residents; that the manager was aware of the tape on the doorknob to K.C.'s bedroom; and that the home staffing was inadequate or not as depicted in its records. These contentions and other areas of related concerns were noted by the investigator in her report. None of those related concerns address the crux of the issue that K.C. was left in her bedroom alone, behind a closed door whose doorknob had been tampered with to prevent it from turning. As a result of this complete lack of line-of-sight supervision, K.C. engaged in known behaviors which were unsanitary and dangerous to her health and well-being.

It is well settled that the policy of the State of New Jersey is to protect individuals with developmental disabilities. N.J.S.A. 30:6D-73. As part of its measures to protect such individuals, the New Jersey Legislature created the Central Registry to identify caregivers who have wrongfully injured individuals with developmental disabilities and to prevent such caregivers from working with such vulnerable individuals. N.J.S.A. 30:6D-73(a), 30:6D-73(d);

N.J.S.A. 30:6D-77; N.J.A.C. 10:44D-1.3. An offending caregiver's name will be placed on the Central Registry if they are found to have abused or neglected a developmentally disabled individual. N.J.A.C. 10:44D-4.1.

Neglect is defined as consisting of "any of the following acts by a caregiver on an individual with developmental disability: willfully failing to provide proper and sufficient food, clothing, maintenance, medical care, or a clean and proper home; or failing to do or permit to be done any act necessary for the well-being of an individual with a developmental disability." N.J.S.A. 30:6D-74; N.J.A.C. 10:44D-1.2. "For inclusion on the central registry in the case of a substantiated incident of neglect, the caregiver shall have acted with gross negligence, recklessness, or in a pattern of behavior that causes or potentially causes harm to an individual with a developmental disability." N.J.S.A. 30:6D-77(b)(2). Definitions of the above terms for a substantiated incident of neglect are provided under N.J.A.C. 10:44D-4.1(c):

1. Acting with gross negligence is a conscious, voluntary act or omission in reckless disregard of a duty and of the consequences to another party.
2. Acting with recklessness is the creation of a substantial and unjustifiable risk of harm to others by a conscious disregard for that risk.
3. A pattern of behavior is a repeated set of similar wrongful acts.

The burden is upon DHS to establish, by a preponderance of the evidence, that petitioners' actions constituted neglect, thereby requiring placement on the Central Registry. N.J.S.A. 30:6D-77(b); N.J.A.C. 10:44D-3.2; See, Atkinson v. Parsekian, 37 N.J. 143, 149 (1962); and Cumberland Farms, Inc., v. Moffett, 218 N.J. Super. 331, 341 (App. Div. 1987). 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).

The record established that S.B. and S.J. were the caregivers required to provide proper care for K.C. They were required to maintain line-of-sight supervision for K.C. because due to her PICA disorder, K.C. was known to ingest harmful substances, including her own feces. Line-of-sight supervision cannot happen through a closed door. The staff members relieving S.B. and S.J. were unable to open the door to K.C.'s room which left K.C. unsupervised and free to engage in known, harmful behaviors.

S.B. and S.J. also bear the responsibility for making sure K.C. was clean and safe during their shift and at the change of shift. This did not happen. It is never acceptable to place two adult diapers on an individual for the staff's own convenience.

The evidence clearly reflects that S.B. and S.J. neglected K.C., a nonverbal developmentally disabled individual, by failing to supervise her and by failing to properly attend to her hygiene needs. They acted with careless disregard to the seriousness of K.C.'s behavioral disabilities. Their conduct demonstrated a total disrespect for the rights and dignity of K.C.

The ALJ **CONCLUDED** that S.B. and S. J. acted intentionally in failing to tend to the hygiene and toileting needs of K.C. There was no justification for using two adult diapers to minimize her care needs. The ALJ **CONCLUDED** that S.B. and S.J. acted intentionally in

failing to maintain line-of-sight supervision, knowing full well that if left unsupervised, K.C. would engage in harmful behaviors. Therefore, the ALJ **CONCLUDED** that S.B.'s and S.J.'s actions were intentional, reckless, and constituted neglect and mistreatment of K.C.

The ALJ **CONCLUDED** that the DHS had sustained its burden of proving, by a preponderance of the credible evidence, that the actions of S.B. and S.J. rose to the level of neglect as defined in N.J.A.C. 10:44D-1.2. Further, the ALJ **CONCLUDED** that S.B. and S.J. acted with careless disregard for the well-being of K.C. which jeopardized her health, safety, and well-being; thereby justifying that their names be entered onto the Central Registry.

INITIAL DECISION'S ORDER

The ALJ **ORDERED** "that the determination of the DHS to place the names of petitioners, S.B. and S.J., on the Central Registry for the May 4, 2020, incident is **AFFIRMED**. Petitioners' appeals are **DISMISSED**."

The ALJ **FILED** her initial decision with the **DIRECTOR OF THE OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY** for consideration.

The recommended initial decision may be adopted, modified or rejected by the **DIRECTOR OF THE OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY,** who by law is authorized to make a final decision in this matter.

FINAL AGENCY DECISION

Pursuant to N.J.A.C. 1:1-18.1(f) and based upon a review of the ALJ's Initial Decision and the entirety of the OAL file, I concur with the Administrative Law Judge's findings and conclusions. The ALJ had the opportunity to assess the credibility and veracity of the witnesses; I defer to her opinions concerning these matters, based upon her reasoned observations as described in the initial decision. **I CONCLUDE and AFFIRM** that S.B. and S. J. acted intentionally in failing to tend to the hygiene and toileting needs of K.C. There was no justification for using two adult diapers to minimize her care needs. **I CONCLUDE and AFFIRM** that S.B. and S.J. acted intentionally in failing to maintain line-of-sight supervision, knowing full well that if left unsupervised, K.C. would engage in harmful behaviors. I **CONCLUDE and AFFIRM** that S.B.'s and S.J.'s actions were intentional, reckless, and constituted neglect and mistreatment of K.C. I **CONCLUDE and AFFIRM** that the DHS has sustained its burden of proving, by a preponderance of the credible evidence, that the actions of S.B. and S.J. rose to the level of neglect as defined in N.J.A.C. 10:44D-1.2. I **CONCLUDE and AFFIRM** that S.B. and S.J. acted with careless disregard for the well-being of K.C. which jeopardized her health, safety, and well-being; thereby, justifying that their names be entered onto the Central Registry.

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** the placement of S.B.'s and S.J.'s names on the Central Registry of Offenders against Individuals with Developmental Disabilities.

Date: 10/26/22 Deborah Robinson

Deborah Robinson, Director
Office of Program Integrity and Accountability