PHILIP D. MURPHY
Governor

TAHESHA L. WAY
Lt. Governor

State of New Jersey
Department of Human Services

Office of Program Integrity and Accountability
P.O. Box 700
Trenton, NJ 08625-0700

SARAH ADELMAN
Commissioner

DEBORAH ROBINSON
Director

FINAL AGENCY DECISION

OAL DKT. NO. HSL 04613-23

AGENCY REF. NO. 23-005

C.O.,

Petitioner,

v.

NEW JERSEY DEPARTMENT OF HUMAN SERVICES,

Respondent.

Richard A. West, Esq., for petitioner (Goodgold West and Bennett LLC, attorneys)

Barkha Patel, Deputy Attorney General, for respondent (Matthew J. Platkin, Attorney General of New Jersey, attorney)

Record Closed: July 11, 2024 Decided: July 23, 2024

BEFORE **JUDE-ANTHONY TISCORNIA**, ALJ:

INITIAL DECISION:

STATEMENT OF THE INITIAL DECISION

Petitioner, C.O. (petitioner or C.O.), appeals her placement on the Central Registry of Offenders Against Individuals with Developmental Disabilities (Central Registry) by the Department of Human Services (Department) pursuant to N.J.S.A. 30:6D-73 and N.J.A.C. 10:44D. The Department substantiated allegations that C.O. neglected P.C., an individual receiving

services from the Division of Developmental Disabilities ("DDD"), on February 14, 2022, while employed at a group home.

PROCEDURAL HISTORY

On December 16, 2022, C.O. appealed the Department's decision to place her name on the Central Registry and requested an administrative hearing. The matter was transmitted as a contested case to the Office of Administrative Law on May 24, 2023, 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 August 3, 2023, covering any DHS records provided by the respondent, in discovery or used as evidence, containing protected information under N.J.S.A. 30:4-24.3, N.J.S.A. 30:6D-78, and the HIPAA Privacy Rule. The hearing was conducted via Zoom on January 10, 2024, and February 23, 2024. Final submissions were received on July 11, 2024, at which point the record was closed.

STATEMENT OF FACTS

The ALJ FOUND the following to be the facts of the case, based on the credible testimony of the witnesses presented at the hearing. On February 14, 2022, C.O. was employed as a program specialist[1] by Deveraux, an entity that owns and operates group homes for individuals with developmental disabilities. On that date, C.O. was working at one such group home, Longhouse Two, in Hewitt, New Jersey, with two other Devereux Direct Support Professionals.

Upon arriving at the residence in the evening, C.O. observed a written instruction, left by the previous shift, instructing C.O. to clean and fold laundry that had accumulated. The laundry room of Longhouse Two is located in the basement of the building. C.O. informed her co-workers that she was going to perform the laundry duty as the note instructed and spent most of her overnight shift doing laundry alone in the basement of Longhouse Two. The four residents and two other Devereux workers were on the next floor above C.O., while C.O. did laundry on the lower level of the building, only emerging from time to time to put baskets of clean laundry on the landing just outside the basement door leading to the stairwell.

C.O. did not have line-of-sight supervision of any of the residents, including P.C., while she worked in the basement. At some point during the evening, P.C. managed to elope from the residence, undetected by the staff. P.C. managed to travel approximately three miles on foot to a convenience store, where he was apprehended by local police and ultimately returned to Longhouse Two.

The outside temperature was below freezing at the time of the elopement, and P.C. was not adequately clothed. This resulted in P.C. receiving frostbite and related injuries due to his prolonged exposure to the elements.

C.O. credibly testified, and **the ALJ FOUND,** that when the elopement took place, she was performing the aforementioned duties in the basement of the Longhouse. She did not witness or hear the elopement, nor did she hear any commotion when the police returned with P.C.

[1] C.O.'s actual job title is Direct Support Professional (DSP); Respondent's Exhibit, R-5, contains an eight-page job description written by Devereux.

C.O. was designated the "person in charge[2]" on the evening in question. This designation is assigned to a different member of the crew for a given shift on an alternating basis and is a term used by Devereux. The factors which determine who is designated "person in charge" on a given shift cannot be determined based on the record, and **the ALJ FOUND** the term is an informal designation used by Devereux, and, therefore, no elevated duty of care may be attributed to its use.

C.O., along with the two other Devereux employees present on the evening in question, were subsequently terminated by Devereux due to their involvement with the elopement of P.C. The Department subsequently conducted an investigation, which resulted in C.O. being placed on the Central Registry.

Legal Discussion

In the case at bar, the Department rendered a finding of "substantiated" regarding C.O.'s conduct when the above-referenced incident occurred. Thus, C.O.'s name was entered into the Central Registry as per the Central Registry Act. See N.J.S.A. 30:6D-73 to -82. This statute seeks to protect developmentally disabled citizens by "identifying those caregivers who have wrongfully caused them injury." N.J.S.A. 30:6D-73(a). As a result, the Legislature established the Central Registry "to prevent caregivers who become offenders against individuals with developmental disabilities from working with individuals with developmental disabilities" and made the safety of such individuals "of paramount concern." N.J.S.A.30:6D-73(b) and (d).

To implement the language and stated purpose of N.J.S.A. 30:6D-73 et seq., DHS has promulgated regulations that prohibit persons included on the Central Registry from employment in facilities or programs of the DDD or with employers providing community-based services to a person with developmental disabilities that receive direct or indirect State funding. See N.J.A.C. 10:44D-1.1.4. As such, under the Central Registry Act, DHS conducts investigations into reported allegations of abuse, neglect and exploitation of developmentally disabled individuals. See N.J.S.A. 30:6D-76. In a case of a substantiated incident of neglect, placement on the Central Registry is warranted if the caregiver acted with gross negligence or recklessness that caused harm to an individual with a developmental disability. N.J.A.C. 10:44D-4.1(c). Under the regulation, gross negligence is defined as "a conscious, voluntary act or omission in reckless disregard of a duty and of the consequences of another party." N.J.A.C. 10:44D-4.1(c)(1). Recklessness is defined as the "creation of a substantial or unjustifiable risk of harm to others by a conscious disregard for that risk." N.J.A.C. 10:44D-4.1(c)(2).

In the case at bar, C.O. testified credibly that upon reporting to her overnight shift at Longhouse Two on the date in question, she reviewed a note from the prior shift instructing her to do laundry. She apprised her coworkers and remained in the basement doing laundry and related tasks for the remainder of the night, only emerging from time to time to place baskets of clean laundry on the landing of the internal stairwell just outside the basement door.

[2] A description of the Devereux job title, "In Charge Designation (DSP-IC)," appears at pages 7-8 of Respondent's Exhibit, R-5. It is not cited.

The Department's witnesses also testified credibly, but the bulk of their testimony regarded the Department's investigation, its purpose, procedures and protocols, related regulations and practices, and also the degree of severity of P.C.'s injuries. Based on the foregoing, **the ALJ CONCLUDED** that the Department has not met its burden of showing by a preponderance of credible evidence that C.O. wrongfully caused P.C.'s injury or why C.O. should be prevented from working with individuals with developmental disabilities going forward. **The ALJ** further **CONCLUDED** that C.O.'s name should be removed from the Central Registry, and her petition should, therefore, be **GRANTED**.

DECISION AND ORDER

The ALJ ORDERED that the placement of C.O. in the Central Registry shall be **REVERSED**. It is further **ORDERED** that any determination that C.O. neglected P.C. be **OVERTURNED**. **THE ALJ FILED** his initial decision with the **DIRECTOR OF THE OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY** for consideration.
This recommended 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.

Within thirteen days from the date on which the recommended decision was mailed to the parties, any party may file written exceptions with the **ADMINISTRATIVE HEARINGS COORDINATOR, OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY.**

EXCEPTIONS TO THE INITIAL DECISION:

The Respondent filed exceptions to the Initial Decision on August 5, 2024. No exceptions were filed by the Petitioner. The Respondent's exceptions states:

"For the reasons set forth below, the Director of the Office of Program Integrity and Accountability should reject the conclusions and recommended decision in the Initial Decision.

Standard

The deciding agency is not required to accept an ALJ's findings of fact or credibility findings where those findings "are arbitrary, capricious or unreasonable or are not supported by sufficient, competent, and credible evidence in the record." N.J.S.A. 52:14B-10(c). The agency is further expressly authorized to "reject or modify findings of fact, conclusions of law or interpretations of agency policy in the decision." Ibid. Here, the agency must reject the ALJ's numerous factual findings and credibility findings which are unsupported by competent and credible evidence and which are unreasonable in light of the evidence.

Factual and Credibility Findings Unsupported by the Record

The Initial Decision fails to recount all the testimony and evidence presented at the hearing. The Initial Decision outlines only a few findings of fact from Petitioner C.O.'s testimony. The Initial Decision does not discuss any findings of fact

based on the Respondent's witnesses' credible testimony or evidence submitted into the record.

First, the ALJ makes a factual finding that C.O. was employed by Devereux as a "program specialist." (Initial Decision at 1). However, C.O. was actually a Direct Support Professional for over two years. (2T:2-16). The job description, duties, and expectations of this position were admitted into evidence as R-5. C.O. testified regarding her job title and her job duties explaining that the staff are responsible for supervising the residents (e.g. monitoring the behaviors, medications, food, etc.) and housekeeping duties (e.g. laundry, preparing food, etc.). (2T8:3-13; 2T43:3-7; 2T61:5-14). C.O.'s specific job title and role are essential to a decision in this matter, and the ALJ's inaccurate findings are material.

Next, the ALJ makes a decisive factual finding that "C.O. observed a written instruction" or note for the overnight shift to clean and fold laundry. (Initial Decision at 2). This specific factual finding is the basis for the ALJ to conclude that C.O. should be removed from the Central Registry because she was completing other "assigned" tasks and not directly supervising P.C. when he eloped. While the ALJ found this testimony from C.O. to be credible and true, this fact is not corroborated in any other part of the record. C.O. prepared a handwritten statement, dated March 9, 2022, when she was interviewed by the DHS investigator (R-3) and never mentioned a written instruction. The handwritten statement, which is more contemporaneous to the February 14, 2022 incident than the hearing testimony two years later on February 23, 2024, detailed her actions during the overnight shift. C.O. wrote in her handwritten statement that she "came before 11 on 2/14/22 I saw a lot of laundry so I want [sic] downstair [sic] to start it." (R-3) (2T35:4-13). During any part of her interview, which is summarized by the DHS investigator in the Investigation Report (R-2) or in her handwritten statement, C.O. did not mention any specific written instruction to complete housekeeping tasks in 2022. Accordingly, the ALJ's finding is utterly unsupported by sufficient, competent, and credible evidence in the record.

Furthermore, the ALJ makes a factual finding that C.O. was doing laundry "on the lower level of the building, only emerging from time to time to put baskets of clean laundry on the landing just outside the basement door." (Initial Decision 2-3). The aforementioned "building" is actually a modest and old split-level home where the main floor has the small kitchen, living room area, and bedrooms a few steps up from the main landing. From the main landing, in front the main door, the staff can also go down approximately ten steps to the laundry machines and basement area. The photographs of the split-level home were entered into evidence as R-4 but not mentioned in the Initial Decision. It is important to illustrate that C.O. was not in a big building or large residence where sound or movements are contained. So, if the ALJ accepted as credible and true that C.O. remained in the basement area for over two hours doing laundry and only emerging to put clean laundry on the landing, it follows that that ALJ should also accept as true that C.O. could hear noises and movements above her and consciously decided to remain isolated from the residents and her colleagues for a prolonged period of time during her shift.

The ALJ fails to acknowledge that C.O. testified about additional times she left the basement. C.O. testified that she first helped H.Z., her colleague, with A.C.'s behavior for a few minutes. (2T42:1-17). C.O. also testified that she helped P.C. with a late-night snack and shower before K.A., her other colleague, put him to sleep. (2T17:1-19; 2T43:2-16). C.O. also took out the garbage and saw a police car at Longhouse 1 around 2:51 A.M. (2T22:1-14). The ALJ states that C.O. only left the basement to put clean laundry on the landing, but C.O. expressly testified that she left the basement for other reasons. Negligently, C.O. did not leave the basement to check on the residents or her colleagues after 12:30 A.M. Even when C.O. placed baskets of clean laundry on the landing, C.O. decided to steer clear of the main floor of the residents where two of her colleagues were supervising four residents. Again, the ALJ's factual findings are unsupportable.

The inconsistency continues when the ALJ makes a factual finding that C.O. did not have line-of-sight supervision of any of the residents, including P.C. (Initial Decision at 3). C.O. testified that she discussed with her two colleagues how to divvy up supervision of the four residents for the overnight shift when the shift began. (2T39:6-25). There is no formal assignment from a supervisor or program manager, so they decide amongst themselves how to delegate supervision and tasks. (2T39:6-25). There is no evidence in the record that just because the staff informally divvy up supervision for the shift, that it equates to the employee removing all responsibility for any other resident's care, safety, and well-being. C.O. did not provide any evidence that her responsibility only extends to residents she selected to watch that shift. To the contrary, the DHS investigator specifically testified that <u>all</u> staff are responsible for <u>all</u> the residents during their shifts. (1T50:3-10). That is why there is no evidence of formal assignments from the supervisors and managers, and why the alleged written instruction to complete laundry did not include any formal supervision assignments either. The ALJ's factual finding in this regard is wholly unsupportable.

For the specific shift on February 14, 2022, the three staff members decided that C.O. would complete the housekeeping tasks **<u>and</u>** watch two residents who do not require line-of-sight supervision. A.C. and P.C., who require line-of-sight supervision, would be watched by her two colleagues, H.Z. and K.A. respectively. (2T14:10-23). Even with this informal delegation of tasks, C.O. specifically testified that they all help each other out. (2T39:13-25). Even that night, C.O. helped with A.C.'s behavior and P.C.'s late-night snack and shower. C.O. testified that if she heard noise when she was dropping baskets of laundry on the landing, she would have helped A.C. or P.C. (2T50:8-20). She consciously decided not to check on the residents unless she heard a noise or yell for help instead of proactively checking that everyone is safe and well. C.O. testified that she asked K.A. why he did not call her for help, and he told C.O. that "Oh, I was thinking if you were sleeping, so there was no need calling you." (2T51:1-7). This testimony –from C.O. herself - demonstrates that (1) C.O. expected to be called if her colleagues needed help, meaning she knew she was also responsible for all the residents in the house; and (2) C.O. or other staff

have slept in the basement before while working on housekeeping tasks during the overnight shift. This testimony disallows the ALJ's faulty factual findings.

Lastly, the ALJ makes a factual finding that C.O. did not witness or hear P.C. elope because she was in the basement, and "did not hear any commotion when the police returned with P.C." (Initial Decision at 3). This finding is wholly unsupported by the record. Aside from the fact that the police never returned to Longhouse 2 with P.C., the ALJ completely disregarded all the testimony provided by the DHS investigator, Lauren Kovall, and the West Milford Township Police Officer, Suzanne Novakowski. The ALJ included only one blanket sentence regarding the Respondent's witnesses without identifying them by name, without discussing their roles in the investigation or incident, and without stating any specific facts that were applied to the ALJ's analysis and conclusions. Instead, the ALJ simply stated that the Respondent's witnesses testified credibly, but the bulk of the testimony was regarding the Department's investigation. (Initial Decision at 4). It seems as though the ALJ is referring to only the DHS investigator, Lauren Kovall. The ALJ fails to reference testimony from Officer Novakowski, her narrative report (R-6), or the dashcam video footage at all. Oddly, the ALJ states that the Respondent's witnesses are credible, but fails to reconcile the specific credible testimony and evidence that contradicts C.O.'s testimony.

The DHS investigator's testimony and investigation report (R-2) along with Officer Novakowski's testimony with the dashcam footage (R-6) are integral to whether C.O.'s testimony is believable, especially regarding Officer Novakowski's visit to Longhouse 2. Specifically, Officer Novakowski testified that when she arrived at Longhouse 2 around 3:15 AM, the whole house was dark and quiet with no lights on. (1T135:1-6). It took a full six minutes of knocking and shining the light into the house for someone to finally open the door at 3:21 AM. (1T139:3-8). When H.Z. and K.A. (not C.O.) came to the door, H.Z. specifically told Officer Novakowski that "it was just the two of them in the house tonight working." (1T139:14-25). Officer Novakowski was at Longhouse 2 for over thirty minutes with the dashcam video footage showing that she was at the location from 3:16 A.M. to after 3:45 A.M. (1T145:1-6). The video footage also provides evidence of much movement and conversations inside the house regarding P.C.'s book and belongings and staff identification. Yet, C.O. never "emerged" from the basement or "heard the commotion." When C.O. asked K.A. why he did not call for help, he told her that he thought she was sleeping. (2T51:1-4). This credible testimony and evidence was wholly ignored in the Initial Decision. The ALJ only noted that C.O. was in the basement and did not hear the commotion (Initial Decision at 3). Even if C.O. was awake, it defies reason that C.O. would be oblivious to the additional voices and movement less than ten steps up the landing. Therefore, her conscious omission is gross negligence justifying placement on the Central Registry.

Incorrect Standard Applied

The ALJ's Legal Discussion in the Initial Decision is scant. The ALJ fails to

discuss DHS's substantiation of neglect entirely. The investigation revealed that C.O. neglected her responsibility to provide care of all the residents, including P.C., by exhibiting tunnel-vision and disappearing into the basement for most of the overnight shift. C.O. willfully failed to do what was necessary for the well-being of an individual with a developmental disability and focused on housekeeping tasks instead. See N.J.S.A. 30:6D-74; N.J.A.C. 10:44D-1.2.

This neglect is gross negligence because C.O. knew the level of supervision required to keep P.C. safe and still did not check on P.C., the other residents, or her colleagues for over two hours. The ALJ did not make any factual findings as to what line-of-sight supervision requires, what C.O. would do when watching P.C. overnight, what she expected her colleagues to do when she was handling other tasks, etc. The ALJ baldly finds C.O.'s testimony credible, pinpointing only few factual findings from her testimony. The ALJ fully ignores all the documentation submitted into evidence and most of C.O.'s testimony. The ALJ focuses solely on the fact that C.O. testified about a written note instructing laundry to be completed during the overnight shift and so she followed that instruction; and because she followed that instruction, C.O. did not neglect her job duties. But the ALJ fails to also acknowledge that C.O. testified she would watch the "two easy" residents who do not require line-of-sight supervision. (2T14:10-20). C.O. never testified that she would **only** complete housekeeping tasks as listed on the alleged note; instead C.O. clearly testified that the housekeeping tasks would be completed alongside watching two residents and helping her colleagues with A.C. and P.C., who both require line-of-sight supervision. C.O. testified that she helped her colleague with A.C. when he was having "a little bit of behavior." (2T16-16-22; 2T21:10-19). C.O. testified that she also helped her colleague with P.C., when P.C. requested a late-night snack and shower. (2T17:1-9). C.O.'s full testimony demonstrates that she was well-aware her first priority was to the residents and to work together with her colleagues on shift to properly supervise the residents. However, for approximately two hours afterwards, C.O. ignored those primary responsibilities which constitutes a conscious omission disregarding the consequences warranting placement on the Central Registry. N.J.A.C. 10:44D-4.1(c)(1). This conscious omission and neglect directly led to P.C.'s injuries.

In a similar Central Registry matter, ALJ Calemmo found that both the caretakers bore the responsibility to ensure that the individual with developmental disabilities is safe and clean during their shift, despite whoever was the last to attend to him/her. See S.B. v. DHS, No. HSL 08020-21 (consolidated) at * 16-17 (Sept. 27, 2022 Initial Decision). In S.B., ALJ Calemmo found that the Petitioners did not maintain line-of-sight supervision over the individual with developmental disabilities for approximately two hours. Even if one staff was the last to see the individual, both staff bear the responsibility to make the individual is safe and supervised at all times.

The finding that C.O. remained in the basement doing laundry and related housekeeping tasks, only emerging from time to time to place baskets of clean

laundry on the landing, is wholly unsupported by sufficient and competent or credible evidence in the record. See N.J.S.A. 52:14B-10(c). Her excuse is unjustifiable because she knew the level of supervision required to keep P.C. safe and missed multiple opportunities to check on him and detect that he had eloped before the police found him. She bore the responsibility with her colleagues to ensure all the residents were safe and she ignored that responsibility for a large part of that shift causing severe injuries to P.C.

Conclusions

The Initial Decision categorically misses the mark. The ALJ's factual findings are incomplete and unsupportable on this record. Without key facts, the Initial Decision further misapplies the standard for placement upon the Central Registry. A review of the expansive testimony presented at the two-day hearing, the detailed Investigation Report (R-2), and the dash cam footage from West Milford Township Police Department (R-6) further necessitate that the Director reject the ALJ's findings and recommended decision.

Accordingly, Respondent respectfully asks that the Director reject the Initial Decision, find that Petitioner's actions constituted neglect of P.C., and uphold her placement on the Central Registry of Offenders against Individuals with Developmental Disabilities.

FINAL AGENCY DECISION DISCUSSION

In the Initial Decision, there is no discussion of any of two thirds (by transcript page total) of the testimony provided by the DHS investigator, Lauren Kovall, and the West Milford Township Police Officer, Suzanne Novakowski, during the hearings; nor is there any mention of the eight documents introduced into evidence as exhibits. The ALJ mentions that, "The Department's witnesses also testified credibly, but the bulk of their testimony regarded the Department's investigation, its purpose, procedures and protocols, related regulations and practices, and also the degree of severity of P.C.'s injuries." (ID – p. 4) Central Registry decisions are based upon investigations - their procedures and protocol; regulations set the parameters and definitions for the application of the facts found in investigations to the Central Registry placement criteria. The Initial Decision fails to consider the majority of the testimony produced at the hearings and seemingly dismisses it as mere procedures, protocols, and regulations. The Legislature established the Central Registry of Offenders against Individuals with Developmental Disabilities (N.J.S.A. 30:6D-73 et seq.) and tasked the Department of Human Services (DHS) with developing and enforcing the regulations through N.J.A.C. 10:44D.

DHS is not required to accept an ALJ's findings of fact or credibility findings where those findings "are arbitrary, capricious or unreasonable or are not supported by sufficient, competent, and credible evidence in the record." N.J.S.A. 52:14B-10(c). DHS is authorized to "reject or modify findings of fact, conclusions of law or interpretations of agency policy in the decision." Ibid. Here, the agency must reject the ALJ's numerous factual findings which are unsupported by competent and credible evidence and which are unreasonable in light of the evidence presented by

the Respondent, which the ALJ has deemed credible (ID – p. 4). The ALJ's dismissal of the Respondent's testimony, evidence, and exhibits is wholly unreasonable.

C.O. was a Direct Support Professional (DSP) for over two years. (2T:2-16). The job description, duties, and expectations of this position were admitted into evidence as R-5. The very first sentence of the DSP job summary states: "The primary focus of the position is individual or group adult care working in shifts." (R-5. P1) Under the heading of Program Delivery and Behavioral Management of the Professional Skills section, Devereux states: "The DSP provides oversight and direction of services, which foster quality customer services and care to the individuals in our programs. The DSP supervises, plans, and coordinates activities for individuals within the scope of the individual's behavior or habilitation plan. A DSP must demonstrate the skills, knowledge and ability to implement an interdisciplinary team approved plan (IEP, IHP,[3] etc.) for an individual receiving services from ... Devereux."(R-5. P.2) Later in the paragraph, additional duties are added, "the DSP may[4] perform a variety of duties which include but are not limited to, general house cleaning and upkeep, cooking with and for program participants, medication administration, assisting individuals with hygiene needs" … and transporting individuals. (R-5. P.2)

C.O. testified about her job title and her job duties, explaining that the staff are responsible for supervising the residents (e.g. monitoring the behaviors, medications, food, etc.) and housekeeping duties (e.g. laundry, preparing food, etc.). (2T8:3-13; 2T43:3-7; 2T61:5-14). C.O.'s specific job responsibilities are essential to a decision in this matter, and the ALJ's inaccurate findings are material. The job summary clearly shows that the purpose of the DSP is to provide care to individuals or groups while working in shifts. There are ancillary duties within the job description, but the main purpose of the DSP job is to provide services to the individual within the context of the individuals', behavior or habitation plans. C.O. failed to provide the shift support needed to provide "awake onsite staffing within the home at all times with visual of field in all assigned staff in all areas of the home while awake and asleep." (R-2, P.6)

From about three to three and a half hours into her shift, C.O. was not seen by any of her fellow employees, an employee from another home who searched the basement for P.C.'s documents, or a policewoman who spent "at least four to five minutes of constant knocking" (1T119:18) on the front door of the residence and another half hour speaking to H.Z. and K.A.; until after 3:45am; when K.A. found C.O. to tell her that the police had come and gone to the hospital with P.C.'s medical documents. For over three hours, C.O. was completely unavailable to help monitor any of the service recipients in the residence. During that time, the other resident requiring line of sight supervision, A.C., had an extended behavioral episode that involved his pounding on the walls; both H.Z. and H.K. attended to him from 1:30 a.m. to 3:00 a.m. (R-2 p. 5) as well as the police visit and attempts to rouse the staff to open the door. To believe that C.O. had made herself available for responding to calls for help or responding to a commotion during this window is unreasonable.

[3] These are Devereux's terms. IHP stands for Individual Support Plan. DHS uses NJISP, which stands for New Jersey Individualized Service Plan.

[4] Emphasis added to original text.

The ALJ made a finding that "C.O. observed a written instruction" or note for the overnight shift to clean and fold laundry. (ID p.2). The ALJ concluded that C.O. should not be on the Central Registry because she was not directly supervising P.C. when he eloped. While the ALJ found this testimony from C.O. to be credible and true, this fact is not corroborated in the record. C.O. prepared a handwritten statement, dated March 9, 2022, when she was interviewed by the DHS investigator (R-3) She did not mention a written instruction. C.O. wrote in her statement that she "came before 11 on 2/14/22 I saw a lot of laundry so I want [sic] downstair [sic] to start it." (R-3) and (2T35:4-13) C.O. did not mention any specific written instructions to complete housekeeping tasks in 2022. ALJ's finding about a note is unsupported by sufficient or credible evidence. Much more importantly, the ALJ never explained how C.O.'s assigning herself, or pursuant to an unverified note, from an earlier shift to do laundry in the basement; excused C.O. from the responsibility of supervising any of the four residents in the home – two of whom required line of sight observation, even while sleeping. There were two other individuals who did not require constant monitoring, but without C.O.'s assistance; bathroom, snack, or other breaks would be impossible for the other two employees during their ten-hour shifts monitoring the two residents who required line of sight monitoring. The ALJ's belief that C.O. could provide sufficient monitoring of the home's four individuals while in the basement and never venturing beyond the first landing is unreasonable and unsupported by the record.

The ALJ found that C.O. did not have the duty of line-of-sight supervision for any of the residents, including P.C. (Initial Decision at 3) The ALJ seemingly disregarded all the testimony provided by the DHS investigator, Lauren Kovall, and the West Milford Township Police Officer, Suzanne Novakowski. The ALJ included only one blanket sentence regarding the Respondent's witnesses without identifying them by name, without discussing their roles in the investigation or incident, and without stating any specific facts that were applied to the ALJ's analysis and conclusions; instead, the ALJ simply stated that the Respondent's witnesses testified credibly. The DHS investigator, Lauren Kovall, previously had 9 years of case management experience before her 6 years working as an investigator; Kovall is familiar with the proper management of group homes. Kovall specifically testified that <u>all</u> staff are responsible for <u>all</u> the residents during their shifts. (1T50:3-10) C.O. testified that she discussed with her two colleagues how to arrange the supervision of the four residents for the overnight shift, at the beginning of the shift. (2T39:6-25). With no formal assignment from a supervisor manager, the Devereux DSPs (C.O., H.Z., and K.A.) decided how to delegate the supervision and tasks amongst themselves. (2T39:6-25) There is no evidence that when staff informally accept supervision of a resident on a shift, that the employee is not responsible for any other resident's care or safety. C.O. provided no evidence that her responsibility extended only to residents she picked to watch that shift. When asked if, "O.C. understood that, as part of her duties, it wasn't just housekeeping duties; that she was also there to supervise the residents, correct?" - C.O. testified, "Yeah." (2T43:2-7) C.O. also testified that shift members only have to call out for assistance or to be relieved. (2T39:13-40:7) The ALJ's factual finding that C.O. had no monitoring responsibility is wholly unsupported and contradicted by testimony from C.O. and Kovall as well as the DSP job description.

C.O. testified that the three staff members decided amongst themselves that C.O. would complete the housekeeping tasks <u>and</u> monitor the two residents not requiring line-of-sight supervision. A.C. and P.C., who require line-of-sight supervision, would be watched by her two colleagues, H.Z. and K.A. respectively. (2T14:10-23). With the informal delegation of tasks, C.O.

specifically testified that they all help each other out. (2T39:13-25). C.O. helped with A.C.'s behavior and P.C.'s late-night snack and shower. C.O. testified that if she heard noise when she was dropping baskets of laundry on the landing, she would have helped A.C. or P.C. (2T50:8-20). However, she decided not to check on the residents - unless she heard a noise or a yell for help. C.O. did not proactively check any residents. C.O. testified that she asked K.A. why he did not call her for help," (2T51:1-7). C.O. showed that she expected to be called when needed and that she knew she was also responsible for all the residents in the house. By her actions, O.C. demonstrated that she was expected to be a part of a team that worked together in supervising each of the resident as needed. The Initial Decision never acknowledged or discussed these cooperative interactions of the staff providing supervision of the residents, nor the testimony of the Respondent's testimony.

The ALJ failed to acknowledge the several times that C.O. left the basement. C.O. testified that she first helped H.Z. with A.C.'s behavior for a few minutes. (2T42:1-17). C.O. helped P.C. with a late-night snack and shower before K.A. put him to sleep. (2T17:1-19; 2T43:2-16). C.O. also took out the garbage and saw a police car at Longhouse 1 around 2:51 A.M. (2T22:1-14). The ALJ states that C.O. only left the basement to put clean laundry on the landing; C.O. expressly testified that she left the basement for other reasons. C.O. was negligent when she failed to leave the basement to check on the residents or her colleagues after 12:30 A.M. Even when C.O. placed baskets of clean laundry on the landing, she did not take the few more steps where two of her colleagues were supervising four residents. T h e ALJ's factual findings are unsupportable.

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 – the Initial Decision, exhibits, transcripts, and submissions - I **REJECT and REVERSE** the Administrative Law Judge's findings and conclusions. Although the ALJ had the opportunity to assess the credibility and veracity of the witnesses, both the Petitioner and the witnesses for the Respondent were deemed credible. As discussed above, evidence was mischaracterized as not being part of the Petitioner's job duties - without any discussion or analysis – and despite evidence to the contrary. The Initial Decision was improperly considered and must be corrected.

Based upon the arguments concerning the evidence presented in the Discussion of the Initial Decision (above), **I FIND AS FACT:**

- C.O. was a trained Direct Support Professional (DSP) with two years of experience working in a group home owned by Devereux; she was hired to supervise and provide assistance with daily activities to individuals with developmental disabilities.
- C.O. was one of three DSPs working the overnight shift (11:00 pm until 9:00 am) that began on February 14, 2022. C.O. and the other two DSPs were responsible for the care and safety of all four of the service recipients living in the residence. Two of the residents, P.C. and A.C., require line of sight supervision at all times, requiring a DSP to be able to see them at all times, even while the resident is sleeping - during which time the DSP remains awake in the room monitoring the resident. The other two residents require a lesser degree of supervision than line of sight during the overnight shift.

- C.O. testified that the three staff members decided amongst themselves that C.O. would complete the housekeeping tasks and monitor the two residents not requiring line-of-sight supervision. A.C. and P.C., the two residents who require line-of-sight supervision, would be watched by O.C.'s two colleagues, H.Z. and K.A. respectively. (2T14:10-23). With the informal delegation of tasks, C.O. specifically testified that they all help each other out. (2T39:13-25). C.O. helped with A.C.'s behavior near the beginning of the shift and handled P.C.'s late-night snack and shower. C.O. testified that if she heard noise when she was dropping baskets of laundry on the landing, she would have helped A.C. or P.C. (2T50:8-20).
- O.C. was responsible for the safety and well-being of all of the residents of Longhouse Two during the overnight shift on February 14, 2022.
- C.O. did not to check on the residents - unless she heard a noise or a yell for help. C.O. did not proactively check on any residents. C.O. showed that she expected to be called when needed and that she knew she was also responsible for all the residents in the house. By her actions of assisting in A.C.'s behavior and in providing a snack to P.C. and showering P.C. early in the shift; O.C. demonstrated that she was expected to be part of a team that worked together in supervising each of the resident as needed.
- The Initial Decision stated that C.O. "remained in the basement doing laundry and related tasks for the remainder of the night, only emerging from time to time to place baskets of clean laundry on the landing of the internal stairwell just outside the basement door." (ID pp 2-3)
    - "At some point during the evening, P.C. managed to elope from the residence, undetected by the staff. P.C. managed to travel approximately three miles on foot to a convenience store, where he was apprehended by local police and ultimately returned to Longhouse Two." (ID p.3)
    - "The outside temperature was below freezing at the time of the elopement, and P.C. was not adequately clothed. This resulted in P.C. receiving frostbite and related injuries due to his prolonged exposure to the elements." (ID p.3)
- From about three to three and a half hours into her shift, C.O. was not seen by any of her fellow employees, an employee from another home who searched the basement for P.C.'s documents, or even a policewoman who spent "at least four to five minutes of constant knocking" (1T119:18) on the front door of the residence and another half hour speaking to H.Z. and K.A.; until after 3:45am, when K.A. found C.O. to tell her that the police had come and gone to the hospital with P.C.'s medical documents. For over three hours, C.O. was completely unavailable to help monitor any of the service recipients in the residence. During that time, the other resident requiring line of sight had an extended behavioral episode that both H.Z. and H.K. attended to from 1:30 a.m. to 3:00 a.m. (R-2,p.5) as well as the police visit and attempts to rouse the staff to open the door.
- O.C. was absent from the supervision of the residents of Longhouse Two from 12:00am, when she stated that she was in the basement doing laundry (R-2,p.6) until after the police left the residence at approximately 3:45am (1T145:18 to 1T146:3). The staff of Longhouse Two, the staff member from the neighboring residence (who entered the basement (91T59:16-60:14)), and the police at the scene never encountered O.C. at Longhouse Two.
- C.O. neglected her responsibilities to oversee the care of all of the residents, including P.C. As a result of inadequate supervision P.C. eloped for multiple hours, causing severe injuries, including frostbite.

I CONCLUDE and AFFIRM THAT C.O. committed an act of Neglect as defined in N.J.S.A. 30:6D-74 and N.J.A.C. 10:44D-1.2, "Neglect" shall consist of any of the following acts by a caregiver on an individual with a 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.A.C. 10:44D-2.1(e)1 states that: "(e) The allegations of the types of injuries, risks or harm that may constitute neglect of a service recipient and that shall be reported include, but are not limited to: 1. Inadequate supervision." The regulatory definition for placement on the Central Registry, N.J.A.C. 10:44D-4.1(c) states:

> "(c) In the case of a substantiated incident of neglect, it shall be determined if the caregiver acted with gross negligence, recklessness or evidenced a pattern of behavior that caused harm to an individual with a developmental disability or placed that individual in harm's way.
>
> 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."

I CONCLUDE and AFFIRM FURTHER THAT C.O., by absenting herself from the supervision of the residents of Longhouse Two, after showering and feeding P.C., C.O. committed an act of neglect. She willfully disregarded the plan of supervision of the residents that she, herself, helped to coordinate. Her lack of participation in the supervision of the residents led to the inadequate supervision (N.J.A.C. 10:44D-2.1(e)1) and contributed to P.C.'s elopement from Longhouse Two. **I FURTHER CONCLUDE and AFFIRM FURTHER THAT** C.O. acted with recklessness in the creation of a substantial and unjustifiable risk of harm to others by a conscious disregard for that risk. I **CONCLUDE and AFFIRM** that there is a preponderance of the evidence in the hearing transcripts, exhibits, and reasoned exceptions demonstrating that C.O. committed an act of neglect as defined in the Statute and the Regulations. C.O., a caretaker, neglected P.C., an individual with developmental disabilities and that C.O.'s placement on the Central Registry of Offenders Against Individuals with Developmental Disabilities is correct and proper.

Therefore, pursuant to N.J.A.C 1:1-18.6(d), it is the Final Decision of the Department of Human Services that I **ORDER** the placement of C.O. on the Central Registry of Offenders Against Individuals with Developmental Disabilities.

Deborah Robinson

Date: 9/4/2024

Deborah Robinson, Director

Office of Program Integrity and Accountability