PHILIP D. MURPHY
Governor

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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 03944-23
AGENCY DKT. DRA # 23-004

H.Z.,

Petitioner,
v.

DEPARTMENT OF HUMAN SERVICES,

Respondent.

Ejike N. Uzor, Esq., for petitioner
Barkha Patel, Deputy Attorney General, for respondent (Matthew J. Platkin, Attorney General, State of New Jersey, attorney)
BEFORE: **WILLIAM J. COURTNEY,** ALJ

ADMINISTRATIVE LAW JUDGE'S (ALJ) INITIAL DECISION

STATEMENT OF THE CASE

Petitioner, H.Z., appeals a finding of respondent, Department of Human Services, Office of Program Integrity and Accountability, ("DHS"), of substantiated abuse by H.Z. of an individual receiving services from the Division of Developmental Disabilities ("DDD") and the placement of his name on the Central Registry of Offenders against Individuals with Developmental Disabilities.

PROCEDURAL HISTORY

Petitioner was employed as a direct support professional ("DSP") by Devereux Advanced Behavioral Health (Devereux") located at 238 Longhouse Drive, Hewitt, New Jersey. Devereux is a residential care center for people with disabilities who need assistance with daily living. P.C. was a resident in one of three buildings at Devereux' s Hewitt, New Jersey facility known as Longhouse #2. P.C. eloped from Longhouse # 2 on February 14, 2022 and suffered injuries while H.Z. and several other Devereux employees were on duty and responsible for maintaining his safety. On or about February 17, 2023 Devereux submitted an incident report documenting allegations of neglect by petitioner as a result of the incident on February 14, 2022. DHS opened an investigation into the matter. The investigation revealed that, based on a preponderance of the evidence obtained; the allegations of neglect resulting in major injury against H.Z. were substantiated. As a result, H. Z.'s name was placed on the Central Registry. H.Z. gave written notice of his intent to appeal on April 27, 2023 and DHS transmitted the matter to the Office of Administrative Law ("OAL") as a contested case, where it was filed on May 5, 2023. Several telephone conferences and case management issues were conducted and addressed prior to the Hearings conducted on, October 20, 2023 and January 23, 2024. The parties were permitted to obtain transcripts and file written summations. The last submission was dated May 15, 2024, at which time the record was closed. The ALJ issued his Initial Decision on November 4, 2024.

FACTUAL DISCUSSION AND FINDINGS OF FACT

H.Z. was hired as a direct support professional ("DSP") at Devereux on or around October 4, 2021. As a DSP, H.Z. was required to provide assistance with activities of daily living to individuals with developmental disabilities at the group home "Longhouse 2," operated by Devereux. Outside of the issue in question, H.Z. has never received any disciplinary action or write-ups against him.

Longhouse 2 is home to four residents. On February 13, 2022, H.Z. reported to work at or around 11:00pm. H.Z. testified he was assigned to provide direct line of view supervision to a resident, A.C., that evening. H.Z. states that he was giving direct aid to A.C. all night with A.C.'s door closed, as A.C. attempts to harm himself and wears hand mitts and helmets that must be replaced every 15 minutes. H.Z. also states that he was instructed that A.C. had eloped weeks earlier and was missing for around 6 hours before he was found that afternoon in the woods. H.Z. testified that he was instructed to give special attention to A.C. because of this history of elopement. H.Z. testified that the staff members who were on duty when A.C. eloped were not relieved of their jobs.

H.Z. testified that another employee, K.A., was working with P.C. the night of February 13, 2022. Among P.C.'s conditions is Pica, a condition in which a person consumes items not considered food. H.Z. testified that he "was not in charge of P.C. at all." P.C. had similar high supervision needs as A.C. H.Z. testified that K.A. brought P.C. into P.C.'s bedroom to go to sleep at approximately 11:00 pm. H.Z. states that he was in A.C.'s room with K.A. from approximately 11:00 pm until approximately 3:00 am. H.Z. testified A.C., the person he was providing direct line of view supervision that night, was having a behavioral episode. H.Z. has provided conflicting statements, however, as to when A.C.'s behavioral episode began. At the hearing, H.Z. testified that at 11:00 pm, A.C. went to the bathroom, and when he returned to his bedroom, he began hitting his head against the wall and destroying the room. H.Z. testified that he helped A.C. with his helmet thereafter and removed it every 15 minutes as he is trained to do. H.Z. then stated that he remained in A.C.'s room for the rest of the evening because A.C. "had the potential of hurting himself at any time. You can't determine when he acts . . . [if you

are not with him] there will be blood and when there is blood you have to do a lot of things." H.Z. said another DSP, C.O., came in to help around 11:40 or 12:00, but she left soon thereafter to continue doing laundry. H.Z. states that K.A. came into the room where he was with A.C. at approximately 1:00 am or 2:00 am to help. H.Z. testified that K.A. was only there for a few minutes and then left to use the bathroom. In the incident report, however, H.Z. stated that at approximately 1:30 am while A.C. was engaged in his behavioral episode, K.A. left P.C. unattended in his room and came to assist H.Z. with A.C. from approximately 1:30 am until 3:00 am. H.Z. stated that during this time, neither he nor K.A. checked in on P.C. H.Z. stated that he asked K.A. about P.C., and K.A. responded that he was asleep. H.Z. stated in the incident report and in his testimony that he did not tell K.A. to go back to P.C.'s room or to get help from another staff member.

Lauren Koval, the Quality Assurance Coordinator of the Office of Program Integrity and Accountability under the Department of Human Services, provided testimony as to her investigation and determination that H.Z. should be placed onto the Central Registry. She stated that if A.C. was really having a behavioral incident for that many hours, 9-1-1 would be called. She also states that when the responding officer arrived, A.C. was asleep, and if he was really having a behavioral episode, it seems unlikely that he would be able to fall asleep just when the responding officer arrived. Koval testified that whether A.C. was having a behavioral episode was "very unlikely because if a client was having that loud of a behavioral incident every other client in the house would've been awake, all the lights would've been on in the house. If the client was having a behavioral incident like that 911 should be called for his safety, as well as H.Z.'s safety."

Tammy McLean, a behavioral specialist at Devereux, also provided testimony. She indicated that she has formerly held the title of program manager ("PM") and managed Longhouse #2 for some time. She did not manage Longhouse 2 on the night in question; however, she has led some of the staff trainings. She testified that she probably trained H.Z. in early 2021, but could not remember. H.Z. testified he did not join until October 4, 2021, so he would not have been trained in early 2021 by McLean. McLean says that she should have trained H.Z. on each house member's specific profile, going over things like their level of supervision, medication, diet, finance, and their goals for the year. With regards to whether, A.C. was having a violent episode this evening, McLean testified that "with like a violent behavior we always tell the staff if they're doing like head banging being like really aggressive you're always supposed to call 9-1-1. Like that's our main thing. You always call 9-1-1 if you can't control it. You always call 9-1-1."

P.C.'s current level of supervision on the evening in question was direct line of sight at all times. However, the record is conflicted on this. He is described as a "one on one client," and must have "an assigned staff" who will "actually physically watch him all night long. However, there is nothing in the behavior plan that P.C. must be watched 24 hours a day, other than that he is listed at "Level 3 Supervision," at least for State funding purposes. (See Oct. 10, 2023, Transcript at 89, lines 20, 22, at 90, lines 20-21.) Further, in direct contradiction to H.Z.'s testimony that he had been assigned to A.C. that evening, Koval testified that no staff member was ever "assigned any client at any specific time." (See Oct. 10, 2023, Transcript at 109, lines 22-24.) Koval also testifies that P.C.'s supervision wouldn't only be the lead DSP's responsibility either. Koval states that "it was the responsibility of all the staff in the home." (See Oct. 10, 2023, Transcript at 113, lines 8-10.)

McLean has worked with P.C. before and is aware of his supervisory needs. McLean testified that P.C. "is an eloper. So he was every 15-minute check. In his bedroom, in the bathroom, in the common area he should have been in visual field." (Jan. 23, 2024, Transcript at 14. lines 11-13.) She states that "he has to be in your line of sight. Like you have to know

where he is at all times." (Jan. 23, 2024, Transcript at 14, lines 15- 16.) When asked "is this just one staff member that's responsible for [keeping P.C. in the visual field] or do you switch off or how does that work?", McLean responded "I'm not sure how Longhouse − how that manager would run their house, but all the staff should have been accountable for [P.C.]." (See Jan. 23, 2024, Transcript at 14, lines 19-24.) McLean was not the manager of the house at the time of the incident, instead it was someone named Katherine.

When asked on the night in question, K.A. stated that he did not know P.C.'s supervision needs. K.A. stated that he believed that once P.C. was asleep, he "could leave him alone." K.A. states that on other overnight shifts he would work, the staff would not sit in the room with P.C., rather "they would just complete 15, to 20-minute checks on P.C. while he was sleeping." (Ibid.)

Jesica Okoto, another DSP who worked at Longhouse 2, testified "nobody was ever assigned one on one to any client in the house." Okoto testified that it is more like every staff member watching every client, and whichever staff member sees a negative behavior from a client will go and respond to that client. (Jan. 23, 2024, Transcript at 86, 22-25.)

Later that night, on February 14, 2022, P.C. eloped from the residence. P.C. was last seen in his bedroom around 1:30 am. P.C. was found by West Milford Police Department ("WMTPD") around 2:50 am, at Utopia Deli−over three miles from Longhouse. P.C. sustained injuries, including frostbite on his feet. On the date in question, it was 9 degrees Fahrenheit outside, and P.C. wore only a green sweatshirt, boxer briefs, and no shoes. P.C. went to the hospital thereafter, where he was evaluated for cold exposure. P.C. was diagnosed with a closed head injury with periorbital ecchymosis of the left eye. He was discharged at approximately 9:30 am on February 14, 2022, and was returned to his group home by staff. P.C. was hospitalized due to the severity of the frostbite on his feet on February 16, 2022.

Officer **Suzanne Novakowski** of WMTPD was the responding police officer. At approximately 2:51 am on February 14, 2022, she arrived at Longhouse 2, having to knock several times on the door and look through the window. She was able to observe the front of the house, but not the back. Novakowski testified that she "did not see any lights on in the residence whatsoever and the living room area, and the staircase, and P.C.'s room were all in the front of the house." Novakowski observed that the upstairs living area was completely quiet, and several chairs were positioned at the top of the stairs, "consistent with being used to block the stairway," with one moved to make a passageway. Novakowski testified that workers in group homes shouldn't have to block exit paths, as they are supposed to be awake, and be alert, and paying attention and doing rounds all the time, so it wouldn't be necessary to have them there. H.Z. states that there were no chairs positioned at the top of the stairs; rather, there were laundry baskets that C.O. placed there. H.Z. states that he had to move the baskets to go downstairs. Novakowski stated that H.Z. responded to the front door after she had waited "at least ten to fifteen minutes," somewhat disoriented "and consistent with possibly just waking up." Novakowski testified that while at the house, she observed a bunched-up blanket and the mattress on the floor with another blanket in the living room, which was the room that H.Z. and K.A. came from and H.Z. told Novakowski that he believed P.C. likely eloped through a window in his bedroom; however, Novakowski believes that P.C. had to have gone down the stairs.

The Department of Human Services ("DHS") investigated the incident, conducting interviews of the three employees who were staffed the night in question, H.Z., K.A., and C.O. DHS independently sustained the allegations of neglect against all three staff members, and all three were placed on the Central Registry. On or around February 15, 2022, H.Z.'s

employment was suspended pending the outcome of the investigation. On the investigation report dated November 14, 2022, C.O., H.Z., and K.A. were all found to have substantiated charges of neglect. This report does not differentiate between the actions of each of these employees, only that "[C.O.], [H.Z.], and [K.A.] did not maintain direct line of sight supervision of [P.C.]," (R-2.)

Koval stated that the severity of the event is why H.Z. should be placed on the Central Registry, highlighting the distance P.C. travelled, the amount of time P.C. was gone, the fact that no one realized he was gone, and the fact that no one went looking for him. She also testified that "if [P.C.] was maybe found ten minutes later on the same street as the group home the case maybe would've been substantiated, but it would not have been to the level of Central Registry."

LEGAL DISCUSSION

It is within "the public interest for the State to provide for the protection of individuals with developmental disabilities." N.J.S.A. 30:6D-73(a). The Central Registry of Offenders Against Individuals with Developmental Disabilities of the Department of Human Services (hereinafter "Central Registry") became effective on October 27, 2010, with the intention of preventing caregivers[1] who become offenders against individuals with developmental disabilities from working with individuals with developmental disabilities. N.J.S.A. 30:6D-73(d). This act was enacted with "the intent . . . to assure that the lives of innocent individuals with developmental disabilities are immediately safeguarded from further injury and possible death and that the legal rights of such persons are fully protected." N.J.S.A. 30:6D-73(c). A caregiver may be placed on the Central Registry in cases of substantiated abuse, neglect or exploitation. N.J.S.A. 30:6D-77(b). Thus, before considering whether H.Z. was appropriately placed on the Central Registry, it must first be considered whether there was a substantiated act of neglect. The burden is on DHS to establish, by a preponderance of the evidence, that petitioner's actions constituted neglect, requiring listing his name on the central registry.[2]

I. Neglect

If a caregiver of an individual with a developmental disability takes any of the following acts, a charge of "neglect" may be substantiated against them: "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. In this case, the **ALJ FOUND** that DHS has established that all staff were responsible for the safety of all of the residents on February 14, 2022. H.Z. knew that P.C. required direct supervision at all times, that P.C. had multiple medical conditions, including pica, and leaving him alone could lead to substantial harm. H.Z. knew that K.A. left P.C. alone for over an hour while K.A. assisted H.Z. with A.C. H.Z. asked K.A. about P.C. but did nothing to provide sufficient care to P.C. when H.Z. learned that P.C.

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[1] A "caregiver" is defined in N.J.A.C. 10:44D-1.2 as "a person who receives State funding, directly or indirectly, in whole or in part, or who volunteers to provide services or supports, or both, to an individual with a developmental disability."

N.J.S.A. 30:6D-77(b); N.J.A.C. 10:44D-3.2;

[2] See, Atkinson v. Parsekian, 37 N.J. 143, 149 (1962); and Cumberland Farms, 218 N.J. Super. 331, 341 (App. Div. 1987)

was not being supervised. Accordingly, the **ALJ FOUND** that H.Z. failed to do an act necessary for the well-being of an individual with a developmental disability. As such, the **ALJ CONCLUDED** that DHS has met its burden, by a preponderance of the evidence, that H.Z.'s finding of substantiated neglect was proper.

In his written summation, H.Z.'s counsel argues, in part, that H.Z. should not be placed on the Central Registry due to tort concepts of contributory negligence. I find this argument unpersuasive because the concepts of neglect and negligence are not the same. While there was some testimony presented that would indicate Devereux may have been negligent in failing to provide proper levels of staffing, alarm systems, cameras, or gates to prevent eloping such negligence does not negate or reduce the statutory obligation of H.Z. as a caregiver to P.C. to ensure his well-being. In fact, it would seem more appropriate to impose a higher standard of care on a caregiver who is operating in an environment which lacks these additional safeguards. In A.W. v. Dep't. of Human Services (OAL DKT. NO.: HSL 12944-19), the attorneys argued similar concepts of mitigating factors. There, the attorneys argued the caregiver should not be found to have neglected the resident, since the facility was short staffed, and he was not properly trained to care for the residents. Even still, the ALJ determined that the petitioner had neglected the resident and affirmed his placement on the Central Registry. No case law or statutory authority has been presented to support a finding that mitigating factors, facility shortfalls, or concepts of contributory negligence apply to a determination of neglect. Thus, H.Z. cannot rely on these arguments to mitigate the determination as to whether he has committed an act of neglect towards P.C.

II. Whether H.Z. was Properly Placed on the Central Registry

Once an act has been substantiated as neglect, it may or may not amount to placement on the Central Registry. "In the case of a substantiated incident of neglect it shall be determined if the caregiver acted with gross negligence, reckless, or evidences a pattern of behavior that caused harm to an individual with a developmental disability or placed that individual in harm's way. N.J.A.C. 10:44D-4.1(c). As there is only a single instance at hand, there has been no "pattern of behavior that caused harm to an individual." "Acting with gross negligence is a conscious, voluntary act or omission in reckless disregard of a duty and the consequence to another party." N.J.A.C. 10:44D- 4.1(c)(1).

The testimony offered by H.Z. that he provided line of sight supervision to A.C. during the relevant time period and therefore could not have provided that same level of supervision to P.C. seems, on its face, to have some merit. It would clearly be impossible for H.Z. to be in P.C.'s bedroom and A.C.'s bedroom at the same time. However, setting aside the specific duty that H.Z. had to provide line of sight supervision to A.C., H.Z. also had a general duty to care for the well-being of all the residents of Longhouse #2. This general duty of care was described by Ms. Koval when she testified that no staff member was ever assigned to any client at any specific time and that P.C.'s supervision was the responsibility of all staff at the nursing home.

In the incident report, H.Z. stated that at approximately 1:30 am while A.C. was engaged in his behavioral episode, K.A. left P.C. unattended in his room and came to assist H.Z. with A.C. from approximately 1:30 am until 3:00 am. Assuming his statement was true, H.Z. knew that P.C. was left alone for at least 1.5 hours without any supervision, yet he did nothing to make certain either K.A. or the other DSP (C.O.) who had been doing laundry, was checking on P.C. His failure to do so was clearly intentional because he asked K.A. about P.C., and K.A. responded that he was asleep. H.Z. stated in the incident report and in his testimony that he did not tell K.A. to go back to P.C.'s room or to get help from another staff member. The **ALJ FOUND** that H.Z.'s general duty to care for the well-being of all residents required

him at the very least to instruct K.A. or C.O. to stay with P.C**.** The **ALJ FOUND** that his failure to do so was a knowing and voluntary act in reckless disregard of his duty and resulting consequences to P.C. H.Z. knew of P.C.'s serious conditions and high needs and left him alone despite knowing this. The **ALJ** therefore **CONCLUDED** that the placement of H.Z.'s name on the Central Registry was appropriate.

ALJ'S ORDER

For the reasons set forth above, **IT WAS ORDERED** that petitioner's appeal was **DENIED**.

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 this recommended decision was mailed to the parties, any party may file written exceptions with the **ADMINISTRATIVE HEARINGS COORDINATOR**, in the Office of Program Integrity and Accountability**.**

FINAL AGENCY DECISION

Exceptions:

No exceptions were filed by either party.

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 (including exhibits, transcripts, and written summations from both parties); 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 the ALJ's opinions concerning these matters, based upon the reasoned observations, as extensively described in the Initial Decision. **I CONCLUDE and AFFIRM** that H.Z. failed to maintain line-of-sight supervision of P.C., knowing full well that if left unsupervised, P.C. would engage in harmful behaviors. H.Z. was correctly found to have been substantiated of neglect, as defined in N.J.A.C. 10:44D-1.2. H.Z.'s inadequate provision care for the well-being of the group home residents was neglect, pursuant to the Central Registry regulations. **I CONCLUDE and AFFIRM** that H.Z. acted intentionally in failing to maintain line-of-sight supervision, knowing full well that if left unsupervised, P.C. would engage in harmful behaviors. H.Z.'s failure to supervise all of the home's residents was a knowing and voluntary act in reckless disregard of his duty and resulted in consequences to P.C. I **CONCLUDE and AFFIRM** that H.Z.'s actions were intentional, reckless, and constituted neglect and mistreatment of P.C.

I **CONCLUDE and AFFIRM** that DHS has sustained its burden of proving, by a preponderance of the credible evidence, that the actions of H.Z. rose to the level of neglect as defined in N.J.A.C. 10:44D-1.2. I **CONCLUDE and AFFIRM** that H.Z. acted with careless disregard for the well-being of P.C. and the other residents of the group home; thereby, justifying

that H.Z.'s name 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 H.Z.'s name on the Central Registry of Offenders against Individuals with Developmental Disabilities.

Date: __12/10/2024_____ Deborah Robinson

Deborah Robinson, Director
Office of Program Integrity and Accountability