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State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Office of Program Integrity and Accountability
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SARAH ADELMAN
Commissioner

DEBORAH ROBINSON
Director

FINAL AGENCY DECISION CONSOLIDATED

A.E.,

Petitioner,

v.

DEPARTMENT OF HUMAN SERVICES,

Respondent.

OAL DKT. NO. HSL 10951-20

AGENCY DKT. NO. DAR# 20-014

H.D.,

Petitioner,

v.

DEPARTMENT OF HUMAN SERVICES,

Respondent.

OAL DKT. NO. HSL 11249-20

AGENCY DKT. NO. DAR# 20-015

D.B.,

Petitioner,

v.

DEPARTMENT OF HUMAN SERVICES,

Respondent.

OAL DKT. NO. HSL 05318-21

AGENCY DKT. NO. DAR# 21-010

William A. Nash, Esq., for petitioners/appellants A.E. and H.D. (Nash Law Firm, LLC, attorneys)

Scott Fegley, Esq., for petitioner D.B. (The Fegley Law Firm, attorneys)

Caroline Gargione, Deputy Attorney General, for respondent Department of Human Services (Matthew J. Platkin, Attorney General of New Jersey, attorney)

Gary W. Baldwin, Deputy Attorney General, for respondent Department of Health, Trenton Psychiatric Hospital (Matthew J. Platkin, Attorney General of New Jersey, attorney)

Record Closed: April 10, 2025 Decided: August 25, 2025

BEFORE KIMBERLEY M. WILSON, ALJ:

INITIAL DECISION

STATEMENT OF THE CASE

Petitioners A.E. and H.D., former employees of respondent Trenton Psychiatric Hospital (TPH), appeal from respondent Department of Human Services' (DHS) determination that their names would be placed on the Central Registry of Offenders Against Individuals with Developmental Disabilities (Central Registry) for abuse stemming from a May 31, 2020, incident involving a TPH resident. Petitioner D.B., also an employee of TPH, appeals from a DHS determination that her name would be placed on the Central Registry for neglect regarding the May 31, 2020, incident, and she challenges this determination.

On May 31, 2020, I.O., a patient at TPH, called the Patient Services Compliance Unit at TPH to report an allegation of physical abuse on behalf of R.V.R. (See R-2 at DOH 027). I.O. reported that H.D. and A.E. physically attacked R.V.R., another TPH patient who only speaks Spanish, because H.D. and A.E. did not want R.V.R. to eat yogurt. (Ibid.) A.E. knocked the yogurt out of R.V.R.'s hand and threw him against a wall. (Ibid.) According to I.O., H.D. threatened to slap R.V.R. if R.V.R. spit on him. (Ibid.) Both H.D. and A.E. yelled at R.V.R. (Ibid.)

I.O. also alleged that H.D. grabbed R.V.R. by the neck, choking him. A.E. grabbed R.V.R. and took him to the bathroom, where both A.E. and H.D. hit him. (Ibid.) I.O. alleged that D.B. watched A.E. and H.D. hit R.V.R. in the bathroom but did not intervene or allow R.V.R. to call the police. (Ibid.) R.V.R. went to the emergency room on June 2, 2020, after he complained of right-side shoulder pain and rib cage tenderness. (Ibid.)

PROCEDURAL HISTORY

A DOH investigation substantiated that on May 31, 2020, A.E. and H.D. abused patient R.V.R. The Investigation also substantiated that D.B. neglected patient R.V.R. Thereafter, A.E., H.D. and D.B. were placed on the Central Registry. As a result, H.D. and A.E. were terminated from employment and D.B. was suspended from TPH for forty-five (45) days.

Petitioners appealed their placement on the Central Registry and removals to the Office of Administrative Law (OAL) as contested cases. By way of Order dated February 16, 2023, those disciplinary matters were consolidated with the Central Registry matters having the predominant interest. There were eight days of testimony: October 18, 2023, October 30, 2023, July 10, 2024, July 25, 2024, July 31, 2024, November 25, 2024, December 4, 2024, and December 11, 2024. Fifty-four (54) exhibits were entered into evidence. Respondents presented testimony from five witnesses while the Petitioners testified on behalf of themselves and presented one additional witness. Respondents and Petitioners filed their respective closing briefs and the record closed on April 10, 2025.

On August 25, 2025, Administrative Law Judge (ALJ) Kimberley M. Wilson issued an Initial Decision (ID or Decision) which found that there was no evidence in the record that either A.E. or H.D. abused R.V.R. on May 31, 2020. See ALJ ID at 44. Moreover, the ALJ further found that there was no evidence that D.B. neglected R.V.R. on May 31, 2020. See id. at 46. As such, the ALJ Concluded that A.E., H.D., and D.B.'s names should not be on the Central registry. See id. at 46-47.

On October 25, 2025, the DAG filed and submitted on behalf of Respondent DHS a Brief of Exceptions to the Initial Decision. On Novemebr 7, 2025 the OAL granted a formal Order of Extension for Appellants' Responses to November 17, 2025 and the deadline for Respndent DHS to file its' Final Agency Decision to January, 8, 2026. Appellants filed and submitted their respective Responses to Exceptions on November 17, 2025.

INITIAL DECISION'S JOINT STIPULATION FACTUAL FINDINGS

Pursuant to the parties' joint stipulation of facts (see J-30 dated October 6, 2023), the Administrative Law Judge (ALJ) found that the following facts are not in dispute. A.E. was hired by the New Jersey Department of Health (DOH) on October 11, 2018. H.D. was hired by the DOH on

August 6, 2006. On May 31, 2020, A.E. was employed as an HST, and H.D. was employed as an HSA. A.E. and H.D. do not have any prior disciplinary history. On May 31, 2020, A.E. and H.D. were working at TPH, Lincoln Building, King Unit. The incident in question occurred during the height of the COVID-19 pandemic while the lockdown was still in effect. A.E. and H.D. were suspended with pay on October 7, 2020, and September 3, 2020, respectively. A.E. and H.D. were suspended without pay on January 8, 2021.

The **ALJ ALSO FOUND AS ADDITIONAL FACTS THAT**:

TPH's Policy & Procedure number 1.901 addresses patient abuse and neglect (patient abuse and neglect policy). (J-8.) Under the patient abuse and neglect policy, physical abuse is defined as "a physical act directed at a patient by an employee, volunteer, intern or consultant/contractor of a type that can tend to cause pain, injury, anguish and/or suffering. Such acts include, but are not limited to, the patient being kicked, pinched, bitten, punched, slapped, hit, pushed, dragged, and/or struck with a thrown or held object." (Ibid.)

The patient abuse and neglect policy defines neglect as "the failure of a caregiver (person responsible for the patient's welfare) to provide the needed services and supports to ensure health, safety, and welfare of the patient. These supports and services may or may not be defined in the patient's plan or otherwise required by law or regulation. This includes acts that are intentional, unintentional, or careless, regardless of the incidence of harm. Examples include, but are not limited to, the failure to provide needed care such as shelter, food, clothing, personal hygiene, medical care and protection from health, leaving a patient who requires supervision unattended, allowing a patient access to harmful substances, and failing to observe appropriate safety precautions." (Ibid.)

Under the patient abuse and neglect policy, a staff person who has reasonable cause to suspect or believe that a patient has been or is being abused by any employee or any other person must report that incident to certain individuals at TPH, including the Patient Services Compliance Unit (PSCU).[3] (Ibid.)

Disciplinary action may result from failing to report knowledge or suspicion of patient abuse, failing to provide a written statement by the end of the shift when the incident occurred or is discovered, providing deliberately false and/or misleading statements to officials investigating an allegation of patient abuse, and failing and/or refusing to cooperate or provide truthful answers during an investigation. (Ibid.)

TPH Policy & Procedure number 2.604 addresses restraints (restraint policy). The restraint policy states that "[TPH] does not use restraint as a means of coercion, discipline, convenience or retaliation. [TPH] does not use restraint to prevent property damage or in response to verbal threats of violence, but only as [a] last resort to prevent imminent physical danger to persons (self or others). When all other measures have failed, restraint may be used when an individual in treatment initiates a strike, grab, choke, hair pull, bite or other dangerous physical assault towards another person." (J-10 at DOH 091.)

The restraint policy states the following regarding physical holds: "Physical holds are used only in an emergent situation to prevent aggressive and/or destructive behavior towards self or others. All physical holds are considered restraints. When an individual initiates a strike, grab, choke, hair pull, bite, etc. to an employee . . . , staff must respond immediately with an approved physical hold learned in crisis training. Physical holds are to be limited to three minutes unless the physician or RN deems a longer time necessary. If a physical hold is used, a second staff person is required to observe the individual." (Id. at DOH 097–DOH 098.)

For reporting, the restraint policy provides the following: "If a physical hold occurs, but the individual is not subsequently placed in mechanical restraints, completion of the Restraint Monitoring form is not necessary. All other requirements of the restraint process are necessary, including completion of a Nursing Restraint Progress Note and a Prescriber Progress Note that includes the incident and the use of the hold. Debriefing is also still required." (Id. at DOH 098.)

Robert Girard (Girard), Quality Assurance Coordinator at Ann Klein Forensic Center and on May 31, 2020, the DHS's Office of Investigations (OI) Investigator, Quality Assurance Specialist, prepared an investigation report dated July 13, 2020, regarding the May 31, 2020, allegations. (R-2.)

ALJ's SUMMARY OF RELEVANT TESTIMONY, CREDIBILITY DETERMINATIONS AND FURTHER FINDINGS OF FACT

Video surveillance footage of the May 31, 2020, incident

There were five stationary cameras that produced video surveillance footage of the incident without any audio. (See Initial Decision pages 13-14). This video surveillance footage is time stamped from 11:10:10 to 11:57:17 am on the date of the incident. The ALJ created a narrative

summary of all the alleged actions and information captured on this silent video surveillance footage by exclusively using the testimony of the three petitioners. (See Initial Decision 14-23). The ALJ then found this narrative summary to be FACT.

ALJ Summaries of Testimony And Further Findings of Fact

ALJ Summary of Eugene Colvin Testimony (Director of Medical Security at Ancora)

Colvin is a master instructor of the Therapeutic Options training system, a system to prevent individuals from being aggressive and violent and to keep others safe when an individual does become aggressive. As a master instructor, Colvin can train other trainers and end-users of the system. HSTs and HSAs receive Therapeutic Options training as part of their new employee orientation, and there should be annual training as well.

Colvin has worked with R.V.R. and described him as a more challenging patient with a reputation within TPH for being explosive. R.V.R. also has a language barrier. When Colvin worked at TPH, he was part of the Special Instructor Services Unit that would provide a rapid response when a patient became aggressive with staff. Colvin was dispatched to address issues with R.V.R. when he was violent. R.V.R. has a history of assaulting staff and other patients.

According to Colvin, it is appropriate to use force on a patient when the patient is doing something to harm themselves or others, such as hitting their head against a wall or trying to hit someone. A physical hold is used to control a person. If a patient punched a direct care staff member, a physical hold needed to be applied. He does not train staff to wait until a patient hits them before initiating that physical hold. It is common for patients to drop to the floor to avoid being placed in a restraint, and R.V.R. was one of the patients who would resist. (See ALJ ID at 24). Based on this summary of Colvin's testimony, the ALJ found as Fact that "Colvin does not train staff to wait until a patient has hit them before initiating a physical hold" (See ALJ ID at 38).

The ALJ further summarized Colvin's testimony as follows. There are three types of body holds. The body control restraint is used most of the time and looks like a bear hug; its goal is to force the patient to hold their arms close to them to prevent the patient from punching or kicking someone. This hold works best from the patient's side or back. He has never seen a patient voluntarily consent to a body control restraint. A one-armed restraint is a more skilled position from the patient's back, where the staff member controls one of the patient's arms and holds the arm

against them. The final body hold is a structured escort position, which is a two-person hold. In this hold, the staff members stand at the patient's side with hands underneath the patient's armpits. The staff members then walk the patient to the desired area.

The ALJ then Found as Fact that Colvin testified that it is possible that when direct care staff is attempting to place a patient in a physical hold and the patient resists, the direct care staff could wind up placing the patient against a wall. He would not say whether this constitutes abuse. Physical holds are not going to be done perfectly when they are implemented. What happens on the unit is not like his training class. (See ALJ ID at 39).

Colvin testified that HSTs and HSAs are not allowed to strike a patient, which would include trying to remove something from the patient's hand. Colvin did not have a specific technique for removing an item from a patient's hand, but he stated that it would not be appropriate to use a physical hold to accomplish that task. Colvin testified that it would not be appropriate to push a patient against the wall to prevent them from spitting.

Colvin admitted that in the midst of the COVID-19 pandemic, he did not know how to address a patient who was eating food out of a garbage can that could be contaminated with COVID-19 when verbal redirection did not work. In response to the question whether it was unreasonable for staff to grab or strike an object out of a patient's hand when that item could be a source of COVID-19, Colvin testified:

> If you feel that, you know, physical skills is used for [imminent] danger to self and others, you know, you would have to stand on your judgment that you felt that this person, if I allow them to do [t]his action that it would more than likely lead to physical harm and then you stay on that judgment. But you're taking, you know, you got to—you got to weigh everything out, you know, any action that you take you want that action to cause less damage than the consequence of not carrying out that action at all, you know.
>
> [T3, 137:14–23.]

For the annual Therapeutic Options trainings, which are done in a classroom setting, Colvin testified as follows regarding how closely the trainings resemble what happens on the floor with actual patients:

> You can't—you can't recreate what happens on the floor. Like I said earlier, there's—there's an infinite amount of variables, so, you give guidelines and you, you know, people you trust, people that are

> going to connect the dots, you know, there's— there's, you know, there's so many different scenarios and you've got to go at training speed, you know, go into training speed.
> [T3, 128:10-17.]

Colvin testified that he does not expect his trainees to be proficient in all of the different skills that he teaches during his trainings. During his testimony, Colvin did not review the video surveillance footage (R-27) of the May 31, 2020 incident. He also provided no testimony regarding whether A.E. or H.D. responded properly with approved physical holds on May 31, 2020. (See ID at p.26).

ALJ Summary of Ogechi Ikpeama Testimony (Training Coordinator at TPH)

Ikpeama noted that in TPH's 2016 Safety Fair packet for employees, the station regarding restraints specifically advised employees that "[p]hysical holds are used only in an emergent situation to prevent aggressive and/or destructive behavior towards self or others. When an individual initiates a strike, grab, choke, hair pull, bite, throw, etc. to an employee, patient, visitor or self, staff must respond immediately with an approved physical hold learned in crisis training." (R-22 at DOH 347.) TPH's 2019 Safety Fair packet for employees includes the same language for the station on restraints. (R-24 at DOH 458.)

ALJ Summary of QAC Robert Girard Testimony Re: His DOH Investigation Report of the May 31, 2020, incident

Girard reviewed witness statements from A.E., H.D., and D.B., emergency room discharge paperwork from Capital Health Regional Medical System (Capital Health), TPH records, and video of the incident for the investigation. Girard interviewed I.O., R.V.R., staff members named G.S. and C.K., A.E., H.D., and D.B. He did not inquire as to whether the King Unit was fully staffed on May 31, 2020. After completing his investigation, he completed a DOH Investigation Report. (R-2.)

During his investigation, Girard did not take statements from all of the eyewitnesses to the May 31, 2020, incident, some of whom were service recipients. Girard acknowledged that there were other witnesses that he could have interviewed for the investigation, including the two TPH patients who were standing in the hall outside of the bathroom when A.E. and H.D. were in the bathroom with R.V.R. as he washed his hands.

Girard's interview of R.V.R. for this investigation was completed through Microsoft Teams. (R-2 at DOH 043–044.) Before interviewing R.V.R., Girard did not assess or inquire into R.V.R.'s capacity for honesty. Because R.V.R. is Spanish-speaking, TPH provided an interpreter for R.V.R.'s interview. The individual serving as the interpreter was not a certified interpreter; she works for TPH as a mental health specialist.

Girard's interview with A.E. regarding the May 31, 2020, incident was conducted over the telephone. A.E. told him that R.V.R. became upset when A.E. took the yogurt away from R.V.R. and began spitting at A.E. A.E. became aware that R.V.R. should not use the telephone because he was too agitated. Girard stated that A.E. was not provided a copy of his interview statement to confirm that no details were missed. It is not TPH policy to provide copies of the interview statement.

Girard's interview with H.D. regarding the May 31, 2020, incident was conducted on June 18, 2020, by telephone, not in person as the investigation report indicates. (R-2 at DOH 050.) H.D. failed to mention the portion of his encounter with R.V.R. near the pay phones. H.D. told Girard that neither he nor A.E. put their hands on R.V.R. During Girard's interview of H.D., H.D. told him that R.V.R. punched and spit on him. D.B. told him to prevent R.V.R. from using the pay phone. H.D. did not see a copy of Girard's investigation report until after he requested a fair hearing.

Girard conducted his interview of D.B. regarding the May 31, 2020, incident, over the telephone. Girard did not give D.B. the opportunity to review his interview summary or synopsis and correct any information that she believed was inaccurate. Girard asked D.B. why she wrote a progress note about R.V.R.'s medical condition two days after the event, and D.B. could not provide him with an answer.

One of the witnesses to the May 31, 2020, incident, G.S., advised Girard that she did not hear D.B. telling H.D. or A.E. to prevent R.V.R. from using the pay phone. (R-2 at DOH 045). G.S. also did not have a good view of the physical actions that H.D. or A.E. used while engaging with R.V.R. (Ibid.)

The day after the incident, June 1, 2020, others examined R.V.R. and did not find any bruising or marks on him. On June 2, 2020, R.V.R. was seen at Capital Health's emergency room. (R-7.) The document that Girard reviewed from Capital Health did not include any examination

findings. The three diagnoses were assault, other bodily force; contusion thorax unspecified; and injury head, unspecified. (Ibid.) Girard acknowledged that there was no information from Capital Health that there were any bruises or marks on R.V.R. In his investigation, Girard noted that R.V.R.'s discharge summary from Capital Health diagnosed R.V.R. with a thorax contusion.[5] (R-7.) Girard could not tell from the video surveillance footage of the incident when this contusion occurred.

Girard acknowledged that R.V.R. could have called 911 that evening after staff left or the following day. R.V.R. was not prevented from calling 911 simply by redirecting him away from the telephone at that specific time. He also acknowledged that the restraint policy requires staff to immediately place a patient in a controlled physical hold when the patient kicks, pushes, or punches someone.

Girard concluded that A.E. and H.D. placed R.V.R. in a physical hold against a wall around 11:36 a.m. R.V.R. was escorted to the bathroom, and when R.V.R. left the bathroom, he walked to the pay phone area. H.D. and A.E. followed R.V.R. into the pay phone area and pushed R.V.R. away from the phone. R.V.R. attempted to assault H.D. and A.E., and H.D. and A.E. placed R.V.R. in a physical hold. D.B. walked into the pay phone area and stood in the doorway. R.V.R. ended up on the floor with A.E. and H.D. standing around him. Eventually, R.V.R. got up and sat down on an adjacent bench, holding the left side of his head. R.V.R. left the pay phone room with A.E. and H.D., and R.V.R. sat in the dayroom, still holding the left side of his head. D.B. walked out onto the unit and met with R.V.R., with D.B. appearing to evaluate R.V.R. This account partially corroborated R.V.R.'s account of the incident. Girard testified that it is common for TPH patients to spit, act out, and act aggressively towards staff. He noted that during the COVID-19 pandemic, it would not be good for someone to eat food discarded in the garbage. Girard was not aware of any TPH policies for treating a patient with a communicable disease differently. Girard knew that there was not a lot of information available about COVID-19 and its effects on the date of the incident, except for that the disease could be deadly.

ALJ Summary of OI Director Edward Tobin

Tobin testified that there is an internal review process for completed investigations where the allegations are substantiated. As the Director of OI, he provides a final review of the investigation report to ensure that the elements of abuse and/or neglect are satisfied. Tobin did not testify as to his

final review of this particular OI investigation. From a review of the investigation report from the May 31, 2020, incident, Tobin did not review and approve it. (R-2 at DOH 067)

ALJ Summary of Petitioner H.D. Testimony

H.D. obtained his medical degree in Haiti. He began working at another New Jersey psychiatric hospital in 2005 and was transferred to TPH in 2015. He was promoted from an HSA to an HST in 2008. According to H.D., R.V.R. only speaks Spanish, and when he tries to explain something to someone in Spanish and people cannot understand him, R.V.R. becomes very agitated. When you try to stop R.V.R. from doing something he also becomes agitated and violent. Those behaviors manifest in punching, spitting, and yelling.

During the COVID-19 pandemic, H.D.'s work changed. During the pandemic, patients did not go to the cafeteria to eat; their meals were brought to and served on the unit. TPH employees were not trained on how to deal with the pandemic, so they used their common sense. He wore a mask when he worked because he understood that COVID-19 could be spread by spittle. The King Unit was short-staffed during the pandemic. Everyone working at TPH was stressed out because they were working with patients who had contracted COVID-19 and they were concerned about contracting the virus and/or spreading it to their families. Staff had to come to work in order to survive. During the pandemic, H.D. requested vacation time off, and the request was denied. They were forced to work thirty-two to forty hours of overtime each week.

On May 31, 2020, H.D. was serving food in the King Unit, and he was wearing a face mask and protective shield to protect against COVID-19. H.D. heard a noise. Because staff has to intervene when there is an issue, he rushed to the other dayroom on the unit and saw R.V.R., fighting. R.V.R. wanted a yogurt that he took out of the trash. There were concerns about R.V.R.'s safety if he were to eat something from the trash, including potential COVID-19 infection and whether R.V.R. would vomit the food. When R.V.R. eats excess food, he vomits it, and staff tries to avoid allowing R.V.R. to eat excess food. Another patient grabbed the yogurt, and when R.V.R. approached the patient, the patient threw the yogurt to H.D. R.V.R. approached H.D. and tried to take the yogurt from H.D. H.D. spoke to R.V.R. in Spanish, explaining to R.V.R. that he could not have the yogurt and attempting verbal redirection. R.V.R. punched H.D. in the stomach. H.D. tried to restrain R.V.R. in the manner that H.D. was trained, but H.D. was not able because R.V.R. was resisting.

D.B. then directed H.D. to take R.V.R. to the bathroom because R.V.R.'s hands were in the trash can. A.E. and H.D. took R.V.R. to the bathroom, and there was no one else in the bathroom but the three of them. In the bathroom, R.V.R. was upset because he had to wash his hands. When he was done, R.V.R. walked to the pay phone area. H.D. heard someone tell them to not allow R.V.R. to use the pay phone, because as part of the de-escalation process, the nurse wanted R.V.R. to sit with her. When he and A.E. tried to prevent R.V.R. from using the pay phone in the phone room, R.V.R. became more agitated than he was before. They told R.V.R. not to use the phone and that he needed to go to the nurse. R.V.R. refused, and he punched them in their stomachs again. When they tried to walk with him, R.V.R. refused to walk and dropped to the floor. When a patient drops to the floor, H.D. leaves the patient alone because the patient is sitting down and causing no harm. H.D. describes this as a defense mechanism because R.V.R. did not want to go with him.

H.D. observed R.V.R. when he dropped to the floor. R.V.R. did not have any injuries, including bumps, bruises, or lacerations. He and A.E. left R.V.R. on the floor, and then they asked him to sit on the floor. R.V.R. walked out of the phone room and went to go sit with the nurse, and they did not interact with R.V.R. after that. After a few minutes, H.D. left the unit to take his break. H.D. denied hitting, slapping, or physically abusing R.V.R. on May 31, 2020. H.D. did not prepare a restraint report or incident report on May 31, 2020, because he was not asked to prepare one. If the charge nurse was not aware of an incident, he would have reported the incident to the charge nurse. According to H.D., this is standard policy.

H.D. prepared a statement about the May 31, 2020, incident the day afterwards but was asked to backdate it. (R-4.) An individual H.D. identified as Ms. Caroline asked him to complete this statement quickly, and he did so. The following day, H.D. was working and was told that he was suspended. The supervisor of nursing asked for H.D.'s key and walked him out. On June 18, 2020, an investigator called H.D., and then an individual named Ms. Yvonne told him to report to work the next day. H.D. went to work on June 19, 2020. Because he had turned in his key on June 1, 2020, H.D. had to go to engineering to get his keys and badge before he

began working. On September 1, 2020, H.D. received a call from Ms. Yvonne advising him that he was suspended and not to report to work the next day.

H.D. was concerned about R.V.R. spitting on him when he was wearing a mask and protective shield because he was concerned about bringing diseases home on his clothing. He was worried about his family and bringing COVID-19 home to them. In May 2020, he did not have a lot of information about COVID-19, but he did know that it was an airborne disease. H.D. was also wearing latex gloves when he was serving lunch but took them off during the incident. When R.V.R. resisted H.D.'s physical hold, he was backing up, and H.D. walked to R.V.R. to apply the physical hold. H.D. did not choke or attempt to choke R.V.R. on May 31, 2020. During his testimony, H.D. recounted several statements in the investigation report attributed to him that were not accurate, including the statement that he never put his hands on R.V.R. in the pay phone area. H.D. testified that when R.V.R. hit A.E., they put R.V.R. in a hold.

ALJ Summary of Petitioner A.E. Testimony

A.E. has a bachelor's degree in banking and finance from a university in Nigeria. He began working for the State at another psychiatric facility as an HSA in 2008 and was transferred to TPH in 2014. A.E. described R.V.R. as violent and easily aggravated for no reason. R.V.R. would attack people at any time, and A.E. described him as intimidating. When R.V.R. is upset, he spits at people and yells. A.E. does not speak Spanish. R.V.R. speaks Spanish and does not speak any English. A.E. agreed that any verbal redirection he may have attempted with R.V.R. may not have been helpful to R.V.R. because R.V.R. does not speak English.

On May 31, 2020, the atmosphere on the unit was intense because of COVID-19. They were short-staffed on the unit, which meant that they had to do more work. A.E. also had to work overtime and had no days off. During that time, he worked about eighty hours per week. He was also concerned that he would contract COVID-19 and bring the virus home to his wife and small children.

A.E. observed R.V.R. asking another patient for food. A.E. stood up, because during the COVID-19 pandemic, patients were not allowed to eat food that others have already touched for fear of contamination or cross-contamination. Food sharing was prohibited. A.E. tried to verbally redirect R.V.R., calmly telling him that it was not hygienic for R.V.R. to eat someone else's food. Once R.V.R. hit H.D. in the stomach, A.E. tried to physically restrain R.V.R. as they were trained to do. D.B. did not instruct A.E. and H.D. to place R.V.R. in a physical hold. D.B. was not aware of what was happening with R.V.R. on May 31, 2020, until after H.D. applied the physical hold on R.V.R. D.B. then told A.E. and H.D. to take R.V.R. to the bathroom so that R.V.R. could wash his hands. While they were in the bathroom with R.V.R., the bathroom door was open the entire time. R.V.R. was calm when he exited the bathroom.

In the pay phone area, when R.V.R. hit A.E. in the face, A.E. then tried to place R.V.R. in a physical hold. R.V.R. did not comply and was resisting their attempts to place him in a physical hold. It is common for patients to drop to the floor to get out of a physical hold, and R.V.R. did that. R.V.R. also held his hand near the left side of his head while he was seated in the pay phone area. According to A.E., this is part of R.V.R.'s behavior. On June 1, 2020, A.E. completed an investigation report regarding the May 31, 2020, incident. (R-3.) A.E. was removed from his position in September 2020. In the video surveillance footage, A.E. was not wearing a mask over his mouth and nose; his mask was under his chin.

A.E. recounted several statements in the investigation report attributed to him that were not accurate, including the statement that D.B. instructed A.E. and H.D. to place R.V.R. in a physical hold to prevent R.V.R. from spitting on staff. (R-2 at DOH 048.) The statement that D.B. instructed him and H.D. to not let R.V.R. use the pay phone also was not true. (Id. at DOH 049.) A.E. told Girard that R.V.R. punched him in the face in the pay phone area, and Girard did not include that information in the report. He said that the statements in the investigation report that neither he nor H.D. placed their hands on R.V.R. in the pay phone area or stopped R.V.R. from using the pay phone were inaccurate because he and H.D. attempted to place R.V.R. in a physical hold after R.V.R. punched A.E.

ALJ Summary of Petitioner D.B. Testimony

D.B. is a registered nurse and has worked at TPH as a charge nurse since July 2008. As a supervisor, D.B. was required to direct care staff, including A.E. and H.D., on the activities on the unit. She testified that TPH did not provide any additional training in early 2020 regarding COVID-19. She said that staff do not need to ask her for permission to place a patient in a physical hold when a patient is combative. Staff can restrain the patient and call her to check the situation. If the patient is in a physical hold, she will call the doctor.

D.B. had contracted COVID-19 twice before May 31, 2020. COVID-19 affected staffing levels because nurses, staff, and patients got sick with COVID-19. On May 31, 2020, the floor was short-staffed. One change to the daily routine was that meals were served on the unit, rather than in the cafeteria. D.B. described this as very difficult, because it was hard to control the patients, who would not follow instructions. There were fewer staff members, making control more difficult. On May 31, 2020, D.B. heard a commotion and came out of the nurse's station. R.V.R. was yelling, physically aggressive, and spitting on staff. H.D. had R.V.R. in a physical hold, and this was the first thing that she saw. D.B. asked staff what was happening.

She did not understand what R.V.R. was saying because he was speaking in Spanish. D.B. instructed staff to escort R.V.R. to the bathroom so that he could wash his hands, and staff complied. D.B. followed H.D., A.E., and R.V.R. into the hallway and stood outside of the bathroom while they were inside. The bathroom door remained open the entire time, and she did not see A.E. or H.D. acting improperly towards R.V.R., including hitting, choking, or slapping R.V.R.

When R.V.R. exited the bathroom, there was nothing about the situation, including H.D.'s physical hold on R.V.R. that she believed was wrong or inappropriate. D.B. then heard a commotion in the pay phone area, where she saw R.V.R. sitting on the floor. She asked H.D. and A.E. what happened, and they told her that R.V.R. was still physically aggressive and spitting. She saw R.V.R. sitting on the floor, and he wasn't doing anything other than screaming and yelling. She told staff to leave R.V.R. alone. She counseled R.V.R. to calm down, and he sat on the bench. She asked R.V.R. to follow her because she had already spoken to the doctor

to obtain medication to calm R.V.R. On May 31, 2020, D.B. examined R.V.R. and did not see any bruising or noticeable marks on him. She also created a progress note in R.V.R.'s chart before the end of her shift about her examination, but that progress note did not include the May 31, 2020, incident. She gave R.V.R. the medication and she asked him in Spanish if he had any pain, using the Spanish word for pain, dolor. R.V.R. responded in the negative. She did not see any signs or obvious injury. From this time until her shift ended at 3:45 p.m. that day, R.V.R. did not tell her that he was injured or hurt.

D.B. recounted complaints that she received about R.V.R. being in the pay phone area. She knows that R.V.R. does not know how to dial the phone, so she was concerned about R.V.R. hanging up the telephone when someone was calling and playing on the telephone. She knew that R.V.R. knew how to answer the phone.

When there is an incident, D.B. is supposed to create an incident report and a progress note in the chart. D.B. did not recall entering a contemporaneous progress note or creating an incident report; she said that there was too much activity on the unit and she was exhausted. She did not have a supervisor coaching her with reminders. D.B. did prepare a progress note on June 2, 2020, indicating it was a late entry from May 31, 2020. (J-7.) Her assistant director of nursing directed her to create this progress note.
D.B. was off on June 1, 2020.

D.B. performed a physical evaluation of R.V.R. when she wrote the incident report on June 2, 2020. The physical evaluation was performed in his room and was not captured on video surveillance. R.V.R. removed his shirt, and she asked him if he had pain in his head and upper chest. R.V.R. responded that he did not.

On September 9, 2020, D.B. received correspondence that her name would be placed on the Central Registry. (J-28.) D.B. testified that she did not instruct H.D. and A.E. to place R.V.R. in a hold to prevent him from spitting on staff and other individuals. She did not give H.D. and A.E. any instructions to prevent R.V.R. from using the pay phone. She also did not witness H.D. and A.E. strike R.V.R., and she did not fail to intervene or report the incident.

For his investigation, Girard called D.B. while she was working to take her statement. D.B. noted inaccuracies in the investigation report, including that she was not in the medication room performing nursing tasks when patients were being served lunch on May 31, 2020. She said that Girard did not ask her why she did not complete an incident report and physical hold/restraint documentation on May 31, 2020. She did not see H.D. or A.E. choke, hit, or physically abuse R.V.R. in the bathroom.

ALJ Credibility Findings of Testifying Witnesses

The ALJ then weighed the credibility of the testifying witnesses to determine the ultimate issues at hand. It is the obligation of the fact finder to weigh the credibility of the witnesses before making a decision. Credibility is the value that a fact finder gives to a witness' 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 observation of mankind can approve as probable in the circumstances." In re Estate of Perrone, 5 N.J. 514, 522 (1950). To assess credibility, the fact finder should consider the witness' interest in the outcome, motive, or bias. "A trier of fact may reject testimony because it is inherently incredible, or because it is inconsistent with other testimony or with common experience, or because it is overborne by other testimony." Congleton v. Pura-Tex Stone Corp., 53 N.J. Super. 282, 287 (App. Div. 1958).

Credibility Determinations for Petitioners A.E., H.D. and D.B.

Having heard the witnesses' testimony and observing the demeanors of A.E., H.D., and D.B. during their hearing testimony, and after reviewing the video surveillance footage during the hearing and repeatedly reviewing it, in both regular time and slow-motion, afterwards, the **ALJ FOUND** their testimony as Credible. At the hearing, the **ALJ FOUND** their respective accounts of the events of the morning of May 31, 2020, to be consistent with the video surveillance footage. The ALJ further noted that the video surveillance footage did not have audio, but to the extent that A.E., H.D., and D.B. testified to what was said during parts of that

footage, their testimony was consistent with the actions depicted. Their respective testimony was deemed direct and forthright.

Credibility Determination for Robert Girard

The **ALJ FOUND** Girard's testimony as professional, forthright and Credible, but specifically noted that there were several discrepancies among his testimony, the video surveillance footage, and the findings in the investigation report. The **ALJ FOUND** these alleged factual discrepancies sufficient enough to, "dictate the outcome of these matters." (See ID at 36).

Credibility Determinations for Colvin, Ikpeama, Tobin and Nelson

The **ALJ FOUND** all four of these witnesses to be professional, straightforward and Credible when providing their respective testimonies.

Credibility Determination for Capital Health Emergency Department Disposition Summary for R.V.R.

The **ALJ FOUND** the Capital Health Emergency Department disposition summary for R.V.R. dated June 2, 2020 (R-7) to be, on its own, hearsay. See Corcoran v. Sears Roebuck & Co., 312 N.J. Super. 117, 126 (App. Div. 1998) (citing Hill v. Cochran, 175 N.J. Super. 542, 546–57 (App. Div. 1980)). Although hearsay is admissible at the OAL and can be used to support other competent evidence, it cannot form the basis of a decision without a residuum of other competent, non-hearsay evidence. See N.J.A.C. 1:1-15.5; Weston v. State, 60 N.J. 36, 51 (1972).

The State relied upon this document as evidence that R.V.R. was injured during the May 31, 2020, incident, and Girard relied upon it in the investigation report. Since the State presented no other competent evidence regarding the disposition summary the ALJ gave the document no weight.

For these reasons, the **ALJ FOUND** the following as **FACT**:

1. I.O.'s allegation that H.D. and A.E. physically attacked R.V.R. because H.D. and A.E. did not want R.V.R. to eat yogurt is not factually supported by the video surveillance footage and is false.

2. I.O.'s allegation that A.E. knocked the yogurt out of R.V.R.'s hand is not factually supported by the video surveillance footage and is false.

3. I.O.'s allegation that A.E. threw R.V.R. against a wall is not factually supported by the video surveillance footage and is false.

4. I.O.'s allegation that H.D. grabbed R.V.R. by the neck, choking him, is not factually supported by the video surveillance footage and is false.

5. I.O.'s allegation that A.E. grabbed R.V.R. and took him to the bathroom, where both A.E. and H.D. hit him, is not factually supported by the video surveillance footage and is false.

6. I.O.'s allegation that D.B. watched A.E. and H.D. hit R.V.R. in the bathroom but did not intervene or allow R.V.R. to call the police is not factually supported by the video surveillance footage and is false.

7. Colvin does not train staff to wait until a patient has hit them before initiating a physical hold.

8. The body control restraint is the type of body hold used most of the time, and it looks like a bear hug; its goal is to force the patient to hold their arms close to them to prevent the patient from punching or kicking someone. This hold works best from the patient's side or back.

9. Another body hold is the structured escort position, which is a two-person hold. In this hold, the staff members stand at the patient's side with hands underneath the patient's armpits. The staff members then walk the patient to the desired area.

10. It is possible that when direct care staff attempt to place a patient in a physical hold and the patient resists, the direct care staff could wind up placing the patient against a wall. Physical holds are not going to be done perfectly when they are implemented. What happens on the unit is not like Colvin's training class.

11. Colvin admitted that in the midst of the COVID-19 pandemic, he did not know

how to address a patient who was eating food out of a garbage can that could be contaminated with COVID-19 when verbal redirection did not work.

12. During his investigation, Girard did not take statements from all of the eyewitnesses to the May 31, 2020, incident, some of whom were TPH service recipients. Girard acknowledged that there were other witnesses that he could have interviewed for the investigation, including the two TPH patients who were standing in the hall outside of the bathroom when A.E. and H.D. were in the bathroom with R.V.R. as he washed his hands.

13. Girard's interview of R.V.R. for this investigation was completed through Microsoft Teams. Before interviewing R.V.R., Girard did not assess or inquire into R.V.R.'s capacity for telling the truth. Because R.V.R. is Spanish-speaking, TPH provided an interpreter for R.V.R.'s interview. The individual serving as the interpreter was not a certified interpreter; she works for TPH as a mental health specialist.

14. Girard's interview with A.E. regarding the May 31, 2020, incident was conducted over the telephone. A.E. was not provided a copy of his interview statement to confirm that no details were missed. It is not TPH policy to provide copies of the interview statement.

15. Girard's interview with H.D. regarding the May 31, 2020, incident was conducted on June 18, 2020, by telephone, not in person as the investigation report indicates. H.D. did not see a copy of Girard's investigation report until after he requested a fair hearing.

16. Girard conducted his interview of D.B. regarding the May 31, 2020, incident, over the telephone. Girard did not give D.B. the opportunity to review his interview summary or synopsis or to correct any information that she believed was inaccurate.

17. One of the witnesses to the May 31, 2020, incident, G.S., advised Girard that she did not hear D.B. telling H.D. or A.E. to prevent R.V.R. from using the pay phone.

18. The day after the incident, July 1, 2020, others examined R.V.R. and did not find any bruising or marks on him.

19. Girard could not tell from the video surveillance footage of the incident when the thorax contusion diagnosed in R.V.R.'s discharge summary from Capital Health Regional Medical Center emergency department occurred.

20. Tobin did not review and approve the investigation report from the May 31, 2020, incident.

21. After R.V.R. washed his hands in the bathroom, H.D. heard someone tell them to not allow R.V.R. to use the pay phone, because as part of the de- escalation process, the nurse wanted R.V.R. to sit with her.

22. H.D. observed R.V.R. when R.V.R. dropped to the floor in the pay phone area. R.V.R. did not have any injuries, including bumps, bruises, or lacerations.

23. H.D. did not choke or attempt to choke R.V.R. on May 31, 2020.

24. TPH staff do not need to ask D.B. for permission to place a patient in a physical hold when a patient is combative. Staff can restrain the patient and call D.B. to check the situation.

25. On May 31, 2020, D.B. heard a commotion and came out of the nurse's station. R.V.R. was yelling, physically aggressive, and spitting on staff.
H.D. had R.V.R. in a physical hold, and this was the first thing that she saw.

26. On May 31, 2020, D.B. did not see A.E. or H.D. acting improperly towards R.V.R., including hitting, choking, or slapping R.V.R.

27. On May 31, 2020, after R.V.R. washed his hands, D.B. heard a commotion in the pay phone area, where she saw R.V.R. sitting on the floor. She asked H.D. and A.E. what happened, and they told her that R.V.R. was still physically aggressive and spitting. She saw R.V.R. sitting on the floor, and he wasn't doing anything other than screaming and yelling.

28. On May 31, 2020, D.B. examined R.V.R. and did not see any bruising or noticeable marks on him. She gave R.V.R. medication and she asked him in Spanish if he had any pain, using the Spanish word for pain, dolor. R.V.R. responded in the negative. She did not see any signs of obvious injury. From this time until her shift ended at 3:45 p.m. that day, R.V.R. did not tell her that he was injured or hurt.

29. On June 2, 2020, D.B. performed a physical evaluation of R.V.R. when she wrote the incident report. The physical evaluation was performed in his room and was not captured on video surveillance. R.V.R. removed his shirt, and she asked him if he had pain in his head and upper chest. R.V.R. responded that he did not.

30. During the COVID-19 pandemic, TPH patients were not allowed to eat food that others had already touched for fear of contamination or cross- contamination. Food sharing was prohibited.

31. During his testimony, Colvin did not review the video surveillance footage of the May 31, 2020, incident. He also provided no testimony regarding whether A.E. or H.D. responded properly with approved physical holds on May 31, 2020.

ALJs LEGAL ANALYSIS AND CONCLUSIONS OF LAW Re: CENTRAL REGISTRY ACT MATTERS

Pursuant to the Central Registry Act, N.J.S.A. 30:6D-73(b):

> The safety of individuals with developmental disabilities receiving care from State-operated facilities or programs . . .

> licensed, contracted, or regulated by the [DHS] . . . or from State-funded community-based services shall be of paramount concern.

The Central Registry Act is intended "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 individuals are fully protected," N.J.S.A. 30:6D- 73(c), by "prevent[ing] caregivers who become offenders against individuals with developmental disabilities from working with individuals with developmental disabilities." N.J.S.A. 30:6D-73(d). An investigation is conducted upon allegations of abuse, neglect, or exploitation of developmentally disabled individuals, concluding with a written investigation report that includes conclusions and the rationale for those conclusions. N.J.S.A. 30:6D-76(e).

Under the Central Registry Act, physical abuse is defined as "a physical act directed at an individual with a developmental disability by a caregiver of a type that causes one or more of the following: pain, injury, anguish or suffering. Such acts include, but are not limited to, the individual with a developmental disability being kicked, pinched, bitten, punched, slapped, hit, pushed, dragged, or struck with a thrown or held object." N.J.S.A.30:6D-74.

The caregiver must have "acted with intent, recklessness, or careless disregard to cause or potentially cause injury to an individual with a developmental disability." N.J.S.A. 30:6D-77(b)(1). Acting intentionally is the "mental resolution or determination to commit an act." N.J.A.C. 10:44D-4.1(b)(1). Acting recklessly is the "creation of a substantial and unjustifiable risk of harm to others by a conscious disregard for that risk." N.J.A.C. 10:44D-4.1(b)(2). Finally, acting with careless disregard "is the lack of reasonableness and prudence in doing what a person ought not to do or not doing what ought to be done." N.J.A.C. 10:44D-4.1(b)(3).

Under the Central Registry Act, neglect is defined as "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 order to be included on the Central Registry for 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). For a substantiated incident of neglect, gross negligence, recklessness, and a pattern of behavior are defined as follows:

> 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.
>
> [N.J.A.C. 10:44D-4.1(c).]

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

A.E. and H.D. Abuse Analysis and Conclusions of Law

The **ALJ CONCLUDED** that there was no evidence in this record that either A.E. or H.D. abused R.V.R. on May 31, 2020. When R.V.R. retrieved a yogurt from the garbage, A.E. attempted to verbally redirect R.V.R. and obtain the yogurt from him. R.V.R. ended up dropping the yogurt, and Patient A threw the yogurt to A.E. and H.D. R.V.R. persisted in trying to obtain the yogurt, yelling at H.D. and A.E. while they blocked him from picking it up from the ground. R.V.R. pushed H.D. and retreated from him, while H.D. advanced towards R.V.R. to put him in a physical hold. The restraint policy mandates that once a patient assaults someone, that patient must be placed in a physical hold to calm them down and stop the behavior.

While H.D. attempted to place R.V.R. in a physical hold, R.V.R. actively resisted H.D., with his hands in H.D.'s upper chest/neck area. There is no evidence that H.D. choked R.V.R. or forced him to remain against the wall; from the camera angles, H.D.'s right hand and arm were placed, at various times during the encounter in the dayroom, either on R.V.R.'s left shoulder or on his arm. When H.D. was unsuccessful in implementing the physical hold, A.E. assisted. The State's witness on physical holds, Colvin, acknowledged that a physical hold may end up with the patient on a wall when the patient resists the implementation of that physical hold. Colvin testified that what happens on the floor is often different than what is trained. Importantly, Colvin did not testify about the video surveillance footage of the May 31, 2020, incident, indicating whether A.E. and H.D. responded to R.V.R. properly with approved physical holds.

When D.B. arrived on scene, she instructed H.D. and A.E. to take R.V.R. to the bathroom to wash his hands, understanding that he had been spitting at A.E. and H.D. It is important to note that this incident occurred early in the COVID-19 pandemic, and undoubtedly, TPH staff was not trying to contract COVID-19.

As H.D. and A.E. walked R.V.R. towards the bathroom, the physical hold that H.D. had been applying on R.V.R. was evident in the video surveillance footage. H.D.'s arm was around R.V.R., restricting R.V.R. from using his hands. R.V.R. washed his hands in the bathroom, and there is no evidence that H.D. or A.E. hit or abused R.V.R. in the bathroom. In fact, the patient making those allegations, I.O., was in the dayroom, an area separate from the bathroom.

When R.V.R., H.D., and A.E. left the bathroom, R.V.R. walked to the pay phone area. H.D. and A.E., following R.V.R., heard a voice telling them that R.V.R. should not use the phone and that he needed to sit with a nurse after his assaultive behavior. H.D. and A.E. obeyed those instructions and followed R.V.R. into the pay phone area. The video surveillance footage does not show A.E. or H.D. knocking the pay phone away from R.V.R.; R.V.R. backs away from the pay phone and hits A.E. Again, A.E. and H.D. attempt to place R.V.R. in a physical hold, and he resists, ultimately dropping to the floor. For this portion of the incident in the pay phone area, I.O. was not present.

The incident ended when R.V.R. voluntarily left the pay phone area and sat in the adjacent dayroom. From the video surveillance footage and the witnesses' testimony, there was no intentional act here, as neither H.D. nor A.E. determined to commit an act of abuse against R.V.R. There was no reckless act, meaning that H.D. or A.E. created a substantial and unjustifiable risk of harm, and finally, there was no careless disregard here, including a lack of reasonableness or prudence in what should or should not be done.

Having watched the video surveillance footage numerous times, again, both in real time and slow-motion, it is not pleasant watching assaultive behavior. On May 31, 2020, R.V.R. assaulted H.D. and A.E. in separate events, and in both instances, H.D. and A.E. behaved as they were trained and instructed; namely, they attempted to implement physical holds on R.V.R. as mandated in the restraint policy. H.D. and A.E. did not violate the patient abuse and neglect policy. The State has failed to prove by a preponderance of the credible evidence that H.D. and A.E. abused R.V.R. on May 31, 2020. For these reasons, the **ALJ CONCLUDED** that H.D. and A.E.'s names should not be placed on the Central Registry.

D.B. Negligence Analysis and Conclusions of Law

The ALJ CONCLUDED that there was no evidence that on May 31, 2020, D.B. neglected R.V.R. When D.B. heard the commotion in the dayroom and the pay phone room respectively, she began giving H.D. and A.E. directions on how to handle R.V.R. in the dayroom, and she instructed H.D. and A.E. to take R.V.R. to the bathroom to wash his hands. In the pay phone room, she instructed H.D. and A.E. to bring R.V.R. to her when he was no longer seated on the floor. She did not see A.E. or H.D. acting improperly towards R.V.R., including hitting, choking, or slapping R.V.R., and the patient reporting otherwise, I.O., often was not present when the incidents on May 31, 2020, were actually occurring.

After R.V.R. left the pay phone room, D.B. examined R.V.R. and did not see any bruising or noticeable marks on him. She gave R.V.R. medication, and she asked him in Spanish if he had any pain, using the Spanish word for pain, dolor. R.V.R. responded in the negative. She did not see any signs or obvious injury. From this time until her shift ended at 3:45 p.m. that day, R.V.R. did not tell her that he was injured or hurt.

Two days later, on June 2, 2020, D.B. performed a physical evaluation of R.V.R. when she wrote the incident report. The physical evaluation was performed in his room and was not captured on video surveillance. R.V.R. removed his shirt, and she asked him if he had pain in his head and upper chest. R.V.R. responded that he did not.

There is no evidence here that D.B. acted with gross negligence, whether a conscious, voluntary act or an omission with reckless disregard of her duty to R.V.R. or consequences to him. She did not act recklessly by creating a substantial and unjustifiable risk of harm to R.V.R. by a conscious disregard for that risk, and there is no evidence of a pattern of repeated behavior of similar wrongful acts.

Again, the State has failed to prove by a preponderance of the credible evidence that D.B.'s name should be included on the Central Registry. D.B.'s conduct on May 31, 2020, did not violate the patient abuse and neglect policy. Based on the facts presented here, The ALJ CONCLUDED that D.B.'s name should not be included on the Central Registry.

ALJ ORDERS Re: CENTRAL REGISTRY ACT MATTERS

The **ALJ ORDERED** that the names of H.D., A.E., and D.B. shall not be placed on the Central Registry.

The **ALJ FILED** the Initial Decision with the **DIRECTOR OF THE OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY**. This 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 the final decision on all issues within the scope of its predominant interest.

If the **DIRECTOR OF THE OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY** does not adopt, modify or reject this decision within forty-five days and unless such time limit is otherwise extended, this recommended decision on all of the issues

within the scope of predominant interest shall become a final decision in accordance with N.J.S.A. 52:14B-10.

EXCEPTIONS TO THE INITIAL DECISION Re: CENTRAL REGISTRY ACT MATTERS

On behalf of Respondent DHS, the DAG submitted a Brief of Exceptions to the Initial Decision on October 22, 2025 asking that the Director reject the ALJ's legal conclusions and applications of agency policy that directly conflict with the controlling regulation and testimony. The court's credibility findings were thought inconsistent with the video recording. The ALJ's findings were deemed unsupportable on the record and the DAG respectfully requested that Respondent DHS should instead affirmatively place A.E., H.D., and D.B. on the Central Registry of Offenders Against Individuals with Developmental Disabilities (Central Registry) N.J.S.A. 30:6D-73 et seq. Respondent DHS hereby adopts, accepts and incorporates the DAG Exceptions in their entirety.

Petitioners filed their respective responses to the DAG's exceptions on November 17, 2025. The Petitioners requested that the Initial Decision be affirmed in its' entirety as they found ALJ's factual and credibility findings to be supported by both the oral testimony and the video recording surveillance footage.

LEGAL STANDARD OF REVIEW

The ALJ's Initial Decision contains numerous reversible errors and misstatements of facts and conclusions of law. An ALJ's factual findings and legal conclusions are not "binding upon [an] agency head, unless otherwise provided by statute." N.J.A.C. 1:1-18.1(c). "In reviewing the decision of an administrative law judge, the agency head may reject or modify findings of fact, conclusions of law or interpretations of agency policy in the decision but shall state clearly the reasons for doing so." N.J.S.A. 52:14B-10(c). Accordingly, an agency head reviews an

ALJ's decision "de novo . . . based on the record" before the ALJ. In re Parlow, 192 N.J. Super. 247, 248 (App. Div. 1983).

Upon consideration of an Initial Decision, an agency head may accept, reject, or modify the recommended decision of the ALJ. N.J.S.A. 52:14F-7(a). The deciding agency is not required to accept an ALJ's findings of fact or credibility findings when they "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; see also N.J.A.C. 1:1-18.6(b); N.J.A.C. 1:1-18.1(c).

A reviewing court shall accord "great deference to an agency's interpretation and implementation of its rules enforcing the statutes for which it is responsible." In re Freshwater Wetlands Prot. Act Rules, 180 N.J. 478, 488-89 (2004) (citing In re Distrib. of Liquid Assets, 168 N.J. 1, 10-11 (2001)). "A court will not substitute its judgment for the expertise of the agency." Dougherty v. Dep't of Human Servs., Div. of Med. Assistance & Health Servs., 91 N.J. 1, 6 (1982) (citing N.J. Guild of Hearing Aid Dispensers v. Long, 75 N.J. 544, 562 (1978)). Furthermore, a strong presumption of reasonableness attaches to the actions of administrative agencies. In re Vey, 272 N.J. Super. 199, 201 (App. Div. 1993), aff'd, 135 N.J. 306 (1994).

Placement on the Central Registry is a two-step inquiry. First, it must be determined if petitioners H.D. and A.E. committed acts of physical abuse against R.V.R., and if so, whether such acts were intentional, reckless, or done with careless disregard for the well-being of R.V.R. For Petitioner D.B., it must first be determined if D.B. committed acts of negligence toward R.V.R., and if so, whether D.B. acted with gross negligence, recklessness or a pattern of behavior that caused harm to R.V.R. or placed R.V.R. in harm's way. (N.J.A.C 10:44D-4.1(b) and (c)). Placement on the Central Registry is governed under N.J.S.A. 30:6D-73, et seq., and N.J.A.C. 10:44D-1.1, et seq. "The primary concern of all providers of services to individuals with developmental disabilities, who are vulnerable to abuse, neglect and exploitation, shall be to assure the safety, health, welfare and freedom from exploitation of the individual with a developmental disability." N.J.A.C. 10:44D- 1.3.

The applicable standard to evaluate Central Registry cases is a preponderance of the evidence, which looks at whether "it is more likely than not" that the evidence reveals abuse or neglect occurred. Woods-Pirozzi v. Nabisco Foods, 290 N.J. Super. 252, 266 (App. Div. 1996). In other words, the standard considers if the evidence "tip[s] the scales in favor of the" Respondent. Travelers Indem. Co. v. Kenvil Steel Products, Inc., 2009 WL 170087, at *3 (App. Div. Jan. 27, 2009).

LEGAL AND FACTUAL DISCUSSION

Respondent will show that the video surveillance footage (R-27) coupled with the totality of the evidentiary record proves by a preponderance of the credible evidence that Petitioners H.D. and A.E. committed prohibited acts of physical abuse by pushing, hitting and dragging R.V.R. Respondent will further show by a preponderance of the credible evidence that these prohibited acts of pushing, hitting and dragging were committed with the requisite mental states sufficient to meet the legal standard required for placement of H.D. and A.E. on the Central Registry. Respondent will also show that the video surveillance footage (R-27) coupled with the totality of the evidentiary record proves by a preponderance of the credible evidence that D.B. committed prohibited acts of neglect against R.V.R. with the requisite mental state sufficient to meet the legal standard required for placement of D.B. on the Central Registry. Comparing and contrasting the video footage with the petitioner's often times inconsistent and inaccurate testimony regarding the same clearly justifies their placement on the Central Registry.

Further to this point, the Respondent strongly objects to the ALJ's summary narrative of the video surveillance footage set forth on pages 14-23 of the Initial Decision. The ALJ positions this summary narrative as objective fact when in reality it was merely the subjective testimony of the three interested-party Petitioners as summarized by the ALJ. As will be shown, the ALJ uses very neutral, innocuous and ambivalent descriptors when summarizing the actual behaviors of the Petitioners as seen on the video footage. (See Initial Decision at 14-23). This selective narrative summary of the events by the ALJ in critical moments stands in stark contrast to the actual events shown on the video footage. There was an overwhelming amount of countervailing video footage, testimony and eye-witness statements sufficient to raise reasonable doubts as to

the accuracy and veracity of the petitioner's cherry-picked recollection of events. This is in addition to numerous instances where the Petitioner's own testimony is internally inconsistent and contradictory. The Respondent takes strong exception to this blanket and unilateral acceptance by the ALJ of the Petitioners' recollections of events. The ALJ in effect utilized the subjective summaries of events provided by the petitioners' as the objective summary of what occurred during the incident. By doing so, the ALJ disregarded the entirety of the clear video surveillance footage, certain eye-witness testimony as well as the professional and objective analysis and investigatory reporting of Mr. Girard. (See R-2, DOH055-058 and DOH061-067).

Respondent will show that the original Investigation Report (Exhibit R-2) substantiating the acts of physical abuse and neglect was conducted in a thorough, independent and professional manner. Said Report relied not only on detailed video surveillance footage but also the statements of the victim, an eye-witness, other hospital personnel and all three petitioners. Attempts by the Petitioners and the ALJ to engage in a granular critique of the methods and practices employed by the Investigator during the investigation are of no substantive concern whatsoever. The evidenced deduced from the investigation more than met the preponderance of evidence standard sufficient to warrant placement on the Central Registry.

Video Evidence Clearly Proves Prohibited acts of Physical Abuse of R.V.R by A.E. and H.D

For purposes of placement on the Central Registry, physical abuse means: "A physical act directed at an individual with a developmental disability by a caregiver of a type that causes one or more of the following: pain, injury, anguish or suffering. Such acts include, but are not limited to, the individual with a developmental disability being kicked, pinched, bitten slapped, hit, pushed, dragged or struck with a thrown or held object." (N.J.A.C. 10:44D-1.2).

There are two main areas within which the substantiated acts of physical abuse occurred, the King Day Room and the Telephone hall corridor. Each location will be addressed in detail and in sequence. All references to video footage is from Exhibit R-27, the exact time stamps referenced are straight from the time stamps of the video footage itself. The petitioners performed these acts of physical abuse with the requisite intentionality, recklessness and/or careless disregard for the well-being and safety of R.V.R. sufficient to require their placement on the Central Registry.

KING DAY ROOM

11:37:36- 11:37:39- H.D. is clearly seen placing both arms on R.V.R. and forcibly pushing him back first into the wall. The distance between initial application of force and R.V.R. crashing into the wall is several feet. It is very important to note that when the video footage is played at normal speed, the speed, impact and violence of the collision of R.V.R.'s head, neck and back into the wall is very noticeable. Slowing the footage down greatly lessens the apparent danger and brutality of the actions by H.D. By repeatedly slowing down the video speed, one can subconsciously fall prey to the belief that the actions, blows and impacts were really not as violent and dangerous as they first appeared.

Further to this point, in the ALJ's personalized narrative summary of this part of the video footage, the ALJ frames it as "H.D. moves towards R.V.R., moving R.V.R. towards a wall, and places his left hand on the back of R.V.R's neck". (See Initial Decision at page 16 at time stamp 11:37:38) Respondent finds this to be a rather benign description by the ALJ of a very violent act and has the effect of casting the actions of the petitioner's in the most favorable light possible. A real-speed playback of this application of force supports the fact that H.D. violently and forcibly pushed R.V.R. into the wall from some distance, not merely "move[d] R.V.R. towards a wall" as the ALJ so innocuously described it.

This violent and prohibited push created a potential risk of serious injury to R.V.R. The ALJ's narrative summary of this event does not account for the distance between initial physical contact between H.D. and R.V.R. and R.V.R. crashing full force into the wall with his back, head and neck. The ALJ wants the reader to conclude that this dangerous push into the wall was neither an act of physical abuse or particularly dangerous because the use of "walls" in physical holds is an approved method of restraint. The ALJ cites certain testimony from Master Instructor of Therapeutic Options Eugene Colvin to buttress this conclusion. Colvin is a master instructor of the Therapeutic Options training system, a system to prevent individuals from being aggressive and violent and to keep others safe when an individual does become aggressive.

Colvin testified, "that it is possible that when direct care staff is attempting to place a patient in a physical hold and the patient resists, the direct care staff could wind up placing the patient against a wall." The ALJ cites this testimony at pages 24 and 44 of the Initial Decision to

help distract from the fact that R.V.R. was pushed violently into the wall, not "placed" against the wall. The implication by the ALJ is that using the wall to restrain R.V.R. was entirely proper in this instance because of Colvin's testimony. Respondent strongly rejects the ALJ's misreading and misapplication of this portion of testimony to look past the violent push by H.D. of R.V.R. into the wall from a distance of several feet. Nowhere in Colvin's testimony does he ever say that such a push would ever be acceptable, safe or TPH compliant behavior. In fact, Colvin specifically testified to the contrary when he was asked if HSAs or HSTs, such as H.D. or A.E., are ever allowed to push a patient against a wall. Colvin definitively stated, "We don't want to push them against the wall that's, you know, that's not safe." (3T89:15-16).

Further to this, Colvin testified about the wall policy and whether it's acceptable to push a patient up against a wall to restrain them and he stated, "We teach a wall technique, it's pretty much—it comes off of the secure hold where a person may be secured against a wall for the administration of medication, but as far as---that's the only wall technique that we teach in Theraputic Options." (3T94:22-25, 3T95:1-6). Arguendo, even in a scenario where it were permissible in theory to use a wall in a physical hold, it is never permissible to forcibly push an individual from several feet away into a wall. That is an exceedingly violent, dangerous and unsanctioned use of physical force that is not approved by TPH policy guidelines on use of physical holds nor by the Therapeutic training the petitioners received from Colvin.

In sum, nowhere in his testimony does Colvin ever explicitly or implicitly state that pushing a patient from several feet away into a wall is a remotely acceptable application of physical force, even if application of said force was initially justified by patient conduct. Respondent finds that this violent and dangerous push by H.D. of R.V.R. meets the definition of physical abuse per N.J.A.C. 10:44D-1.2.

11:37:44- A.E. clearly makes contact with the left side of the head of R.V.R. with his right hand in a downward slapping motion while H.D. has R.V.R. still pinned against the wall and unable to fully defend himself. It is imperative to note that such a downward slap to the head by A.E. of R.V.R. is not a permissible application of force. This is also the side of the head that R.V.R. will later be seen grabbing at in apparent physical pain. Further to this point, Eugene Colvin was specifically asked on direct if HSTs or HSAs, such as A.E. and H.D., are "ever allowed to strike a patient". Colvin directly replied, "No." He was then asked on direct, "are there no—no

circumstances whatsoever that they're allowed to strike a patient" and Colvin replied, "no circumstances" (3T88:11-16). Respondent finds that this slap of R.V.R. by A.E. in and around his left shoulder and neck area meets the definition of physical abuse per N.J.A.C. 10:44D-1.2.

11:37:48- A.E. then applies his own bodyweight to R.V.R. as he leans in and pins R.V.R. along the wall while using his strength to drag R.V.R. sideways, causing R.V.R. to dangerously bang against a nearby table. Respondent finds that this violent dragging along the wall of R.V.R. by A.E. meets the definition of physical abuse per N.J.A.C. 10:44D-1.2.

11:37:54- H.D. gets back into the fray and applies additional physical force evidenced by his right elbow being captured on screen in an angled position near the head of R.V.R. He is clearly using this arm as leverage to apply additional force to a defenseless R.V.R. This leverage was so forceful that R.V.R. continued to be further dragged along the wall and into the side of the nearby table. Respondent finds this violent dragging along the wall of R.V.R. by both A.E. and H.D. meets the definition of physical abuse per N.J.A.C. 10:44D-1.2.

11:38:04-11:39:27-The danger of the table causing potential injuries to R.V.R., especially if it flipped over and they all fell on it, was so obvious that D.B. stepped in to physically clear the table from the side of R.V.R. Once the table was cleared, A.E. and H.D. were able to hustle R.V.R. out of the room and away from any witnesses and into the nearby Bathroom. Interestingly, at the 11:38:17 mark, D.B. walked in front of the bathroom door and made sure to clear two potential witnesses from the area. She then quickly left the area.

<u>TELEPHONE CORRIDOR</u>

11:39:52- 11:39:55- RVR is seen attempting to make a phone call, ostensibly to call the police to tell them what had just been done to him. It is critical to note that R.V.R. is not a threat to himself or others and is attempting to self-isolate and de-escalate. It is safe to infer that R.V.R. wanted nothing further to do with A.E. or H.D. and was legitimately concerned for his safety.

11:39:55- if you freeze frame and isolate the video at 11:39:55 you can clearly see the phone receiver is being held by RVR in his right hand and along his right ear. RVR is doing nothing wrong and is absolutely no threat to himself, other patients or any other staff. According to

testimony from A.E. and H.D., at this same time they attempt to verbally re-direct R.V.R. to put the phone down.

11:39:56-11:39:57 Almost immediately after the verbal re-direct both A.E. and H.D. enter the frame and are clearly seen physically wrenching/taking the phone receiver from R.V.R. The ALJs summary narrative of this time stamp acknowledges, "they took the telephone from R.V.R." (See Initial Decision at 19.) Respondent concurs and reiterates that a close look at the video clearly shows that A.E. and H.D. forcibly took/wrenched the phone receiver from the hand of R.V.R. in an impermissible act of physical abuse and then violently shoved him away from the phone and against the wall. Respondent finds the forcible taking of the phone receiver from R.V.R. and the forcible pushing into the wall of R.V.R. by A.E. and H.D. meets the definition of physical abuse per N.J.A.C. 10:44D-1.2.

11:40:01- At exactly this time and in direct response to having the phone wrenched form his hand and being shoved into the wall by A.E., R.V.R. throws a punch at A.E. in an attempt to defend himself. The Petitioners have argued as a defense to their conduct that R.V.R.'s punch somehow triggered a justified application of a physical hold on R.V.R. Respondent rejects this line of reasoning as R.V.R. only threw a punch at A.E. after R.V.R. had been assaulted without provocation or justification by the petitioners. A.E. and H.D. are not be allowed to initiate assaultive behavior against R.V.R. and then use R.V.R.'s attempts at self-defense to be a trigger for application of a physical hold.

The key metric to use is whether the initial forcible taking of the phone and subsequent shoving into the wall was in compliance with TPH guidelines for the use of force. TPH's policy on physical holds clearly states that, "Physical holds are used only in an emergent situation to prevent aggressive and/or destructive behavior towards self or others. All physical holds are considered restraints. When an individual initiates a strike, grab, choke, hair pull, bite, etc. to an employee . . . , staff must respond immediately with an approved physical hold learned in crisis training." (Joint Exhibit 10 at DOH097).

Nowhere in the guidelines does it state nor imply that a caregiver can "create" the emergent situation giving rise to the physical hold. In this instance and as clearly shown on the video footage, RVR was physically assaulted while minding his own business. R.V.R. was literally alone in the telephone area and by definition there was no "emergent situation" created

by R.V.R. sufficient to require the petitioners to have to "prevent aggressive and/or destructive behavior" on the part of R.V.R. Quite the opposite, the petitioners are the ones that literally engaged in assaultive behavior when they rushed R.V.R. and wrenched the phone out of his hands and forced him against the wall.

It is irrelevant if he had been warned not to use the phone by the Petitioners and that there was a verbal redirection before initiating physical contact. Their physical attack on RVR would still be without merit or justification under existing TPH policy guidelines. R.V.R. was isolated and engaging in benign and non-threatening behavior. A.E. and H.D. entered the area where R.V.R. had self-isolated and with pre-meditation and intentionality re-engaged and re-escalated by applying unwarranted physical force on R.V.R.

Further to this, Colvin on direct was asked for scenarios or circumstances when it would be appropriate to use force on a patient. Colvin testified that, "we want to use force in a situation to keeping people safe. You know---if that patient is doing something to harm himself or to harm someone else, then a physical skill could be used to create safety if nothing else is available." (3T79:16-24). R.V.R. was presenting none of these behaviors and the video is clear that the petitioners were the aggressors. Respondent finds no justification for the assaultive conduct of H.D. and A.E.

11:40:03- The video tape clearly and definitively shows H.D. cock his open right hand and slam it into the lower neck area in the back of RVR's head. It is very important to play the tape at normal speed to fully grasp how forceful and violent the downward swing was by H.D. As previously noted, HSTs and HSAs, such as A.E. and H.D., are "not allowed to strike a patient". (3T88:11-16). Again, the force and the severity of this blow cannot be justified under TPH policy guidelines nor can the Respondent look past it. For the Respondent to allow such behavior would be in direct violation of the requirements, intent and spirit of the entire statutory and regulatory regime established to protect the developmentally disabled in New Jersey. Respondent finds H.D.s hitting of R.V.R. meets the definition of physical abuse per N.J.A.C. 10:44D-1.2.

Respondent wants to stress that the ALJ's narrative summary version of this exact sequence is inaccurate and misleading. On page 19 of the Initial Decision at the exact same time stamp of 11:40:03, the ALJ summarizes this event by stating, "H.D. walks towards R.V.R. and places (emphasis Respondent) his right hand on R.V.R.'s upper back." (Initial Decision at page

19). Respondent respectfully but completely disagrees with this benign portrayal of what is clearly shown by the video to be a violent, forceful and prohibited smack/hit by H.D. This is yet another clear example of the ALJ overlooking and/or smoothing out clear acts of physical abuse by the Petitioners. It is impossible to reconcile the ALJ's narrative summary version of this sequence with the actual video footage. Again, the video footage speaks for itself and is a critical component in substantiating abuse against the Petitioners.

11:40:06- The video tape clearly and without room for interpretation shows H.D. cock his right hand and slam it again into the lower rear neck area of R.V.R. Again, striking a patient is not allowed. (3T88:11-16). Respondent finds H.D.s hitting of R.V.R. meets the definition of physical abuse per N.J.A.C. 10:44D-1.2.

Respondent wants to stress again that the ALJ's narrative summary version of this exact sequence is inaccurate and misleading. On page 20 of the Initial Decision at the exact same time stamp of 11:40:06, the ALJ summarizes this event by stating, "H.D.'s back is towards the camera. A second hand is present, which appears to be R.V.R.'s hand. A.E. pushes that hand forward and leans towards R.V.R." (Initial Decision at page 20).

Respondent again respectfully disagrees with this narrative summary of the second slap/hit by H.D. as the ALJ completely omitted it from her summary despite said hit being clearly visible on the video footage. Respondent is at a loss as to how the ALJ is reconciling her narrative summary of the video footage with the actual events shown on the video. Suffice it to say, Respondent is relying on what is shown in the actual video footage when determining substantiation of physical abuse.

11:41:02-11:46:31- Eventually RVR gets himself off the ground and is then seated in a chair in the telephone room clearly grabbing the left side of his head with his hand. He appears to be in physical pain and is clearly showing the behavior of one who has been injured.

Based on all the video footage analyzed above, it is clear to the Respondent that it has been established beyond a preponderance of the credible evidence that A.E. and H.D. physically abused R.V.R. per N.J.A.C. 10:44D-1.2. These acts of abuse include but are not limited to forcefully and violently pushing R.V.R. into a wall from a distance of several feet causing his head, neck and back area to impact with a wall in a dangerous manner. Forcibly hitting R.V.R's

head and shoulder area with a hand while pinned against this same wall. Forcibly dragging R.V.R. along this same wall. Forcibly wrenching a phone receiver from R.V.R.'s hand and pushing him into a wall in the telephone corridor. Twice forcibly and violently slapping/hitting R.V.R.'s head with an open hand while pinned against a wall in that same room.

Video Evidence Clearly Proves A.E. and H.D. acted with recklessness and Careless Disregard for safety and well-being of DVR

Respondent will prove beyond a preponderance of the credible evidence that A.E. and H.D. acted with recklessness and careless disregard for the safety and well-being of R.V.R. as required by N.J.A.C. 10:44D-4.1(b) sufficient to warrant their placement on the Central Registry.

Respondent finds that the various acts of physical abuse listed supra are prima facie evidence of A.E. and H.D. acting with recklessness and careless disregard for the safety and well-being of R.V.R. These acts of abuse clearly created a "substantial and unjustifiable risk of harm" to R.V.R. and evinced a "conscious disregard for that risk". (NJAC 10:44D-4.1b). In the alternative, these acts of abuse evinced a "careless disregard and lack of reasonableness and prudence in doing what a person ought not to do." (NJAC 10:44D-4.1b)

For example, it was clearly "reckless" of H.D. to violently push R.V.R. into a hard wall from several feet away. H.D. knew or should have known of the risk of serious injury from such a push and yet he did it anyway. At an absolute bare minimum H.D.'s actions evinced "careless disregard" for the safety of R.V.R. Either way, H.D.'s push more than met the "mental state" required to warrant placement on the Central Registry.

As another example, it was clearly "reckless" for H.D. to forcibly hit R.V.R. twice in the telephone corridor. Such actions clearly created a "substantial and unjustifiable risk of harm" to R.V.R and evinced a "conscious disregard for that risk." The same with A.E. hitting R.V.R. when he was defenseless and pinned against the wall of the King Day Room. These are all impermissible acts that by their very nature show no real care or concern for R.V.R. and cannot be justified nor allowed.

Despite all of this, the ALJ ultimately concluded that, "On May 31, 2020, R.V.R. assaulted H.D. and A.E. in separate events, and in both instances, H.D. and A.E. behaved as they were trained and instructed; namely, they attempted to implement physical holds on R.V.R. as

mandated in the restraint policy. H.D. and A.E. did not violate the patient abuse and neglect policy. The State has failed to prove by a preponderance of the credible evidence that H.D. and A.E. abused R.V.R. on May 31, 2020." (Initial Decision at 46).

Respondent wants to address the ALJ's conclusions in two parts. First, Respondent does not accept that R.V.R. assaulted H.D. and A.E. in the telephone corridor. As noted earlier, A.E. and H.D. initiated assaultive contact with R.V.R. first, thereby creating their own "emergent situation" that they then used to justify implementing a physical hold. Secondly, the ALJ frequently references the attempts at implementing physical holds as a quasi-justification for A.E. and H.D.'s actions. All throughout the Initial Decision, and in particular pages 44 and 45, the ALJ repeatedly references the fact that the petitioners were trying to "put him in a physical hold" or "attempted to place R.V.R. in a physical hold" or they were "unsuccessful in implementing the physical hold" or they again "attempt to place R.V.R in a physical hold". The ALJ basically concludes that if the attempted holds were justified then the petitioners engaged in permissible physical contact with R.V.R. Said another way, if the petitioners were initially justified in applying a physical hold due to the conduct of R.V.R. than ipso facto the totality of their conduct is to be deemed proper and shielded from allegations of physical abuse or neglect.

Respondent strongly objects to this interpretation of the law and regulations and holds that meeting the requirements for initiating a physical hold is the absolute bare minimum necessary to justify forcible physical touching. It does not and cannot ever shield petitioners from their conduct when implementing such holds. To allow otherwise would permit caregivers to engage in brutality against vulnerable patients during an attempted physical hold as long as the initial hold was properly triggered. Initiating a justified physical hold does not automatically nullify a subsequent substantiation of physical abuse for said physical hold.

The duty to avoid and refrain from physical abuse carries forward throughout the entirety of the physical hold from initiation to cessation. In short, to permit a caregiver to employ a prohibited act against a developmentally-disabled person, even if it were toward an alleged legitimate end, i.e. to implement an approved hold, would contravene the goal of the authorizing statute and regulation. Rather, in proper circumstances according to applicable policy and

training, caregivers can invoke approved maneuvers to carry out any legitimate ends, i.e. self-defense or protecting others, but cannot resort to prohibited acts.

In this case, even if said physical holds were initially justified, and the Respondent does not concede this, video surveillance footage conclusively proved that such physical holds morphed into prohibited acts of physical abuse when actually implemented by the petitioners. At all times during "attempts" at implementing these physical holds, the Petitioners were in a position of power, privilege and authority over the patient and therefore had to act with the utmost care and concern for the physical and mental safety of R.V.R. The Petitioners are not granted carte blanche authority when applying a physical hold, even if initially warranted, to engage in acts of physical abuse against a vulnerable patient.

Video Evidence Clearly Proves D.B. Neglected R.V.R. with Careless Disregard for his well-being

For purposes of analyzing the video footage for D.B., she was seen on video during the first attack in the King Day Room, as well as in front of the bathroom where she cleared out potential witnesses and most critically at the door of the Telephone Corridor eye-witnessing and directing a portion of A.E. and H.D.'s aggression toward R.V.R. She was also in the Medical Room where she performed a cursory physical exam of RVR when he presented with injuries. All references to video footage is from Exhibit R-27, the exact time stamps referenced are straight from the time stamps of the video footage itself.

KING DAY ROOM

11:37:50- D.B. can be seen in frame witnessing the scuffle along the wall and the dragging of R.V.R. along the wall. D.B. was an eye-witness to a good portion of the physical melee. As a nurse, D.B. had an affirmative responsibility to ensure the safety of R.V.R., and should have immediately and proactively checked on his physical condition.

11:38:04-11:38:15- D.B. moves the table that R.V.R. was being dragged into in order to clear the way for RVR to be hustled out of the room and away from witnesses. She then follows A.E. and H.D. as they physically shove RVR into the bathroom.

BATHROOM

11:38:19-11:38:45- D.B. walks to the front of the bathroom door and then clears out two potential witnesses who were in front of the door and might have heard something possibly occurring in the bathroom. DB then quickly leaves the area herself and leaves R.V.R. alone with A.E. and H.D.

KING DAY ROOM DOOR TO TELEPHONE CORRIDOR

11:40:08-11:41:03- D.B. is seen on videotape standing in front of the door to the telephone corridor clearly communicating with A.E. and H.D. and witnessing and directing some of the assaultive actions of A.E. and H.D. D.B. then leaves the area and again does not check on R.V.R. to see if he has been injured. At 11:42:32 she returns to check in on A.E. and H.D. and again leaves without an even cursory hands-on medical check on R.V.R.

KING DAY ROOM SITTING AREA

11:47:16-11:47:30- R.V.R. is clearly seen seated and continuously grabbing at his left ear as D.B. re-enters the sitting room area and walks right past D.V.R. and again neglects to conduct even a cursory exam of D.V.R. Despite D.B. witnessing the initial altercation in the King Day Room and a portion of the altercation in the telephone corridor, D.B. never conducts a medical check on RVR for any potential injuries or trauma. It is critical to note that R.V.R. grabs and holds his ear for long stretches of time, before, during and after D.B. re-enters the sitting area. He is clearly in physical pain and discomfort.

11:53.51- After D.B. failed to proactively perform any medical checks on R.V.R., he gets up to leave the day room and affirmatively seek medical attention from D.B. He is still grabbing the left side of his face.

MEDICAL ROOM-

11:56:52-RVR is finally seen interacting with DB and is pointing out the left side of his face. By 11:57:12 (20 seconds later) D.B. had concluded her exceedingly cursory exam of R.V.R. and began to lead him away from the Medical Room.

Based on all the video evidence, it is clear to the Respondent that it has been established beyond a preponderance of the credible evidence that D.B. Neglected R.V.R. in a manner sufficient to justify her placement on the Central Registry. There is no legitimate dispute that A.E. and H.D. abused D.V.R. as clearly shown above. (R-27) D.B.'s conduct in failing to stop or prevent the abuse of R.V.R. and failing to report it constitutes neglect. Under the Central Registry Act, "neglect is defined as "willfully failing to provide proper and sufficient food, clothing, maintenance, medical care or a clean and proper home; or failure 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-1.2 As per the statutory requirements for placement on the Central Registry, D.B,'s actions are sufficient to place her on the Central Registry.

N.J.A.C. 10:44D(c) provides, "[I]n 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." The statute further defines "gross negligence," "recklessness," and "a pattern of behavior." Ibid.

Based on a preponderance of the evidence, placement on the Central Registry for neglect is governed by a two-step analysis: (1) there must be a substantiated incident of neglect against an individual with developmental disabilities; and (2) the facts of the case must show that 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." N.J.A.C. 10:44D 4.1 (c); see also N.J.C.A. 30:6D-77(b)(1).

Here, the video evidence sufficiently satisfies all the elements necessary for D.B.'s placement on the Central Registry. D.B. clearly neglected R.V.R., an individual with a developmental disability, by recklessly and repeatedly failing to prevent and/or stop the abuse of R.V.R. inflicted by H.D. and A.E, whom she supervised. Video evidence of the scene at the time

of the incident clearly shows D.B. watching H.D. and A.E.'s abuse of R.V.R. and not doing anything to stop it. The video evidence reveals a pattern of neglectful behavior on multiple occasions. In sum, D.B.'s actions clearly align with State protocol regarding caregiver incidents of neglect under N.J.A.C. 10:44D-4.1(c) (2) and (3), therefore justify her placement on the Central Registry.

It is equally apparent that D.B. "acted with gross negligence, recklessness or evidence of a pattern of behavior that caused harm to an individual with developmental disabilities or placed that individual in harm's way." N.J.A.C. 10:44D-4.1(c). According to the regulation, "acting with gross negligence is a conscious, voluntary act or omission in reckless disregard of a duty and of the consequences to another party; acting with recklessness is the creation of a substantial and unjustifiable risk of harm to others by a conscious disregard for that risk, and a pattern of behavior is a repeated set of similar wrongful acts." Ibid.

Here, it is beyond dispute that the D.B. acted negligently and recklessly, but, at a minimum, with careless disregard to R.V.R.'s wellbeing. The video footage from this incident, once again, speaks for itself by showing D.B. neglecting to maintain and ensure R.V.R.'s safety. (R-27). The evidence substantiates the finding of neglect against D.B., who failed to intervene during the abusive incident. D.B. was clearly present during the events and did not take any action to stop the abuse or to seek assistance for R.V.R. when he was visibly being harmed. (1T100:25-101:4). Her inaction is a clear violation of her responsibilities as a caregiver.

Petitioners Testimony Inconsistent with Video and Other Evidence thereby diminishing their credibility

As a further rebuttal to the ALJ's over-reliance on petitioner's testimony and prior statements when creating the inaccurate narrative summary of events, the Respondent points out numerous inconsistencies and inaccuracies in petitioner's own accounts of events, especially when compared and contrasted against the video footage. Respondent holds these inconsistencies to be significant and often in contra-distinction with critical moments in the video surveillance footage thereby undermining key factual and legal conclusions in the Initial Decision.

The Petitioners' account of the incident presents several inconsistencies when reviewed in conjunction with the video surveillance footage and other evidence in the record. For instance, compare Petitioners' blanket denials of any hands-on contact in the pay phone area, with their own written statements. (1T108:3-11; 1T103:24-104:9; 2T113:22-25; 2T114:1-8; R-2; R-3; R-4; R-27). A.E. testified that he did not touch R.V.R. in the pay phone area. However, during cross examination, A.E. admits that "[w]e stopped him . . . we blocked the pay phone," which is in direct contradiction to his earlier denial to Girard that either he or H.D. put their hands on or physically stopped R.V.R. from using the pay phone. (6T147:4-19). A.E. further disputed the investigation report that D.B. told them to stop R.V.R. from using the pay phone, then concedes the investigation report accurately quotes him saying exactly that, which is another credibility determination that is not weighed by the Decision. (6T145:4-24; R-2).

Additionally, H.D. failed to even acknowledge that he pushed R.V.R. in the pay phone area, claiming instead that he only stood in front of him. (Compare R-4, R-27 from 11:39:53 AM to 11:40:45AM, and 5T145:8-18). H.D. neither wrote in his written statement nor told Girard that he placed R.V.R. in a physical hold and held him up against the wall. (1T103:24-104:9; R-4). H.D. also did not provide any details to Girard regarding the payphone area and that he and A.E. physically removed R.V.R. from the phone. However, the video surveillance from the incident shows A.E. and H.D. physically restraining R.V.R., holding him against the wall, and dragging him to the bathroom. (1T120:10-121:14; R-27).

The ALJ's credibility determinations are inherently contradictory given that the ALJ credits Petitioners' versions of events, despite the various inconsistencies, while finding that the discrepancies in Girard's testimony "dictate the outcome" of the Decision. Notably, the Decision fails to enumerate what the alleged discrepancies were in Girard's testimony. The ALJ must identify and reconcile those discrepancies — especially where they relate to what the video surveillance actually shows.

The Decision states that "[a] trier of fact may reject testimony because it is inherently incredible, or because it is inconsistent with other testimony or with common experience, or because it is overborne by other testimony." ALJ ID at 36 (citing Congleton, 53 N.J. Super. at

287). Yet, immediately after setting that standard, the ALJ accepts Petitioners as credible because, as is claimed, their accounts "are consistent with the video surveillance footage" – despite multiple points in the records, even in the Decision, showing inconsistencies. (ALJ ID at 36; 1T108:3-11; 1T103:24-104:9; 2T113:22-25; 2T114:1- 8; R-2; R-3; R-4; R-27).

The ALJ then issues categorical "false" findings about I.O.'s allegations based solely on the video, even though Girard testified that the video corroborated core elements of I.O. and R.V.R.'s accounts. ALJ ID at 38. The Decision states six times that I.O.'s allegations are "not factually supported by the video . . . and [are] false." Ibid. But Girard testified the video did in fact corroborate both Petitioners' core accounts, and the record summarizes those corroborations. (1T121:15-18; R-1; R-2). The ALJ never explains why her reading of the silent footage should prevail over the investigator's video-corroborated testimony, particularly after calling Girard "credible." ALJ ID at 36.

The Decision finds Petitioners to be "credible because [their testimony is] consistent with the video" and finds Girard "credible," but then rejects Girard's conclusions and adopts Petitioners' contested version without making point-by-point credibility findings where the footage is indeterminate. That is at odds with the Decision's own legal standard.

The Petitioners' statements are contradicted by the records, yet the ALJ credits them as credible. During cross examination, A.E. admitted, "[W]e stopped him . . . we blocked the pay phone," contradicting his earlier denial to the investigator that neither he nor H.D. placed their hands on or physically stopped R.V.R. from using the pay phone. (6T147:4-19). When confronted with the Investigation Report which stated "neither [A.E.] nor [H.D.] put their hands on R.V.R. while in the pay phone area," A.E. disowns that prior statement again admitting physical contact with the patient testifying "we physically restrained him." (6T90:22-91:15). A.E. further disputed the investigation report line that nurse D.B. told them to stop R.V.R. from calling for help using the pay phone, then concedes the investigation report accurately quotes him saying exactly that, which is another credibility determination that is not weighed by the Decision. (6T145:4-24; R-2).

Girard testified that H.D. omitted that he placed R.V.R. in a physical hold and held him against the wall. (1T103:24-104:9; R-4). He also omitted any details regarding the pay phone area and, during his interview with Girard, said neither he nor A.E. put their hands on the patient—statements that were inconsistent with the video surveillance. (1T103:24-104:9; 2T113:22-25; 114:1-2; R-4). Respondent's closing brief tied these points together and highlighted these contradictions the Decision never reconciles with its blanket credibility finding for Petitioners. (1T103:24–104:9; 2T113:22–25; 114:1– 8). These admissions are prior inconsistent statements on central facts of whether staff physically abused a developmentally disabled patient. Under the Decision's own cited standard, they should have diminished Petitioners' credibility, not brushed past to find their accounts "consistent with the video." ALJ ID at 36. The credibility inconsistencies in the Decision spills into and undermines the legal conclusions reached by the Decision.

DOH Investigation Properly Substantiated Abuse and Neglect

Respondent strongly objects to the ALJs granular critique of the investigatory methods and choices of Mr. Girard when conducting his DOH investigation that ultimately substantiated the acts of abuse and neglect. (R-2) The ALJ in effect is substituting its' factually unjustified judgment for that of Investigator Girard as to how to conduct a proper investigation. (ALJ ID at 39-40). This, despite the fact that Girard is a highly experienced and dedicated investigator trained by the State specifically to conduct thorough and objective investigations to protect the developmentally disabled community. Girard, by the nature of his position and training, is best positioned to conduct timely, detailed and objective investigations of allegations of abuse and neglect and is well versed in the laws of abuse and neglect as they pertain to TPH patients.

Further to this point, Robert Girard was a Quality Assurance Specialist, OI Investigator at the time he conducted his investigation of the incident in question. He has a BS in business management and an associates degree in Nursing. He is also a registered nurse (R.N.) in New Jersey. He has since been promoted to a Quality Assurance Coordinator at Ann Klein Forensic Center working for the Department of Health, Office of Investigations. In 2016 he attended the labor relations alternatives serious incident investigator training. He also took the same course as a refresher in 2019 and 2023. At these trainings he received intensive traininh in conducting

investigations, collecting evidence and reviewing documentation. He has 15 years of psychiatric nursing experience and has done over 400 investigations (emphasis Repsondent) regarding abuse and/or neglect. (See 1T19:16-22, 1T20:15-24, 1T21:1-24).

Yet despite this wealth of training, expertise and experience held by Mr. Girard, the ALJ concluded that, "there were several discrepancies among his testimony, the video surveillance footage, and the findings in the investigation report…[that] dictate the outcome of these matters." (ALJ ID at 36). All the while, the ALJ had to nevertheless concede, acknowledge and accept in the same paragraph that Mr. Girard's testimony was credible, professional and forthright. (ALJ ID at 36). So, the ALJ concedes and accepts the credibility and professionalism of Mr. Girard but nevertheless seeks to micro-manage his investigation after the fact by raising extraneous objections/critiques to some of his investigatory methodologies and choices.

The Respondent strongly rejects to these attempts by the ALJ to imply if not state directly that Mr. Girard's substantiated findings of abuse and neglect in his investigation were somehow not supported by the totality of the record or are suspect due to how he conducted his investigation. (ALJ ID Findings of Fact at 39-40). Respondent reaffirms its position that Girard conducted the Investigation in a professional and competent manner and that the substantiated conclusions contained therein were proper and fully supported by the totality of the evidence, especially but not limited to, the video surveillance footage. Respondent will address these issues in seriatim below but will first review the DOH investigation in detail to best show how professionally Mr. Girard conducted this Investigation.

Mr. Girard first became aware of the alleged incident when I.O., an individual receiving services from the Trenton Psychiatric Hospital (TPH) called the Patient Services Compliance Unit (PCSU) to report an allegation of abuse on behalf of R.V.R., who can only speak Spanish. I.O. made this call to the PCSU on June 1, 2020, the day after the incident occurred. (R-2, DOH039). In this recorded phone call, I.O. alleged that he witnessed R.V.R. get physically attacked by petitioners H.D. and A.E. "because they didn't want him to eat yogurt" and that they "threw him against the wall" and H.D. "choked" R.V.R. and both men took R.V.R. to the bathroom where they "hit him." I.O. also claimed in this phone call that Petitioner D.B.

witnessed this abuse and did not intervene and did not allow R.V.R. to use the phone to call the police. (R-2, DOH039). R.V.R. was sent to Capital Health System (CHS) Emergency Room (ER) on June 1, 2020 complaining of right side shoulder pain and tenderness to the rib cage since the evening of May 31, 2020. R.V.R. was objectively and professionally examined by medical personnel and returned with a diagnosis of, "assault, other bodily force, contusion thorax, unspecified, injury head, unspecified, and 4.5mm nodule in the right middle lobe." (R-2, DOH041).

Per Mr. Girard's scope of duties as a DOH Investigator, once he became aware of these allegations of abuse and neglect he was required to conduct, at a bare minimum, a preliminary investigation to see if these claims were of some merit and warranted a further and more comprehensive investigation. One of the critical next steps in Girard's investigatory process was a second-by-second exhaustive review of the video surveillance footage for the incident date of May, 31, 2020 from the relevant time stamps of 11:10 to 11:59 a.m. This exhaustive review was conducted by Girard on June 10, 2020 and is the same video surveillance footage reviewed supra in detail. (R-2, DOH055-058).

After meticulously reviewing this footage frame-by-frame Girard then interviewed eyewitness I.O. to compare and contrast his version of events with that shown by the video surveillance footage. It is important to note that I.O. stated in his interview that he spoke with R.V.R. after the incident and, "R.V.R. reported being hit in the head and body by petitioners H.D. and A.E." and "R.V.R. complained of pain to the left ear" and I.O. could see the skin behind R.V.R.'s "left ear was reddened and scratched." (R-2, DOH040). This contemporaneous data point of R.V.R. complaining of pain corresponds exactly with contemporaneous video footage of R.V.R. grabbing at the left side of his head in the telephone corridor and outside of it in the dayroom sitting area as well as when he proactively sought medical attention from D.B. (R-27 from 11:41:02 to 11:56:52).

On June 17, 2020 Girard conducted a telephone interview with victim R.V.R. to gain further insight into the details surrounding the incident. R.V.R. stated that, "two black staff.. attacked him in the King day room" and took him to the bathroom where "he was punched on the

left side of the head twice by the tall staff member and kicked on the right arm by the short staff…and both staff threw water on him.. and there were no other people in the bathroom." He further stated that, "he sustained an injury to the left side of his head and to the right side of his ribs/back, which continues to cause him pain." (R-2, DOH044). R.V.R.'s contemporaneous complaints of pain and injury again corresponds with the actual physical abuse clearly seen on the video surveillance footage. It also buttresses the statements of I.O. regarding R.V.R.'s complaints of pain and injury made to him soon after the incident as well as R.V.R.'s personal behavior on video after the attacks. (R-27 from 11:41:02 to 11:56:52). On top of all this, R.V.R.'s complaints of pain and injury would also seem to be objectively borne out by the Capital Health Discharge Paperwork of June 2, 2020 discussed supra. (R-2, DOH041) and which is certainly of more gravity than D.B.'s cursory examination of R.V.R.-which in the video lasted about 20 seconds in total. (R-27 from 11:56:52 to 11:57:12).

In addition to the above, Girard also interviewed two other hospital personnel as well as all three petitioners and accessed numerous documents and training records as part of the Investigation. (R-2, DOH068). Respondent reiterates its' full support of the Investigation both in the manner in which it was conducted as well as in its' substantiated findings of abuse and neglect.

The ALJ's first attempt to undercut the findings of Girard's investigation was to call into question why Girard did not first assess or inquire into R.V.R.'s capacity for telling the truth before interviewing him and also why he did not use a certified Spanish language interpreter when he interviewed Spanish speaking R.V.R. (ALJ ID at 39). The implication of raising these non-existent issues is to draw the reader to conclude that errors must have been made by Girard, sufficient enough to call into question the ultimate findings of the investigation. Nothing could be further from the truth.

Respondent counters these assertions by citing N.J.A.C. 1:1-15.8, which provides that every person is qualified to be a witness if he or she has some personal knowledge of the matter, special experience, training or education. N.J.A.C. 1:15.8(a)-(c); see also N.J.R.E. 601. The presumption of witness competency is a legal question for the judge and not the investigator.

N.J.A.C. 1:15.8(c). Requiring Girard to vet "capacity for telling the truth" prior to taking a statement would invert the evidentiary requirements of witnesses at an OAL hearing and graft a non-existent investigative pre-screen onto the practice of all investigators at the Office of Investigations.

The Investigator's role is to gather statements from witnesses and corroborate those statements-not to perform clinical competency evaluations. (1T20:15-21:21). To interview R.V.R., who is Spanish speaking, Girard used an interpreter. (1T100:4-7). There is no requirement for the investigator to use a certified interpreter. Girard documented that R.V.R.'s account was "somewhat" complete, as is "typical with everybody," and then tested it against video, staff statements and records. (2T112:12-113.8). The Patient Services Compliance Unit gives "patients the ability to contact and report allegations of abuse, neglect and exploitations." (1T24:20-23). This unit exists precisely so service recipients can report abuse/neglect and those reports then trigger an investigation by the Office of Investigations. (1T24:14-25:25; 1T118:4-12). This framework presumes patient's reporting as true, so patients are in fact encouraged to report any type of misconduct.

The duty to be truthful and cooperate is squarely imposed on staff witnesses which further shows why Girard does not, and should not, perform capacity tests of patients. TPH's Code of Conduct makes it disciplinable for employees to provide misleading of false information or to refuse to cooperate or provide truthful answers in an investigation. (J-13) This duty to cooperate and be truthful applies to Petitioners A.E., H.D. and D.B. and not to patients like R.V.R. who are developmentally disabled and not employees.

In sum, the ALJ raised issues and concerns and imposed standards upon Girard's interview of R.V.R. not supported by law or policy. There is nothing at all actionable in how Girard conducted his interview of R.V.R. nor in his use of a non-certified Spanish language interpreter. Girard's interview methodologies and choices as concerning R.V.R. were conducted in full compliance with existing legal and policy standards and requirements and thus any subsequent substantiated acts of abuse or neglect are in no manner negated. Respondent rejects any assertions or implications by the ALJ to the contrary.

The second attempt by the ALJ to undercut the findings of Girard's investigation centered around the fact that Petitioners were not afforded an opportunity to sign off on their interview statements to Girard nor edit the same before the investigation was finalized. (ALJ ID 39-40). This is again another "issue" raised by the ALJ that is designed to cast a negative light on the investigation and imply that the investigation's ultimate conclusions are to be doubted. This is another attempt to graft onto Girard a responsibility neither he nor any other Investigator would have, namely, to make potential perpetrators co-authors of the very investigation that could potentially substantiate claims against them. Simply put, Girard was not under any obligation whatsoever to show any of the petitioners their witness statements. The Investigator's report is the investigator's findings-it is not a co-authored document with alleged perpetrators. Interviewees do not have a right to edit an investigator's findings. These investigations are supposed to be independent and conducted by a non-interested, non-biased investigator, not edited and re-written by witnesses in support of their version of events.

Allowing a witness, especially one who is accused of abusing a developmentally disabled patient, to edit findings in an investigation collapses the line between objective and biased findings. It undermines the independence of the investigator and the report. (R-2). Once a witness sees what the investigator has found, they can consciously change their statements to downplay allegations or better fit a narrative more favorable to them.

Indeed, both H.D. and A.E. changed or "clarified" core facts during the hearing. For example, H.D.'s statements during the interview with Girard were not consistent with the video surveillance or his written statement (1T103:24-104:9; R-4; R-27) when Girard compared H.D.'s statements during his interview and his written statement. (1T105:4-14; R-2; R-4). A.E.'s statements during the interview were not consistent with the video surveillance when they entered the pay phone room. (1T108:3-11; R-3). R.V.R. was physically removed from the phone and an altercation occurred, but A.E. told Girard that he did not touch R.V.R. Similarly, D.B. changed or "clarified" facts from her interview statement and her testimony. In her interview statement, D.B. said, R.V.R. "does not know how to use the pay phone and the door to the room where the pay phone was located was closed/locked." (R2 DOH053). During direct examination,

D.B. testified that R.V.R. "can use the pay phone…but he has a behavior that he hang (sic) up the phone, so I will tell staff to just monitor him." (8T68:15-18). Later, during direct when asked what was "wrong" with her statement to Girard, D.B. testified that "the door was open" to the pay phone room. She did not find an issue with the rest of her statement to Girard. (8T68:17-18). On cross-examination, D.B. testified that R.V.R. knows how to use the pay phone (8T84:17-19) and that patients can use the pay phone. (8T122:1-3). Giving the Petitioners the investigation statement up front would only magnify the risk by letting them harmonize their story to the findings rather than the truth.

Based upon the above legal and factual discussion, the Respondent finds that the totality of the evidentiary record establishes beyond a preponderance of the evidence that the names of H.D., A.E. and D.B. should be placed on the Central Registry. This conclusion was reached after a thorough and detailed review of the entire record, including but not limited to all proffered testimony as well as timely and contemporaneous witness statements, investigations and critical video surveillance footage.

FINAL AGENCY DECISION Re: CENTRAL REGISTRY ACT MATTERS

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- **THE DIRECTOR OF THE OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY CONCLUDES AND AFFIRMS** the following:

I CONCLUDE AND AFFIRM that DHS has sustained its burden of proving, by a preponderance of the credible evidence, that the actions of H.D. rose to the level of physical abuse as defined in N.J.A.C. 10:44D-2.1 (c) in the form of pushing, hitting and dragging R.V.R.

I CONCLUDE AND AFFIRM that DHS has substantiated its burden of proving, by a preponderance of the credible evidence, that H.D. acted recklessly and with careless disregard for the well-being of R.V.R., as defined in N.J.A.C. 10:44D-4.1(b), thereby justifying the placement of H.D.'s name on the Central Registry.

I CONCLUDE AND AFFIRM that H.D. be placed on the Central Registry and therefore **REVERSE AND REJECT** the ALJ'S ORDER that H.D.'s name not be placed on the Central Registry.

I CONCLUDE AND AFFIRM that DHS has sustained its burden of proving, by a preponderance of the credible evidence, that the actions of A.E. rose to the level of physical abuse as defined in N.J.A.C. 10:44D-2.1 (c) in the form of pushing, hitting and dragging R.V.R.

I CONCLUDE AND AFFIRM that DHS has substantiated its burden of proving, by a preponderance of the credible evidence, that A.E. acted recklessly and with careless disregard for the well-being of R.V.R., as defined in N.J.A.C. 10:44D-4.1(b), thereby justifying the placement of A.E.'s name on the Central Registry.

I CONCLUDE AND AFFIRM that A.E. be placed on the Central Registry and therefore **REVERSE AND REJECT** the ALJ'S ORDER that A.E.'s name not be placed on the Central Registry.

I CONCLUDE AND AFFIRM that DHS has sustained its burden of proving by a preponderance of the credible evidence, that the actions of D.B. rose to the level of neglect as defined in N.J.A.C. 10:44D-2.1 (c) by recklessly and repeatedly failing to prevent and/or stop the abuse of R.V.R. inflicted by H.D. and A.E, whom she supervised.

I CONCLUDE AND AFFIRM that DHS has substantiated its burden of proving, by a preponderance of the credible evidence, that D.B. acted with recklessness by creating a substantial and unjustifiable risk of harm to R.V.R with a conscious disregard for that risk., as defined by N.J.A.C. 10:44D-4.1 (c), thereby justifying the placement of D.B.'s name on the Central Registry.

I CONCLUDE AND AFFIRM that D.B. be placed on the Central Registry and therefore **REVERSE AND REJECT** the ALJ's ORDER that D.B.'s name not be placed on the Central Registry.

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 placements of H.D., A.E. and D.B. on the Central Registry of Offenders against Individuals with Developmental Disabilities.

Having affirmed the placement of the names of H.D, A.E. and D.B. on the Central Registry of Offenders against Individuals with Developmental Disabilities, I submit this decision to the Civil Service Commission for their deliberation of whatever matters, within their purview, may be left unresolved.

Date: 12/31/2025 Deborah Robinson

Deborah Robinson, Director
Office of Program Integrity and Accountability