PHILIP D. MURPHY
Governor

TAHESHA L. WAY
Lt. Governor

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Office of Program Integrity and Accountability
P.O. Box 700
Trenton, NJ 08608-0700

SARAH ADELMAN
Commissioner

DEBORAH ROBINSON
Director

FINAL AGENCY DECISION

OAL DKT. NO. HSL 10382-20

AGENCY DKT. NO. DRA 20-012

T.P.,

Petitioner,

v.

NEW JERSEY DEPARTMENT OF

HUMAN SERVICES,

Respondent

Robert R, Cannan, Esq. for petitioner (Marman & Cannan, LLC, attorneys)

Michael R. Sarno, Deputy Attorney General, for Respondent Department of Human Services, Office of Program Integrity and Accountability (Matthew J. Platkin, Attorney General of New Jersey, attorney)

Record Closed: June 2, 2025 Decided: August 14, 2025

Before **Kim C. Belin**, ALJ

INITIAL DECISION:

STATEMENT OF THE INITIAL DECISION

Petitioner T.P. (petitioner or T.P) appeals his placement on the Central Registry of Offenders Against Individuals with Developmental Disabilities (Central Registry) by the Department of Human Services (Department) pursuant to N.J.S.A. 30:6D-73 and N.J.A.C. 10:44D. The Department substantiated allegations that T.P. physically abused F.Z., an individual receiving services from the Division of Developmental Disabilities ("DDD"), on October 27, 2019 while employed at a state licensed facility.

PROCEDURAL HISTORY

By letter, dated September 23, 2020, the director of the Office of Program Integrity and Accountability (OPIA) notified T.P. of its investigative findings and its determination to place his name on the Central Registry. T.P. filed an appeal, and DHS transmitted the matter to the Office of Administrative Law (OAL), where it was filed as a contested case on November, 2, 2020, pursuant to N.J.S.A. 52:14B-1 to -15 and N.J.S.A. 52:14F-1 to -13. An Order to Seal was entered on December 10, 2020.

The DHS filed for summary decision on October 6, 2021. The petitioner failed to file a timely response but was granted an extension until December 21, 2021, wherein the response was filed. The respondent submitted its reply on January 10, 2022. In an order dated February 24, 2022, the Honorable Kim C. Belin, ALJ denied the respondent's motion.

Hearings were held on July 25, 2022, August 16, 2022, November 21, 2022, February 23, 2023, April 9, 2024, July 17, 2024, and November 14, 2024. Transcripts were ordered, and the record was held open pending the same. After numerous extensions, the respondent submitted its written summation on June 2, 2025, and the record was closed on that date. The petitioner did not submit a written summation.

INITIAL DECISION'S FACTUAL DISCUSSIONS AND FINDINGS

The **ALJ FOUND AS FACTS THAT**:

T.P. was employed by Trenton Psychiatric Hospital (TPH) as a registered nurse from January 9, 2017, until his termination on October 29, 2019. T.P. was the charge nurse on duty on October 27, 2019. F.Z., a patient receiving services from the New Jersey Department of Health (DOH) Division of Behavioral Health Services (DBHS) and Trenton Psychiatric Hospital, reported to his mother that he was assaulted by staff. His mother reported these allegations on October 30, 2019. An Unusual Incident Report was filed on November 4, 2019, finding that F.Z. was physically abused by T.P. on the evening of October 27, 2019.

The New Jersey Department of Health (DOH) conducted an investigation of the alleged physical abuse with Ms. Jan Rudder of the Office of Investigations for DOH as the primary investigator. Jan Rudder has been an investigator for DOH since August 2018. She has investigated allegations of abuse, exploitation, neglect, physical, psychological, and sexual abuse at TPH. Her objective was to determine if these allegations were substantiated. She has completed 240 investigations. Ten percent of the cases were substantiated, and ninety percent were not. She has a degree in special education and had worked as case manager for the DDD from September 2008 through 2011.

Jan Rudder interviewed person served F.Z. and his mother M.Z. Jan Rudder also interviewed three Human Services Assistants at TPH as well as T.P and another colleague also considered as an alleged perpetrator. Ms. Rudder also reviewed F.Z.'s Treatment Plan, the Body Chart documenting injuries sustained by F.Z., the DDD eligibility from, training records for T.P., the TPH Therapeutic Options Manual (Manual), the video surveillance footage, and the TPH policies on restraint, abuse and neglect.

Rudder received the unusual incident report (UIR) from the unit on October 27, 2019. The incident occurred in the dayroom in the Kennedy unit at TPH. T.P. was an R.N. and was the charge nurse on the day of the incident. Rudder requested the training records and the video footage. She interviewed F.Z.'s mother, who stated that F.Z. was assaulted by two male staff members at TPH. There were bruises on F.Z.'s body. F.Z. told her he did not want to be touched by staff, and he was upset. Rudder also interviewed three other staff members who shared that F.Z. was throwing chairs, overturning tables and was impatient because staff would not change the television to the program F.Z. wanted to watch. Their statements did not match what Rudder saw on the video footage.

All staff who witnessed the incident were asked to provide written statements, including T.P. Rudder interviewed T.P., who said that F.Z. was agitated and throwing chairs and that F.Z. attacked T.P. T.P. did not mention that F.Z. was dragged across the floor, that T.P. pushed F.Z. or that F.Z. spit on T.P.

Specific to the video surveillance footage, Rudder saw T.P. push F.Z. nine times and saw another employee drag T.P. across the floor. She reviewed the video footage at least twenty times because there was a lot of activity. Rudder reviewed the Manual to determine the approved methods to handle a patient. Staff members can separate patients but not by pushing, pulling or shoving. She concluded that what she saw on the video was not approved by the manual. She saw T.P. participate in dragging F.Z. across the floor. She believed what she saw on the video was physical abuse.

Due to COVID, Rudder interviewed T.P. by telephone. T.P. was not represented by a union representative when he spoke to Rudder. T.P. did not tell Rudder that F.Z. punched T.P. in the face and knocked off his glasses and broke them. Rather, T.P. said that F.Z. pushed him and got into his personal space. T.P. did not tell Rudder that F.Z. had spit in his mouth. Rudder did not see T.P. drag F.Z. across the floor. Rudder saw T.P. push F.Z. from the back, causing him to fall into the wall.

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

T.P. was the only nurse on duty for his shift on both sides of the Kennedy Unit on October 29, 2019, where he had to handle twenty-three patients with developmental disabilities. One of these patients was F.Z., who was known as a combative patient with a history of physical aggression against staff and a diagnosis of intermittent explosive disorder. (R-5.) On the day in question, the video footage shows F.Z. turning over chairs in the day room of the Kennedy Unit. (R-1 at 8:11:11).

In the video, F.Z. is wearing a baseball cap and headphones. T.P. is wearing a purple shirt. The video has no sound. (R-1.) In the video, F.Z. and the petitioner are seen in the day room. T.P.'s back is against the wall, and F.Z. is directly in front of him. F.Z. raised both hands into the air and stomped his foot several times. T.P.'s arms were folded across his chest. (R-1 at 8:17:29—8:17:50). F.Z. knelt on one knee and then the other in front of T.P. F.Z.'s arms were behind his head. T.P. walked away from him to speak to M.S. F.Z. followed T.P. (Id at 8:18-36-8:19-59). T.P. exited the nurse's station and walked over to M.S. and attempted to hand an object to M.S.

F.Z. followed T.P. and tried to grab the object from T.P [1] T.P. used his right arm to redirect F.Z. from the object. (Id. at 8-22-8).

F.Z. is persistent in attempting to get the object from M.S. F.Z. appeared to direct T.P. away and reached toward M.S. (Id. At 8:22:20–8:22:59.) T.P. walked in front of M.S. and held F.Z.'s arms while M.S. pointed the object at the television as if to change the channel. (Ed. At 8:23:28–8:23:35.) The first push occurred when T.P. followed behind F.Z. and pushed F.Z. from behind into the wall. F.Z. was not facing T.P. but was facing M.S., who was seated in a chair. F.Z. raised his arm to brace himself from hitting the wall. (Id. at 8:24:37.)

While T.P. was standing against the wall, F.Z. reached forward to put his hands around T.P.'s neck, and T.P. pushed him away. (Id. at8:27:50.) F.Z. reached forward again to put his hands around T.P.'s neck, and T.P. pushed him away. (Id. at 8:27:53.) F.Z. reached forward a third time toward T.P.'s neck, and T.P. pushed him away more forcibly. (Id. at8:28:06)

T.P. extended his arm in front of him, creating space between himself and F.Z. (Id. at 8:28:12.) F.Z. leaned into T.P. who was against the wall, but T.P. did not respond. (Id. at 8:28:31) F.Z. again leaned into T.P. and T.P. pushed him away. (Id. At 8:28:34–37.) F.Z. leaned into T.P another time and T.P. again pushed him away. (Id. At 8:29:05.) Once again, F.Z. leaned into T.P. and T.P. pushed him away. (Id. at 8:29:31.) T.P. walked away from F.Z.

While the three men were standing in front of the television, F.Z. punched M.S.; T.P. attempted to separate the two men. (Id. at 8:33:08—10.) T.P. was unsuccessful, and the two men ended up on the floor with F.Z. on top of M.S. (Ibid.) T.P. assisted M.S. in standing up, and M.S. reached for the restraint chair that he had previously brought into the room. (14, at 8:34:29.) T.P. and M.S. were unable to get F.Z. into the restraint chair. (Id. at 8:34:40–57.) F.Z. grabbed M.S.'s leg and T.P. attempted to get F.Z. to release M.S.'s leg. (Lat8:39:06.) A tussle ensued, and T.P. lost his shoe. F.Z. was able to get up and run after M.S., who was walking toward the nurses' station. T.P. attempted to separate the two men, and F.Z. turned his attention to T.P. whereby T.P. pushed F.Z. to create space between them. (Id. at 8:40.)

The Manual contains a section on Positive Behavior Support (PBS) that states that PBS seeks to provide a "positive environment in which the person's needs for safety, stimulation, meaning, and relationship are addressed and met." (È-19 at DOH 187.) However, it does recognize that physical restraints may be necessary "in situations in which a person presents dangerous and violent behavior despite a provider's best efforts at prevention." (Ibid.) The Manual outlines specific techniques for staff to protect themselves. For example: visual boundary and verbal stop. This involves "extending your hand and telling the person to stop advancing toward you." (R-19 at DOH 197.)

In the section on Choke Releases, the Manual states that for a front choke release, "[p]lace your palm against the person's inside wrist, close to his hand. Assertively thrust the person's hand

[1] The object is likely the remote for the television.

away from you as you pivot on your lead foot." (lg. at DOH 206, emphasis added.) The Manual does not prohibit staff from physically touching patients. The Manual states: "CAUTION! Never put your hands on someone to control them unless their behavior is so dangerous that it would be negligent if you didn't. Deciding to put your hands on someone is serious business." (Ids at 209.) The Manual outlines the following physical assist techniques:

a. Supportive escort.

b. Secure escort (this is a two-person escort).

c. Body shield (for intercept, physically redirect or separate two people who are fighting).

d. Body control restraint (to manage someone harming him/herself or someone else).

e. Arm control restraint.

f. Guide to the floor.

g. Supine restraint. (Id. at DOH 211—222.)

The Manual recommends:

> Any person receiving services whose behavior may pose a danger to self or others, and consequently, may be the subject of physical management by staff, should have a comprehensive support plan in place. This plan should be the product of an interdisciplinary or multidisciplinary team that includes the individual receivihg services or the individual's guardian. The plan should detail the individual's support needs, provide guidance in how to best support the person's growth, and describe the process for eliminating the use of physical interventions with that person.
>
> [IA at DOH 209.]

TPH Policy 1.901 entitled "Patient Abuse and Neglect" states: "physical abuse refers to 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." (R-8 at DOH 58.)

INITIAL DECISION'S LEGAL ANALYSIS AND CONCLUSIONS OF LAW

The **ALJ FOUND THAT**:

It is the policy of this State to provide for the protection of individuals with developmentat disabilities by identifying those caregivers who have wrongfully caused them injury. N.J.S.A.

30:6D-73(a). The Central Registry was created and designed to prevent the employment or maintain the employment of a person who is placed on the Central Registry. N.J.A.C. 10:44D-1.1 (b).

> Under the Central Registry Act:
>
> "Abuse" means wrongfully inflicting or allowing to be inflicted physical abuse, sexual abuse or verbal or psychological abuse or mistreatment by a caregiver upon an individual with a developmental disability.
>
> "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 developmental disability being kicked, pinched, bitten, punched, slapped, hit, pushed, dragged or stuck with a thrown or held object.
>
> [N.J.A.C. 10:44D-1.2.]

To be included on the Central Registry due to an act of physical or verbal abuse, the caregiver must have "acted with intent, recklessness or careless disregard to cause or potentially cause injury to an individual with a disability." N.J.S.A. 30:6D-77(b)(1).

> N.J.A.C, 10:44D-4.1(b), the corresponding regulation, defines each mental state:
>
> 1 . Acting intentionally is the mental resolution or determination to commit an act.
>
> 2. Acting recklessly is the creation of a substantial and unjustifiable risk of harm to others by a conscious disregard for that risk.
>
> 3. 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.

The burden of proof falls on the agency in enforcement proceedings to prove a violation. Cumberland Farms Inc. v. Moffett, 218 N.J. Super. 331, 341 (App. Div. 1987). In this matter, DHS bears the burden of establishing the truth of the allegations 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.'" Jaeqer v. Elizabethtown Consol. Gas Co., 124 N.J.L. 420, 423 (Sup. Ct. 1940) (citation omitted). The evidence must "be such as to lead a reasonably cautious mind to the given conclusion." Bornstein v. Metro. Bottlinq Co., 26 N.J. 263, 275 (1958). Precisely what is needed to satisfy this burden necessarily must be judged on a case-by-case basis.

The record here reflects that F.Z. was a combative patient with a history of attacking staff. Indeed, on the night of October 27, 2019, F.Z. flipped over chairs and tables in the dayroom. T.P. was the only nurse on duty for his eight-hour shift, handling patients from both sides of the Kennedy Unit, including F.Z. T P. stated that he requested help before his shift

started to no avail. T.P. testified that F.Z. threatened to kill him and suffocate him by kneeling on his neck. The video evidence showed F.Z. standing directly in front of T.P., stomping on F.Z.'s foot and kneeling on the floor. The video also showed F.Z. reaching forward to choke T.P. three times.

F.Z. was persistent in trying to get the television remote from the staff. The video evidence shows T.P. making attempts to verbally and physically redirect F.Z. and create visual and physical boundaries between himself and F.Z. and M.S. and F Z. The respondent described this latter conduct as pushing, and T.P. described it as physical redirection.

The Manual outlines various techniques to handle patients who are physically aggressive. The Manual does not prohibit staff from physically touching patients and acknowledges that there may be times when safety demands physical contact. (R-19 at DOH 209.) However, the Manual cautions that such physical contact should be used with extreme care. (Id.) Ms. Rudder, Colon, and Ikpeama testified that T.P. pushed F.Z. as many as seven times. Specifically, Ms. Rudder reported that

> [From 8:27.53 pm [sic] to 8:29:31 pm [sic] Mr. [T.P.] and Mr. [F.Z] have physical contact with each other multiple times. During this time, Mr. [T.P.] was observed pushing Mr. [F.Z.] backwards approximately seven times. From 8:40:00 pm [sic] to 8:40:02 pm [sic] Mr. [T.P.] was observed pushing Mr. [F.Z.] backwards an additional two times."
>
> [R-6 at DOH 39.]

The ALJ determined that only T.P.'s first push of F.Z. from behind constituted physical abuse sufficient to place T.P. on the Central Registry. The ALJ was not persuaded that the subsequent "pushes" by T.P. were anything other than acts of physical contact specifically intended to create space between T.P. and F.Z. The ALJ asserted that these "pushes" were done by T.P. without intent, recklessness or careless disregard. The ALJ was "persuaded" to believe that T.P. was making a great effort to create physical boundaries with a combative F.Z. and that T.P.'s movements became more amplified to create a greater distance between them. In short, the ALJ concluded that the subsequent pushes were justified by T.P. due to aggressive behavior by F.Z. and under-staffing issues and were in compliance and comportment with the Manual guidelines.

As to the first initial push from behind by T.P., the ALJ did find this behavior to be problematic. The video showed that from 8:24:37 p.m. to 8:24:40 p.m., the petitioner approached F.Z. from behind and pushed him into the wall. Ms. Rudder included this in her report. (R-6 at DOH 31, 39.) T.P. stated that he was trying to move F.Z. away from M.S. (T6:161:13—17)[2] T.P. further stated that he was concerned and attempted to escort F.Z. in another direction away from M.S. because T.P. saw that F.Z. had made a fist white he was talking to M.S. (T6:161:21-25;

[2] T6 refers to the transcript of the hearing held on July 14, 2024.

162:1-6.) This, however, was inconsistent with the guidance from the Manual, which described the "Supportive Escort" as:

> [stand behind the person and slightly to one side. Place your left hand on the person's left arm, just above his elbow. Keep your elbow down and cup your hand around the back of the person's arm. Place your right hand on the person's waistline, just to the right of his spine. Guide the person forward, using only enough contact and pressure to keep him moving forward. Again, if the person begins moving forward on his own, it may be appropriate to discontinue the physical contact.
>
> [R-19 at DOH 211.1

The video does not show that T.P. followed this guidance. The video shows that T.P. walked up behind F.Z. and pushed F.Z. forward, causing F.Z. to reach out his arm to brace himself from hitting the wall. It does not appear that T.P. was attempting to move F.Z. away from M.S., as T.P. asserts.

Accordingly, The **ALJ CONCLUDED** that the Respondent had sustained its burden of proving by a preponderance of the evidence that T.P.'s actions did in fact rise to the level of physical abuse as defined in N.J.A.C. 10:44D-2.1(c) when T.P. physically pushed F.Z.

The **ALJ CONCLUDED** that T.P. acted recklessly and with careless disregard for the well-being of F.Z., an individual protected by N.J.S.A. 30:6D-73, thereby justifying that his name be entered onto the Central Registry.

INITIAL DECISION FINAL ORDERS

The **ALJ ORDERED** "that the determination of abuse by the respondent Department of Human Services against T.P. be **AFFIRMED**. The **ALJ FURTHER ORDERED** that T.P.'s name be placed on the New Jersey Registry of Offenders Against Individuals with Developmental Disabilities."

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

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

EXCEPTIONS TO THE INITIAL DECISION:

The respondent filed exceptions to the Initial Decision on August 22, 2025. No exceptions were filed by the Petitioner. The Respondent's exceptions were summarized by the Respondent:

"For the reasons set forth below, the Director of the Office of Program Integrity and Accountability should first modify the Initial Decision with regard to the stated issue of the case and two minor factual clarifications. Second, the Director should expand on the ALJ's reasoning

for affirming T.P.'s placement on the Central registry. More specifically, the ID ultimately concluded that on October 27, 2019, T.P.'s first push of the patient with a developmental disability from Trenton Psychiatric Hospital ("TPH"), who was identified as F.Z., justified the agency's decision, but that his subsequent seven other pushes did not. DHS maintains that based on the law and established record, those other pushes further justified T.P.'s placement on the Central Registry."

LEGAL STANDARD OF REVIEW

Upon consideration of an Initial Decision, an agency head may accept, reject, or modify the recommended decision of the Administrative Law Judge (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). Therefore, "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." *Id*.

EXCEPTIONS TO THE INITIAL DECISION

Stated Issue of the Case

On page 3 of the Initial Decision, the ALJ inadvertently framed the issue of the case as being, "whether respondent has proven the charges by a preponderance of the credible evidence, and, if proven, whether the penalty of removal was justified and reasonable, and whether T.P.'s name should be placed on the Central Registry."

The issue of T.P.'s removal from his job as a penalty for pushing F.Z. was never a part of this appeal. This appeal encompasses only the determination to place T.P. on the Central Registry. The inadvertent inclusion of an extraneous employment discipline matter as an issue of this appeal will only help to create confusion if left in the record.

Minor Factual Modifications

There are two minor errors in the factual/testimonial portion of the ID. First, on page 6 in the last paragraph, it states, "F.Z. grabbed T.P.'s arm, pushed T.P., spat on T.P. and used profanity toward F.Z." (See ID, pg. 6) (emphasis added). Instead, it should read that F.Z. used profanity toward "T.P." at that point.

Second, on page 11 within the first sentence, it says that ". . . there was training in two-year cycles for therapists." (See ID, pg. 11). Instead, it should read that the two-year training cycles were for "nurses," which was Petitioner's position at the time.

ALJ Improper Application Of Intent Requirement For Placement on Central Registry

Despite finding that T.P. pushed F.Z. eight times, the ID determined that only Petitioner's first push at 8:24:37 p.m. to 8:24:40 p.m., when T.P. "approached F.Z. from behind and pushed him into the wall," justified his placement on the Central Registry. (See ID, pg. 22). With regard to the subsequent seven pushes, however, the ID determined that while "some of those

attempts to create distance looked like T.P. was pushing F.Z. away," the ALJ was "not persuaded that these instances of physical contact constitute physical abuse or that T.P. was acting with intent, recklessness or careless disregard." (See ID, pgs. 21-22).

The Department strongly objects to this interpretation of the facts and law by the ALJ and properly asserts that the seven subsequent pushes by T.P. after the initial push constituted seven more separate and distinct additional acts of physical abuse by T.P. (See N.J.S.A. 30:6D-74; N.J.A.C. 10:44D-1.2 (listing "pushed" as an act of "physical abuse").

Referral for placement on the Central Registry is required if the caregiver "wrongfully" inflicts, or allows to be inflicted, "physical abuse," and that the caregiver "acted intentionally, recklessly or with careless disregard to the well-being of the service recipient resulting in injury to an individual with a developmental disability or by exposing the latter to a potentially injurious situation." N.J.A.C. 10:44D-4. I(b); see also N.J.S.A. 30:6D-77(b)(l).

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 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).

Pushing a developmentally-disabled individual explicitly constitutes an act of physical abuse. More specifically, under the Central Registry Act, "abuse" is defined in both the authorizing statute and regulation as "wrongfully inflicting or allowing to be inflicted, physical abuse, sexual abuse or verbal or psychological abuse or mistreatment by a caregiver upon an individual with a developmental disability." N.J.S.A. 30:6D-74•, see also N.J.A.C. 10:44D-1.2.

"Physical abuse" is more specifically defined in both the statute and regulation 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." Id It then relevantly explains that "[s]uch 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." Id (emphasis added).

First, once the ALJ determined that T.P.'s physical acts rose to the level of a "push" of a developmentally-disabled individual, which is explicitly prohibited under N.J.A.C. 10:44D-1.2, the intent requirement looks at whether a petitioner intended to do the act, i.e. the push. A petitioner's professed justification as to the reason for committing the prohibited act in response to patient behavior does not negate the intent to commit a "push."

To interpret the "intent" element under the authorizing statute and regulation in a subjective manner -- rather than as an objective component is erroneous as a matter of law. From a commonsense vantage point, to adopt a subjective view of the "intent" requirement would force DHS to accept caregivers' various forms of abusive conduct against developmentally-disabled persons as long as they express some supposed "good-faith" intention. In that scenario, DHS would almost never be able to substantiate a caregiver's placement on the Central Registry despite the latter committing abusive acts against a developmentally-disabled person and, consequently, would miserably fail in its statutory mission to carry out the Legislature's "paramount concern"

in protecting the "safety of individuals with developmental disabilities." N.J.S.A. 30:6D-73(b). This perspective both undermines the Legislature's intent and is simply unworkable.

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 create a physical boundary, 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. Pursuant to the applicable clear laws on the matter, each of the eight times that T.P. pushed F.Z. was a prohibited act if he intended to commit the push. See N.J.S.A. 30:6D-74; N.J.A.C. 10:44D-1.2.

Second, the case law is in accord. For example, in T.B. v. Dep't of Human Servs., 2019 WL 4928835, at *10-11 (N.J. Adm. July l, 2019), even though petitioner contended that he "never intended to slap" the developmentally-disabled person, the ALJ nonetheless concluded that "petitioner acted intentionally, recklessly and/or with careless disregard when he stepped towards [the victim] with his right arm raised at him while [the victim] was in a restraint chair."

Likewise, in TM. v. Dep of Human Servs., 2023 WL 6620238, at *3 (N.J. Adm. Aug. 9, 2023), the video evidence showed that petitioner "punch[ed]" and "pushe[d]" K.S., a developmentally-disabled person, and shoved him into the back of a vehicle. At the OAL hearing, petitioner claimed that "he was not intending to harm" K.S., yet the ALJ rejected this claim in light ofthe objective evidence. Id. at * 16. That is, despite petitioner's claimed subjective intent not to harm the victim, the ALJ found that the "choice of action by T.M. was done carelessly and zealously" and that he "acted with careless disregard, lacking reasonableness and prudence, when he physically engaged in pushing, shoving, and bear hugging KS. to forcibly get him into the vehicle." Ibid. Thus, the ALJ analyzed the "intent" prong through an objective lens.

Other cases consistently show that the intent requirement for Central Registry purposes is an objective standard and not undermined by a petitioner's supposed subjective intent or purpose. In E.O. v. New Jersey Dep 't of Hum. Servs., 2023 WL 3513888 (App. Div. May 18, 2023), for instance, the Appellate Division affirmed the agency's determination to place petitioner on the Central Registry. 2023 WL 3513888, at *8. In doing so, it upheld DHS's definition of "'careless disregard,' [3] i.e. by reference to the accompanying regulations, when considering petitioner 's actions." Ibid. (emphasis added). The agency also found, which the Appellate Division affirmed, that petitioner acted with "careless disregard" through her "lapse in judgment and her inappropriate and unnecessary engaging with the aggressor." Id. at*4.

Accordingly, the Appellate Division, agency and OAL rightfully construe the "intent" requirement through analyzing a petitioner's objective actions. See also DM v. Dep 't of Human Servs., 2022 WL 178771 1, at *7 (App. Div. June 2, 2022) (stating that petitioner's "actions showed not only intention, but recklessness and a careless disregard for the safety of the" victim) (emphasis added)).

---

[3] The agency noted N.J.A.C. 10:44D-4.l(b), which provides that one acts with "careless disregard" through a "lack of reasonableness and prudence in doing what a person ought not to do or not doing what ought to be done."

Thus, the circumstances in this case should be no different. Respondent agrees with the ALJ that a caregiver can "create physical boundaries with a combative" patient and can even, as the record reflects, use physical contact to do so under the proper circumstances. (See ID, pgs. 18, 22). But, that physical act must amount to approved methods of physical contact[4] and cannot include a prohibited act, which was the case here, even if the circumstances reveal other factors as the ALJ noted like patient aggression or understaffing issues. Id. at 21-22.

To that end, the ID claimed that the video showed T.P. push F.Z. three times at 8:27:50 p.m., 8:27:53 p.m., and 8:28:06-09 p.m., but that these pushes were justified due to F.Z. putting "his hands around the petitioner's neck" or "toward the petitioner's neck," see ID at pg. 16, #10-12, and even concluded that video evidence showed F.Z. "reaching forward to choke T.P. three times," id. at pg. 21. "Indeed," the ID continued, "F.Z.'s attempts to choke T.P. warranted assertive action" under the applicable training/policy guidelines. Id. at 22. The video evidence, however, does not clearly show that F.Z. was putting, or attempting to put, his hands "around" Petitioner's neck, but rather only clearly shows that his hands were near Petitioner's shoulder/neck, face area. On the other hand, if a threatened choking or an actual choking of T.P. had occurred, there are approved "choke hold releases" to remedy such under TPH's training. (See Exhibit R-19, pgs. 62-64 (DOH 205-07)). Thus, DHS affirms that a caregiver again has approved means to respond to physical violence, but cannot employ prohibited acts to do so.

In sum, once the ID agreed that T.P. "pushed" F.Z. on eight occasions and committed a prohibited act, and the evidence establishes that he intended to commit the act of pushing against F.Z., the intent requirement was satisfied. A caregiver cannot intend to commit a prohibited physical act of abuse in response to patient behavior even if it is for a professed legitimate purpose. Rather, the caregiver must resort to only approved methods of carrying out his alleged legitimate purpose. It is not acceptable to commit prohibited abusive acts in response to patient behavior, and the intent requirement is satisfied if the caregiver intended to do the prohibited act.

FINAL AGENCY DECISION

Pursuant to N.J.A.C. 1:1-18.1(f) and based upon a review of the ALJ's Initial Decision and the entirety of the OAL file – the Initial Decision, exhibits, transcripts, and submissions – **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 T.P. rose to the level of physical abuse as defined in N.J.A.C. 10:44D-2.1(c), physical acts of aggression in the form of pushing F.Z.

I CONCLUDE AND AFFIRM that T.P. acted recklessly and with careless disregard for the well-being of F.Z., an individual protected by N.J.S.A. 30:6D-73, justifying that his name be entered onto the Central Registry.

I CONCLUDE and AFFIRM that any and all references to employment discipline/action against T.P. as being an issue of the case be completely stricken from the Initial Decision.

---

[4] The ID lists several approved methods: Supportive escort; Secure escort; Body shield; Body control; Arm control restraint; and Guide to the floor. (See ID, pg. 18).

I **CONCLUDE and AFFIRM** that the minor errors in the factual/testimonial portion of the Initial Decision referenced above be corrected to more accurately reflect the facts.

I REJECT AND REVERSE the ALJ's application of a subjective intent standard regarding acts of prohibited physical abuse for purposes of placement on the Central Registry. It is settled case law that the intent requirement for placement on the Central Registry is an objective standard and is not undermined by a petitioner's supposed subjective intent or purpose.

I FURTHER REJECT AND REVERSE the ALJ's decision that the additional seven pushes by T.P. were insufficient to constitute additional grounds for placement on the Central Registry.

Pursuant to N.J.A.C. 1:1-18.6(d) it is the Final Decision of the Department of Human Services that **I ORDER** the placement of T.P. on the Central Registry of Offenders against Individuals with Developmental Disabilities.

Date: 09/25/2025 Deborah Robinson

Deborah Robinson, Director
Office of Program Integrity and Accountability