State of New Jersey
DEPARTMENT OF HUMAN SERVICES
OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY
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KIM GUADAGNO
LT. GOVERNOR

JENNIFER VELEZ
Commissioner

FINAL DECISION
OAL DKT. NO. HSL 4133-12
AGENCY DKT. NO. DRA #12-001

DEPARTMENT OF HUMAN SERVICES,

Petitioner,

v.

T.J.,

Respondents.

A. INTRODUCTION

On April 27, 2011, the Department of Human Services notified T.J. that her name would be placed on the Central Registry of Offenders Against Individuals with Developmental Disabilities as a result of a determination that she had neglected a resident at the Woodbine Developmental Center. On March 22, 2012, the matter was received by the Office of Administrative Law as a contested case. A hearing was held on October 22, 2012, October 23, 2012, November 15, 2012, January 28, 2013, May 8, 2013, May 9, 2013, and July 24, 3013 (the last date was not noted in the Initial Decision). The record was closed upon receipt of written closing arguments on February 27, 2014. An order of extension to issue the Initial Decision was granted on April 8, 2014.

B. THE INITIAL DECISION

The Initial Decision was based upon the testimony of nine witnesses, seven for the Petitioner and two (including TJ) for the Respondent. The witnesses were examined by Gene Rosenblum, DAG, for the petitioner, William A. Nash, Esq., for the respondents, and the Administrative Law Judge (ALJ), W. Todd Miller.

The Department alleged that: TJ was asleep five feet from a service recipient under her care, with her back to the recipient; TJ's chair was covered in a plastic bag (creating a potential pica hazard for the service recipient and other residents in the pica unit); the service recipient was placed in a wheelchair to prevent him from walking around, which constitutes an unauthorized restraint; the service recipient under TJ's care was found to have a clothing protector (bib) in his mouth (which was unauthorized and was a pica hazard); TJ failed to document this incident of pica; and failed to provide one-to-one enhanced support to an individual with severe pica.

The Administrative Law Judge (ALJ) found that there were four eyewitnesses to the incident. One, a member of the upper management of the developmental center that the ALJ determined should be held to a higher standard for implementing policy and overseeing operations, was found "not credible" because of unexplained entries in a book that he brought into evidence sua sponte. Another witness for the petitioner was found by the ALJ to be "incredible" – giving vague answers and acting confused. Another of the petitioner's witnesses was found to be "marginally credible". The ALJ found that since she was facing discipline when she authored her incident reports, the ALJ was concerned that some statements therein might be shaded or embellished. The respondent was the only other eyewitness. The ALJ found that the respondent's testimony was vague and inconsistent, with poor independent recall of the incident.

The ALJ, based upon competing eyewitnesses, apparent conflicts between witnesses, credibility shortcomings, unconvincing excuses, insufficient proofs, and inconsistent policy applications, concluded that the Department had failed to meet its burden of proof concerning the individual allegations within the neglect charge. After reviewing the proofs and making credibility determinations, the ALJ concluded that the Department of Human Services failed to meet its burden of proof (gross negligence or recklessness) that respondent neglected the service recipient under her care.

CONCLUSION:

The ALJ concluded that the Department of Human Services had failed to demonstrate neglect attributable to the respondent, as defined by N.J.A.C. 10: D-4.1(c), by a preponderance of the credible evidence. The ALJ ordered that respondent's name should not be placed in the Central Registry of Offenders Against Individuals with Developmental Disabilities and suggested disciplinary action, instead.

C. EXCEPTIONS

Exceptions to the Initial Decision were received. The Deputy Attorney General (DAG), representing the Department of Human Services, argued that the initial decision was faulty due to flawed credibility findings. The DAG argued that the interpretation of the log book was unsupported because the entries were ambiguous and no one with personal knowledge had testified as to the meanings of the entries. The conclusions were argued to be unreasonable and not supported by sufficient evidence in the record.

The response from the respondent argued that the initial decision should be upheld. The entries in the log book were argued to speak for themselves. The respondent argued that the credibility determinations were proper and that there was a de facto policy at the facility that would preclude a finding of abuse. The respondent disagreed with the characterization that respondent was asleep and the classification of a restraint in the wheel chair. The respondent argued that the initial decision was correct in its determination that Sherry Manwaring's testimony was incredible.

D. FINAL DECISION

The Initial Decision must be rejected and modified due to errors of law. The errors of law mandate the reconsideration of the entire record of testimony recorded in the seven volumes of transcripts, evidential documents, closing arguments, and exceptions. The Initial Decision does not apply the correct law – the Central Registry of Offenders against Individuals with Developmental Disabilities (N.J.S.A. 30:6D-73 et seq. and its attendant regulations N.J.A.C. 10:44D). The Department of Human Services' review of the entire record reveals baffling conclusions based on unexplained, unexamined and questionable evidence. The Initial Decision never mentions the testimony and evidence given by four witnesses. These witnesses testified, among many other pertinent issues, about the requisite and reasonable level of care that is expected of a caregiver. The appeal that was to be decided in this case was founded on negligence. The Initial Decision, while it quotes the Central Registry law in its text, never discusses a level of care and cannot, therefore, equitably rule out or establish a breach of a duty in that care. Roughly half of the testimony and importantly, the portions that presented the proper policies and procedures was never mentioned and evidently, never considered. With no foundation for and a definition of a duty of care, there can be no basis for determining negligence, or a breach of that duty. Further, the Initial Decision is founded upon credibility findings that are not supported by sufficient, competent, rational, or trustworthy evidence. The Initial Decision in this case is arbitrary and capricious and must be rejected and modified.

The only question to be decided by the court, at the time of hearing, was whether or not the respondent, T.J., had been correctly placed on the Central Registry of Offenders against Individuals with Developmental Disabilities. At one point in time, that question had been consolidated with a Civil Service disciplinary matter with the Central Registry matter given the predominant interest. The Civil Service matter was severed, due to a summary disposition, two months before the start of the hearings, but disciplinary references shadowed the entire proceedings and are even made part of the Initial Decision. TJ was placed on the Central Registry for negligent care of an individual with developmental disabilities who had been entrusted to her care. The Central Registry is in statute and regulation; Developmental Center discipline is defined in an Administrative Order to spell out employment rules. The Central Registry is a product of the Legislature to protect the vulnerable population of individuals with developmental disabilities.

The Court heard testimony from Cynthia Brown, George Ackley, Cecelia Hope, and Richard Sweeten over three days of the hearing, encompassing roughly one half of the recorded

transcripts. This testimony dealt with the duties of an enhanced support caregiver. None of this evidence is mentioned in the Initial Decision and evidently ignored in its formulation.

Cynthia Brown, during questioning by the parties and the ALJ, explained the rules pertaining to the use of wheel chairs, the need to document in the log book, and the nature of pica procedures. Cynthia Brown, as an Assistant Resident Living Supervisor, had the same job title as Manwaring and had been accused by the respondent of having told staff that it was proper to confine residents, particularly TN, in a wheel chair. Brown denied that she had ever told anyone that TN should be placed in his wheelchair, except for its approved purpose – transport out of the cottage. Brown emphasized the importance of the pica regimen and the danger of enhanced support personnel sleeping on duty and the procedures available for relieving staff.

George Ackley, a clinical psychologist who helped develop TN's Behavior Support Plan, testified as to pica, wheel chair procedures, and enhanced support procedures in general as well as specifically how these topics pertain to TN. Dr. Ackley answered questions from the parties and the ALJ. Dr. Ackley explained that an enhanced support staffer is to provide intense protection, supervision, and observation. The duty of anyone giving one to one care of an individual with pica, and TN's enhanced support caregiver, is to constantly watch and constantly intervene if he were to get hold of something that he might ingest. In particular, TN is not to be confined in his wheel chair; it is only for transport out of the cottage. TN is to be constantly monitored. TN is to be allowed to walk freely about the cottage with the enhanced support staff following and monitoring him for dangerous behavior. Ackley's descriptions were consistent with the procedures on TN's client card.

Cecelia Hope, the assistant supervisor of professional residential services, testified that she is a supervisor of the supervisors at Woodbine Developmental Center and is also a trainer of those supervisors. Ms. Hope provided testimony about the policies and procedures under questioning from the parties and the ALJ. Ms. Hope also testified about pica dangers to the residents and how the Woodbine staff were trained to prevent ingestion of dangerous items by monitoring and intervention.

Ms. Hope testified that all Woodbine employees receive in-service, as well as continuing training on Enhanced Support. The training includes permissible interventions and documentation of the support. Hope explained that enhanced support is required for certain clients with high risk behaviors, such as pica. Ms. Hope testified that enhanced support required being within an arm's length of the client and watching the client continuously. Ms. Hope testified that documenting the enhanced support process promotes accountability; "Accountability of the staff that they are alert and providing the specified service for the man" (10/23/12 page 222).

Ms. Hope testified concerning the proper procedure a supervisor should use upon finding a staff member sleeping on duty. Ms. Hope responded, "The person is approached, and we verbally call their name approximately three times. If they don't respond, we physically prompt them by touching them. If they don't respond, we touch them again until they are alert, and then, they're taken off the floor until we have them in a state where, you know, they can perform their duties. If it's such that they can return to work, they're returned to work" (11/15/12 page 6). Disciplinary actions can be taken against the employee, later on a different shift.

Richard Sweeten, a quality assurance specialist in the Office of Investigation, gave testimony under questioning by the ALJ and the parties. Sweeten testified that the investigators report to the Department of Human Services central office in Trenton, rather than to anyone in the Woodbine Developmental Center, in order to eliminate conflicts of interest. Mr. Sweeten testified about the investigation of neglect that was conducted by the Office of Investigations; he detailed the various individuals and the records of their interviews. Sweeten testified about pica, enhanced supervision, wheel chair policies, and various documentation required in the facility.

The Court also heard testimony from the four eyewitnesses to the incident; the parties and the ALJ questioned each of them. All of the eyewitnesses, except TJ, had basically the same description of pica and the use of TN's wheelchair that had been described in greater detail by the four unmentioned witnesses (above). Seven of the eight witnesses at trial testified that TN's wheel chair was for transport when he was being taken out of the cottage. It had a lap tray that was secured in the back and a belt. With the lap tray in place, TN could not get out of the wheel chair. Without the tray, the wheel chair is just another chair (or as the ALJ put it, "I'm saying a chair is a chair is a chair" without restraints (5/8/13 page180)). Staff were trained, however, that the wheel chair is not for continual and habitual use by TN as a traditional chair and he should be encouraged to use a traditional chair as appropriate. Although, TN is afforded the freedom of movement to sit in his wheel chair, TN is to be verbally redirected to another more appropriate spot. Unless there is a prior approval from a supervisor, staff's placing TN in his wheel chair with the tray down (without the intent to transport him outside of his cottage) is considered an unapproved restraint.

All of the witnesses were aware of pica behaviors (because all Woodbine employees are required to take such training) and noted that TN's cottage housed a great many individuals with pica. The cottage was often referred to as the pica cottage. The cottage itself had to be monitored and kept clean of items that could be ingested by the residents. Certain items, such as trash can liners and cleaning products were kept in locked closets. TN's pica behaviors were so acute that he required an enhanced support attendant to remain within arm's length and constantly monitor that he did not ingest anything inappropriate, twenty-four hours per day. There were three shifts a day scheduled solely for a single person to follow TN around the cottage and enter his behaviors every half hour into a log book. The testimony was elicited by both parties and the ALJ. The pica testimony of quite a few witnesses was tested to the bounds of absurdity with questions about whether TN or staff should be dressed because the client card states that TN could try to ingest clothing or whether windowsills should have been removed from his room. Witness after witness testified that creating a completely pica safe cottage is impossible, so TN is assigned an enhance support care giver to remain within an arm's length wherever he wants to move throughout the cabin, constantly monitoring that he does not attempt to put anything inappropriate in his mouth; should TN obtain an object, the enhanced support staffer is to verbally prompt TN to put it down, or as a last resort, to take the object away from him. The enhanced support staff person is required to enter a record of TN's behaviors every thirty minutes, in order to document the services provided to TN. This is the proper level of care for TN.

The ALJ identified four eyewitnesses to the incident: Sherry Manwaring, Delores Lee, Joseph Egbeh, and TJ. All testified about the actual events during the incident. Their testimony is the only evidence cited in the initial decision.

Manwaring

Sherry Manwaring testified that she made her rounds of Woodbine's residential cottages on the night of January 12 to 13, 2011. She arrived at Cottage 16, TN's cottage, at about 3:40am, and met with Dolores Lee, the cottage supervisor. Cottage 16 housed men with pica, maintaining special precautions, such as keeping the area free of small items and keeping items that were particularly dangerous if mouthed or swallowed under lock and key (such as latex gloves, chemicals and plastic trash bags). Ms. Manwaring testified that TN had particularly severe PICA. Because of his severe PICA, TN was assigned an enhanced support staffer whose sole responsibility was to monitor him and to stay within arm's length of him in order to stop him from putting inedible things in his mouth. The enhanced support staffer was also required to make notations describing TN's activities in the log book, at least once every 30 minutes.

TJ read (and had in her possession) TN's client card, which described his pica behavior. The client card also noted that TN was ambulatory, but he had a wheelchair that was used only for out-of-cottage transport. Ms. Manwaring testified that TN liked to walk around, even at night. She testified that, while he could be encouraged to go to sleep at night, if he wanted to get up and walk around, it was his right to do so. Ms. Manwaring testified that if TN did choose to get up and walk around at night, his enhanced support staffer was responsible to go with him and to monitor him, while remaining within arm's reach of TN.

When she and Ms. Lee arrived at TN's room, Ms. Manwaring saw TN asleep in his wheelchair. His head was slumped over and he had a bib, or "clothing protector," hanging out of his mouth. The lap tray of his wheelchair was positioned across the chair in front of him, and locked into place at the back of the chair. Ms. Manwaring testified that with the lap tray in this position, TN could not get up.

Ms. Manwaring testified that TJ was curled up in a chair, almost in a fetal position, with her legs folded up onto the chair's seat. TJ was turned around, facing the back of the chair, with her arms crossed on the chair's back and her head resting on her arms. Ms. Manwaring could not see TJ's eyes. TJ's back was facing TN. Ms. J. was well beyond an arm's length of TN.
There was a plastic trash bag covering the back of TJ's chair. Ms. Manwaring testified that plastic bags are a particularly risky item for individuals with pica (not only TN, but the other men in the pica cottage). The trash liners can be ingested or can choke a person. For this reason, they are kept under lock and key.

Ms. Manwaring testified that she called TJ's name but received no response from TJ. When Ms. Manwaring called TJ's name a second time, TJ roused and turned. TJ appeared groggy. When Ms. Manwaring asked TJ what TN was doing, TJ just looked at her, eventually responding with "sleeping."

Ms. Manwaring testified that she asked TJ for TN's one-on-one log book. Ms. Manwaring noted that there were no entries in the log book after 12:30 a.m. that night. TJ was responsible for recording TN's activities in the log at least every 30 minutes. Ms. Manwaring testified that she put her own initials next to the 12:30 a.m. entry in the log book (as well as incorrectly noting in the log that the time was 2:50am, rather than the correct time, 3:50am). The log book entries noted that TN was awake in bed when TJ began her shift at 11:15pm and that TN was sleeping at 12:30 am. The log book contained no notation to explain why or how he got to his wheelchair after he was in bed, or why he was later sleeping in his wheelchair. When Ms. Manwaring arrived at about 3:40am, the log book contained no entries at all after 12:30am; the log at that time contained only the following entries for the night shift of January 12 to 13, 2011:

> 11:15 pm 1st shift [accompanied by Ms. J.'s signature]
> Staff received [T.N.] in bed, he's awake T.J.
> 11:30 pm Mr. [N.] is sitting in his wheelchair wake
> 12:00 am Mr. [N.] is still sitting up
> 12:30 am Mr. [N.] is sleeping

Ms. Manwaring told TJ to put TN to bed. She told TJ to catch up on her log book. Ms. Manwaring testified that she also noticed that Ms. Lee had not initialed the one-on- one log book for TN. Ms. Lee was required to initial the log book every hour to document her making rounds of the rooms in the cottage. Ms. Manwaring walked back to the office with Ms. Lee and advised Ms. Lee that she needed to monitor the men and staff. Manwaring asked Lee to make sure that TN was put to bed. Ms. Lee left the office to do so, and reported back to Ms. Manwaring that TJ had put TN to bed with the assistance of another staffer, Joseph Egbeh. Manwaring filed a description of this incident in her own log and sent an email describing the incident to management for investigation. Manwaring's statements to investigators after the incident were all consistent with her contemporaneous documentation.

Lee

Delores Lee, the overnight supervisor of the pica cottage, testified that she accompanied Manwaring on her rounds of Cottage 16 that night. She never filled in any of her required paperwork and never initialed any of the log books of her employees. Lee maintained that she made her required rounds of the cottage that night, but failed to make any of her required documentation. Because Lee had not made any contemporaneous documentation of the incident, there could be no comparison to later statements. The statements given to investigators were vague (the ALJ noting in his decision that she was facing discipline for her failures to supervise and document). Lee's testimony gave a description of the room which could not be reconciled with its actual measurements.

Egbeh

Joseph Egbeh, had the same job as TJ; however, he was assigned to look in on and report in his log book about several men in the cottage who required far less supervision than TN. Egbeh testified that he was situated right outside the doorway of the room containing TJ and TN during

the night of the incident. Egbeh testified that he entered TN's room every half hour to check on another resident that he was responsible for observing. Egbeh's log book was complete with notations every half hour. Egbeh testified that he had no discussions with TJ. Egbeh testified that he never told TJ that TN could be placed in his wheel chair at night. Egbeh denied that he helped TJ place TN into his wheel chair. Egbeh denied that he could see what was going on with TN or TJ during the shift, except that TN was in his wheel chair at 1:30 am. Egbeh seemed to testify during the ALJ's questioning that when TN was in his wheel chair, his lap tray was down (11/23/12 page 164), but backed away into incoherence when the ALJ pressed him on that being a restraint. Egbeh was not an actual witness to the events inside of the bedroom when Manwaring arrived, but did aid TJ in returning TN to his bed after Lee directed him to do so.

TJ

TJ testified that she had worked at Woodbridge Developmental Center since 2006. She had been trained as a Human Services Assistant. She had been trained in abuse and neglect, pica, enhanced support techniques, and mechanical restraints. Although TJ was normally scheduled to work in another cottage, TJ had asked for and been given extra shifts in cottage 16 – the pica cottage. By her own testimony she had requested and been assigned to work some twenty shifts in the pica cottage, within the previous year. At the beginning of her shift (11pm on 1/12/11), TJ was given various keys to the cottage and was assigned to provide one-to-one enhanced supervision of TN. TJ was given and testified that she had read TN's client card that describes his risks (especially pica, in this instance), required behavioral supports, behavioral plan, and other important details for his care. Although TJ testified that she was not given a detailed orientation to all of TN's behaviors by the supervisor or the staff member she was relieving, she testified that she was aware that TN's personal binder contained that information and was aware she could access that information by calling out to the other staff or supervisor on the floor.

TJ testified that she went directly to a locked closet containing items that had to be controlled within the pica cottage to protect its residents and obtained a trash can liner from the closet. TJ went to TN's room and wrapped the trash can liner over the back cushion of the chair in TN's room. The orange cushioned chair was meant for the residents and not for staff; staff were to use plastic chairs that were situated throughout the cottage.TJ testified that she covered the chair because she has "an issue with germs. So I covered the chair for my own personal reasons." (5/8/13 page 46)

TJ, in her testimony, described her job duty as the enhanced support staff person for TN this way, "Stay within arm's length of him at all times and document in the log book every half hour." (Ibid page 28) At the hearing, TJ testified that she placed TN in his wheel chair because he was running around with his colostomy bag partially out of its attachment to his body slopping its contents at around 3:30am, just before Manwaring arrived. TJ testified that she and Joseph Egbeh forcibly placed TN in the wheel chair. TJ testified that Egbeh told her that Egbeh had been told by a supervisor that it was acceptable to put TN in the wheel chair at night. TJ denied being more than an arm's length away from TN, being asleep, and had no explanation for the large gaps in the log book entries. TJ's first statement to investigators stated that she put TN in the wheel chair because he might fall out of bed and hurt himself. TJ's second statement to

investigators stated that TN was moving around the room and picking at his feeding tube. TJ's statements were at odds with each other and very different from her testimony at trial.

TJ's testimony was not supported by other evidence or the testimony of others. Egbeh denied, under oath, that he had helped TJ put TN in the wheel chair. Egbeh denied, under oath, that he had told TJ that it was acceptable to place TN in his wheel chair at night. Cynthia Brown, the supervisor named by TJ, denied, under oath, that she had told Egbeh (or anyone else) that it was acceptable to place TN in his wheel chair at night. TJ's testimony was contradicted by or at odds with the other witnesses in the hearing; she is the only person to even suggest that TN should purposely be placed in his wheel chair by a staff member.

WITNESS CREDIBILITY

Although findings of credibility in an initial decision are to be given deference, the reasons cited in this decision for attributing credibility are so baseless and unsupported by facts that they must be modified. Roughly half of the testimony, concerning the proper policies and procedures, was never mentioned and evidently, never considered. With no foundation or developed understanding of the policies, a determination of the veracity of testimony concerning the application of those policies is invalid – not based on sufficient, competent, rational, or trustworthy evidence.

The reasons cited in the initial decision for slighting Manwaring's credibility are not borne out in the extensive record of the proceedings. The assessment of other witnesses' warrants reexamination. The determinations of credibility made in the initial decision must be reevaluated and modified.

Of the four witnesses cited by the initial decision, Manwaring was the only person doing her job –caring for the safety of TN. Delores Lee could not show that she had made any of her hourly rounds of the cottage; she did not fill out her own log. There were no notations by her in TN's log book, and Egbeh had no notations or recall of her making rounds. Lee made no greater effort to correct TN's situation than she was commanded to, by her supervisor. Lee did not report the incident. Lee's interviews and testimony was noted as being shaded to avoid disciplinary action. Joseph Egbeh was not assigned any responsibility for the care of TN. His testimony showed that he filled in his log book and evidently looked after his assigned clients, however he was vague and evasive, avoiding derogatory evidence against his fellow employee and his direct supervisor. Setting aside the grievous breaches of her duty of care that are the subject of this appeal, TJ did not fill out her log; she did not complete or update her log with a "late entry" notation as required; nor did she correctly fill out the log book from the time of the incident (and the direction given to her by her supervisor) until the end of her shift.

Manwaring is the only person involved who is actively making her rounds, documenting her own log (and those that she is required to verify), tending to the care of clients, supervising staff, correcting policy violations and reporting them. Manwaring's documentation in all of the log entries is on the record and undisputed. Manwaring's correction of the situation, upon finding TN restrained in his wheel chair while unattended, is undisputed. Manwaring's description of how she behaved when she found TJ away from TN and not paying any attention to him is exactly the policy described in Cecelia Pope's testimony on how to wake a sleeping employee.

Manwaring counseled Lee on her lapses in supervision and documentation. Manwaring documented the incident and reported it to the proper authorities. Manwaring's unflagging attention to and enforcement of policies is in stark contrast to the other "eyewitnesses" cited in the initial decision. The enormous amount of time at hearing establishing the policies of the Developmental Center and the initial decision's failure to recognize which witnesses were aware of them, let alone following them, undermines the credibility determinations that it contains.

Log Book

The ALJ entered TN's log book into evidence with no basis, explanation, or context - other than declaring it a business document – at the end of a seven day hearing (the transcript shows the logbook being produced on May 9, 2013 at the order of the Court and marked for identification on that date; on the last hearing date, the Court declared that it was in evidence, over objections). The log book contained approximately a month of entries (a month is only an approximation, the exact period of time covered by the log book was never examined by the Court). There were three shifts on every one of those days. For each day, there were, at the very least, three different enhanced supervision providers who were required to make entries every 30 minutes, three cottage supervisors required to make hourly entries, and supervisors of the cottage supervisors who were required to make an entry every shift. Every shift had, at least, three different authors. Every day would have had nine different authors. Granting that there were many of the same people making entries during a work week, there are an enormous number of authors who would have been making and notating their own personal observations of TN's behaviors. The log book's entry into evidence was done so with no more foundation than it was a business record. There was no evidence given on how entries were to be made, what the entries were to contain, or what specific training was given to the authors – what levels of detail were required, jargon or shorthand phrases or colloquialisms that were permissible. The ALJ made his own interpretation of the many entries, by the numerous authors, with no contextual evidence. The ALJ's personal interpretation of the log book without any evidence as to its relevance, the quality of its authors or entries, or its context in relationship to the case at hand is specious and not a valid basis to form a finding of credibility.

The impossibility and the capricious nature of citing the log book in forming a credibility determination can be demonstrated by the only shift entry about which there is any evidence. The only people testifying on the record who wrote in the logbook were Manwaring and TJ. Manwaring, whose job required her to review that the staff were maintaining the log and documenting their enhanced supervision of TN, testified that TJ had not maintained the log and was several hours behind in making her required half-hourly entries. Manwaring testified that she initialed the book and told TJ to update her log book entries. TJ admitted in her testimony that she had not made timely entries in the log book. In fact, after having been advised to catch up the log, TJ left a second gap in her entries, at the end of her shift. Cecelia Lee testified that she was supposed to review and initial the log book every hour during the shift, but did not do so. This is the only sworn testimony about the quality of the log book's contents in the hearing record (outside of its use as a business record). Of the three people responsible for entries on this one particular shift; one failed to do it properly, even after being directed to do it correctly, one made no entries that she was required to make, and one made a required entry, but with an incorrect time. The quality of the entries during this 8-hour period is hardly an indication that

anything in the log book could be believed; however, it is the only evidence on the record of its content. The brevity of this shift's entries did not give enough detail to indicate what was happening during the shift, as evidenced by the need for seven days of testimony. There are no indicia of veracity or reliability, as to the log book's entries. The use of the log book to make determinations of credibility is arbitrary and capricious. Further, the unexplained entries in the log book referring to "in wheelchair" are not reliable and certainly not descriptive enough to differentiate between TN being forced into his wheelchair and restrained by the use of the lap tray and belt for the convenience of the staff member and TN sitting in his chair before being encouraged to sit in a more appropriate spot. The distinction between the two scenarios is significant and the point of the hearing. The use of unexamined phrases or jargon to derive a finding of a general or a proper policy is arbitrary.

The other reason cited in the initial decision for discounting Manwaring's credibility was an unfounded declaration of prejudice against TJ by Manwaring. The finding of prejudice and animus against TJ, due to a two-year old complaint against Manwaring, is not consistent with any testimony. TJ testified she had had only one contact with Manwaring during the two years since her filing a grievance. At that meeting, Manwaring had been civil towards TJ. As TJ testified, "Right"(before the incident), "I seen (sic) her on Day shift in Cottage 15 in the dining room and she said, 'Hi' and that was it." (5/8/13 pages 90 – 91) In the two years after filing the complaint, TJ had never pursued it or sought a resolution. Manwaring testified that she was unaware that TJ had even filed a complaint against her. Melissa Rodriguez, who had been the manager of Woodbine's Human Relations office, testified that Manwaring would not have been made aware that a complaint had been filed against her by TJ. TJ's unsupported accusation of retaliation in a two year old incident, especially in defense of a situation where she was subject to discipline, is not a valid basis on its own for credibility determination. Another reason mitigating against bias is that no one in the management of the Developmental Center plays a role in the placement of employees on the Central Registry. This is a Central Registry case where the decision on whether to proceed from an ordinary negligence case was not made by anyone in Woodbine. The initial decision's finding of animus and prejudice is arbitrary and capricious.

The initial decision states that TJ worked a double shift on the date of the incident. In fact, TJ worked the second shift and went home in the afternoon. TJ did not sleep during the eight hours before the 11pm to 7am shift that she had requested to work in order to earn overtime. The "short staffing" that is referred to in the testimony is what provided the open shift that TJ volunteered for. There was no testimony that the shift of the incident was short staffed. There was no evidence that any of the usual positions were unfilled that night. Also, the initial decision mentions abuse several times; the case concerns neglect and should not be confused with abuse.

For the reasons discussed above, I must reject the determinations of law and credibility in the initial decision and modify these determinations. The determinations do not have sufficient basis in the record. The conclusions reached in the initial decision are, therefore, arbitrary and capricious and must be modified.

FINDINGS AND CONCLUSIONS OF CREDIBILITY

Manwaring's testimony is consistent, believable, and supported by independent evidence. Her behavior is consistent with the voluminous and detailed evidence in the record as to proper policies and procedures expected at Woodbine. Manwaring was the only eyewitness who was attentive to the care of TN. She was demonstrably making her rounds, documenting her observations, supervising, directing, and correcting her employees. I CONCLUDE that Sherry Manwaring's testimony is credible.

Joseph Egbeh testified that he was not assigned to the care of TJ. He is documented as being present right outside of TN's door, checking on and recording his observations of the residents under his care. Egbeh seemed vague or evasive about matters concerning other employees' activities or responsibilities; his claiming to be or actually being unable to observe in the dark room is hard to determine. I CONCLUDE that Joseph Egbeh's testimony is marginally credible.

Delores Lee's testimony that she made rounds of the cottage is not supported by documentation or verification by Egbeh. Lee's testimony concerning the placement of people and objects in TN's room is physically impossible. Lee faced discipline for which she may have shaded her testimony. I CONCLUDE that Delores Lee's testimony is NOT credible.

TJ's testimony that she was within an arm length of TN and paying attention to his welfare, especially protecting him from his pica, is not supported by any reliable evidence, other than her own assertions. She had no believable explanation as to why she failed to fill in the log book completely; a device designed to document a client's behaviors and keep the enhanced support provider alert. Her own testimony was inconsistent and was not corroborated by other evidence. Her assertion of bias was not supported, in fact, it was refuted by her own testimony and two other witnesses. TJ has a strong motivation to testify unfaithfully. I CONCLUDE that TJ's testimony is NOT credible.

STATEMENT OF APPLICABLE LAW

The Legislature, for the purpose of the Central Registry, defined neglect as "any of the following acts by a caregiver on an individual with a developmental disability: willfully failing to provide proper and sufficient food, clothing, maintenance, medical care, or a clean and proper home; or failure 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 Neglect allegations are investigated by an organization that reports outside of the Developmental Center –the Office of Investigations – in order to avoid conflicts. If the investigation finds, by a preponderance of the evidence, that neglect is substantiated; the case is reviewed for the presence of "gross negligence, recklessness, or 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. If the investigating unit believes that one of those elements is present, the case is forwarded to a designee of the Commissioner. The Commissioner's designee will review the case de novo to confirm or deny that there is a preponderance of evidence to verify that an act of neglect occurred that involved recklessness, gross negligence, or as part of a pattern of behavior. If the Commissioner's designee confirms such a level of neglect, a notice of intent to place the offender on the Central Registry is sent to the offender, as well as a notice of appeal rights.

FINDINGS AND CONCLUSIONS OF LAW

I CONCUR with the initial decision that TJ was inattentive and groggy. However, I believe that TJ was inattentive and groggy to the point that she was not caring for TN. TJ was unaware of TN's actions. Manwaring's testimony, supported by Hope's, showed that Manwaring had arrived at the second of three verbal callouts supervisors are to use with sleeping employees, as described in the policies. I CONCLUDE that TJ is negligent in failing to provide TN with proper and sufficient maintenance. I further CONCLUDE that TJ's being oblivious to the one client to whom she has been assigned, whose pica presents such a danger that she is required to constantly observe him while remaining within an arm's reach, is gross negligence. TJ's disregard to her duty of care was in reckless disregard for the consequences faced by TN while he is unattended; there is an unacceptable potential to cause harm that TJ consciously chose to ignore.

I FIND that Manwaring's consistent and detailed descriptions of the events during her visit to TN's room to be an accurate account of the events. I CONCLUDE that TN was locked into his wheel chair. TN was rendered unable to exercise his right to move about the cottage. Freedom in his choice of movement is a major part of his behavior plan, as described by Dr. Ackley; TJ's restraint of TN in the wheel chair constitutes neglect of an individual by depriving him of the level of care and level of maintenance which is TJ's duty to provide. I further CONCLUDE that TJ's action of locking TN in his wheel chair is grossly negligent, as it showed a total lack of regard or attention toward TN's care – a conscious and voluntary abdication of her duty to provide TN with proper care and supervision.

I FIND that TJ's use of a trash can liner to cover the back of the chair in TN's room a dangerous and unnecessary introduction of a hazard into the pica ward, especially in light of her failure to remain attentive. Manwaring testified that there was no specific prohibition to the use of a chair covering (including clothing protectors) and that in other areas of the campus they had been used, however, the use had been declining. I find TJ's reason for covering the seat to be as she stated a personal germ phobia. Her testimony about feces, urine, and colostomy bags is not corroborated by any other evidence and her testimony was not credible. Manwaring testified that the cushioned chairs are for residents and there are plastic chairs throughout the pica cottage for the use of staff. These plastic chairs should be cleaned by staff, if they are dirty. Egbeh confirmed that these plastic chairs are throughout the pica cottage. The trash liners in the pica cottage are a recognized hazard to the residents and are therefore kept under lock and key in a closet. I find that Manwaring's testimony that she discovered TN in his wheel chair with a clothing protector (bib) in his mouth credible and TJ's denial incredible. I CONCLUDE that the unnecessary introduction and insufficient control over an item considered to be a hazard into a pica environment, TJ's failure to monitor TN, and allowing him to place a bib in his mouth is an act of negligence. I further CONCLUDE that this negligence rises to the level of gross negligence because it evidences a conscious and voluntary act on the part of TJ in failing to provide for the well-being of TN, and the other residents around him; a decision by her to avoid her duty to keep the residents safe. The actions also represent recklessness, because they show in TJ a total disregard for her duty of care for TN and a disregard for the consequences that might befall TN due to her actions.

I FIND that the weight of the credible evidence shows by a preponderance of evidence that TJ was outside of an arm's length from TN during the incident. I FIND that TJ failed to maintain the log book and failed to report an incident of pica. I FIND that TJ failed to obtain permission to use an unapproved restraint. I CONCLUDE that these three failures by TJ during the shift are negligence in that they are willful failures by TJ to provide adequate care, maintenance, and supervision to TN. I further CONCLUDE that because these were deliberate acts or omissions done recklessly without reasonable consideration of her duty to TN and knowing indifference to TN's safety; they represent gross negligence.

Careful consideration was given to the entirety of the Initial Decision of the Administrative Law Judge, as well as the entire record of testimony, evidential documents, closing arguments, and exceptions. Because the ALJ had the opportunity to listen to the testimony and observe the demeanor of the witnesses, his findings concerning credibility were given proper deference. Because the initial decision contained errors of applicable law, the entire record was given a greater scrutiny. Upon review, several conclusions and determinations were found to lack a showing of support or reliability in the record. Even after factoring in the proper deference for the observation of witnesses, the evidence in the record was so much more compelling that certain determinations were arrived at in an arbitrary and capricious manner. The recommended decision of the ALJ is hereby **REJECTED and MODIFIED** by the Office of Program Integrity and Accountability.

I find that TJ was grossly negligent in her provision of care to TN. I further find that TJ was properly placed on the Central Registry of Offenders against Individuals with Developmental Disabilities. Therefore, pursuant to N.J.A.C 1:1-18.6(b), it is the Final Decision of the Department of Human Services that T.J. (the respondent's name) shall be placed in the Central Registry of Offenders Against Individuals with Developmental Disabilities.

Date: 10/8/14

Lauri Woodward

Lauri Woodward, Director
Office of Program Integrity and Accountability
Department of Human Services