MIKIE SHERRILL
Governor

DR. DALE G. CALDWELL
Lt. Governor

State of New Jersey
Department of Human Services
Office of Program Integrity and Accountability
P.O. Box 700
Trenton, NJ 08625-0700

STEPHEN CHA, MD, MHSR
Commissioner

DEBORAH ROBINSON
Director

FINAL AGENCY DECISION

OAL DKT. NO. HSL 13946-25

AGENCY DKT. NO. DRA 25-007

M.F.,

Petitioner,

v.

NEW JERSEY DEPARTMENT OF HUMAN SERVICES, OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY

Respondent

M.F., Petitioner, pro se

Elizabeth A. Davies, Deputy Attorney General, for Respondent Department of Human Services, Office of Program Integrity and Accountability (Jennifer Davenport, Attorney General of New Jersey, attorney)

Record Closed: May 15, 2026 Decided: June 5, 2026

BEFORE **SUSAN MCCABE**, ALJ:

INITIAL DECISION:

STATEMENT OF THE INITIAL DECISION

Petitioner M.F. appeals her placement on the Central Registry of Offenders Against Individuals with Developmental Disabilities (Central Registry) by the Department of Human

Services pursuant to N.J.S.A. 30:6D-73 and N.J.A.C. 10:44D . The Department substantiated allegations that M.F. neglected J.M., a developmentally disabled individual who was in her care, by failing to supervise him as required. This substantiated neglect by M.F. of J.M. resulted in J.M. ingesting non-food items ultimately requiring surgery to remove the ingested objects.

PROCEDURAL HISTORY

On July 15, 2025, the director of the Office of Program Integrity and Accountability notified M.F. of the finding of substantiated neglect and the determination to place her name on the Central Registry of Offenders Against Individuals with Developmental Disabilities (Central Registry).

On July 24, 2025, M.F. filed an appeal for the substantiated finding and placement on the Central Registry. On August 1, 2025, respondent, the Department of Human Services (DHS) transmitted this case to the Office of Administrative Law (OAL), where it was filed as a contested case on August 4, 2025, under N.J.S.A. 52:14B-1 to -15 and N.J.S.A. 52:14F-1 to -13. On September 18, 2025, I entered an Order to Seal.

On March 23, 2026, the ALJ held the hearing; on April 8, 2026, the ALJ received the closing brief from M.F.; and on May 15, 2026, the ALJ received the closing brief from the DHS and closed the record.

FACTUAL FINDINGS

The **ALJ FOUND AS FACTS THAT**:

Bancroft is a New Jersey nonprofit corporation providing community-based residential treatment facilities for adults and children with intellectual and developmental disabilities. Bancroft employed M.F. as a program associate.

J.M., an adult male receiving services from the DHS Division of Developmental Disabilities, resides at the Bancroft facility in Woodstown, New Jersey. J.M.'s diagnoses include moderate intellectual disability, psychiatric disorder, epilepsy, post-traumatic stress disorder,

borderline personality disorder, bipolar disorder, depression, and pica—a mental health disorder involving the compulsive consumption of non-food items.

Since 2019, Bancroft has used Behavior Support Plans and Individualized Service Plans for J.M., periodically updating them to ensure his safety. The Behavior Support Plan dated May 15, 2024, and the Individualized Service Plan dated June 17, 2024, were the active plans during the incident on February 4, 2025. Both plans required staff to always provide "close supervision," which the Behavior Support Plan defined as "being physically close enough to provide hands-on assistance." The Individualized Service Plan specifically required staff to remain close enough to prevent pica attempts and elopement.

On May 20, 2024, Latoya Chestnut (Chestnut), program manager for Bancroft, texted staff advising that J.M. required "2:1" staffing (two staff members) at all times. Chestnut emphasized that staff should remain within "arms reach," noting that failure to do so would be considered a breach of supervision and constitute neglect. However, neither the "arms reach" requirement nor the 2:1 staffing ratio was ever formally incorporated into J.M.'s Behavior Support Plan or Individualized Service Plan. M.F. received training on the active Behavior Support Plan and Individualized Service Plan in June and July 2024, respectively.

On February 3, 2025, M.F. worked an overnight shift at Bancroft. Although management knew she was six months pregnant at the time, M.F. did not request any pregnancy-related accommodations. She also felt ill during her shift but did not report her condition. Her shift was scheduled to end at 9:00 the following morning. However, because J.M. initially refused to attend his off-site day program, the two incoming day- shift staff members departed with the other four residents, leaving M.F. alone to monitor J.M.

After the others left, J.M. changed his mind and became agitated when he realized he had missed the transport. He began moving throughout the residence and between floors. Security footage shows M.F. looking at her cellphone numerous times during this period. While M.F. used the phone at least partially to text Chestnut regarding J.M.'s behavior, the footage also shows M.F. failing to follow J.M. closely as he moved between levels of the home. On three occasions, M.F. had her back turned to J.M., preventing her from supervising him.

On February 4, 2025, at 11:08 a.m., J.M. entered another resident's bedroom. M.F. attempted to keep the door open with her leg, but J.M. pushed her leg away, locked the door, and barricaded it with a recliner. Inside the room, J.M. consumed eight disc batteries, four AA batteries, and two eye hooks.

M.F. called 911 and notified Chestnut. When Chestnut and another staff member arrived, they forced the door open and medical personnel transported J.M. to Inspira Medical Center. J.M. underwent an esophagogastroduodenoscopy and colonoscopy to remove the foreign objects. Although she was not asked, M.F. accompanied J.M. to the medical center to ensure he received appropriate medical assistance. M.F. did not return to Bancroft until approximately 5:00 p.m. on February 4, 2025, which resulted in an eighteen-hour work period. M.F. suffered an injury to her leg but did not require medical treatment.

On March 7, 2025, DHS Investigator Chelsea Doughty interviewed M.F. and presented the security footage, including footage of J.M. using a staircase alone. M.F. admitted her supervision was not "close." Although M.F. claimed the area at the bottom of the stairs was safe from swallowable items, a physical inspection by investigators revealed two unlocked bedrooms, an unlocked bathroom with a medication cabinet, and an open closet with multiple items inside.

CONCLUSIONS OF LAW

The **ALJ CONCLUDED THAT**:

M.F.'s failure to closely supervise J.M.—an act necessary for his well-being—constituted a **substantiated finding of neglect** under N.J.S.A. 30:6D-74. The ALJ based this conclusion on the following:

New Jersey policy protects individuals with developmental disabilities by identifying caregivers who wrongfully cause them injury. N.J.S.A. 30:6D-73. The law defines a "caregiver" as any individual receiving state funding to provide services or support to a person with a developmental disability. N.J.S.A. 30:6D-74.

Under N.J.S.A. 30:6D-74, injury to these individuals includes abuse, exploitation, or neglect, which specifically occurs when a caregiver "fail[s] to do or permit to be done any act necessary for [their] well-being." Every reported incident must be investigated to determine whether the finding is "substantiated" or "unsubstantiated." N.J.S.A. 30:6D-76(c).

In this case, M.F. received specific instructions and training requiring her to supervise J.M. closely at all times. These instructions defined "close supervision" as remaining physically close enough to J.M. to provide hands-on assistance. Chestnut reiterated this requirement by text, reminding staff that J.M. must remain within "arm's length" and warning that a failure to maintain this distance constitutes neglect.

Security footage and M.F.'s own admission during the investigation demonstrate that she failed to keep J.M. physically close enough to assist him or prevent self-injury. Although M.F. asserts that her pregnancy and illness hindered her ability to keep pace with J.M., the video footage tells a different story. At several points, M.F. made no effort to keep pace; instead, she lingered behind, using her cellphone while J.M. moved between floors and throughout the residence without close supervision.

Furthermore, M.F. never sought pregnancy accommodations, nor did she request sick leave on February 3 or February 4, 2025. M.F. confirmed she did not inform her coworkers or manager that she felt too unwell to perform her duties or remain on shift.

M.F. points to her attempt to block the bedroom door and her decision to accompany J.M. to the medical center as evidence of diligence. However, these subsequent actions do not mitigate the initial failure. Regardless of whether these actions stemmed from genuine compassion or a desire to protect her employment, the fact remains that M.F.'s inattentiveness allowed J.M. to suffer an injury requiring medical interventions. This injury could have been avoided had M.F. maintained the level of supervision required by her training and J.M.'s safety plans.

The **ALJ FURTHER CONCLUDED THAT**:

M.F.'s failure to closely supervise J.M. constitutes both gross negligence and recklessness under N.J.S.A. 30:6D-77(b)(2), as those terms are defined under N.J.A.C. 10:44D-4.1(c)(1) and (c)(2), and that **M.F.'s name must be placed on the Central Registry.** The ALJ based this conclusion on the following:

The Central Registry exists to prevent state-operated facilities or programs from employing individuals who have wrongfully caused injury to persons with developmental disabilities. N.J.A.C. 10:44D-1.1(a). Under the Central Registry Act, neglect includes the "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.

To include a caregiver on the Central Registry for a substantiated incident of neglect, the agency must show that the caregiver "acted with gross negligence, recklessness, or in a pattern of behavior that causes or potentially causes harm." N.J.S.A. 30:6D-77(b)(2).

N.J.A.C. 10:44D-4.1(c)(1) defines gross negligence as a conscious, voluntary act or omission in reckless disregard of a duty and the consequences to another party. It defines recklessness as the creation of a substantial and unjustifiable risk of harm through a conscious disregard for that risk. N.J.A.C. 10:44D-4.1(c)(2).

In this case, M.F.'s failure to closely supervise J.M. constitutes a substantiated finding of neglect. The remaining issue is whether that failure rose to the level of gross negligence or recklessness, thereby necessitating M.F.'s placement on the Central Registry. M.F. was fully aware of J.M.'s diagnoses and was extensively trained on the requirement for constant, close supervision. Despite this, she repeatedly allowed J.M. to distance himself from her. Although M.F. was required to remain near enough to provide immediate hands-on assistance to prevent pica and elopement attempts, she instead prioritized her cellphone, turned her back to J.M. on three occasions, and allowed him to move between floors and rooms without closely following him. As a result, J.M. successfully evaded M.F., entered a resident's bedroom, and locked and barricaded the door. This provided him with the opportunity to ingest multiple dangerous objects, which required invasive medical interventions to remove.

M.F.'s disregard for her training and the established safety protocols constitutes gross negligence. Her decision to remain physically distant and distracted was a conscious, voluntary

omission performed in reckless disregard of her duty to J.M. and the potential consequences of his well-known pica disorder. Furthermore, her actions were reckless, and by allowing a resident with a compulsive eating disorder to move out of her sight and reach, she created a substantial and unjustifiable risk of harm and consciously disregarded that risk.

INITIAL DECISION FINAL ORDER

The **ALJ ORDERED** that M.F. neglected J.M. in violation of N.J.S.A. 30:6D-74 and that she be placed on the New Jersey Central Registry of Offenders against Individuals with Developmental Disabilities under N.J.S.A. 30:6D-77(b)(2).

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.

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

Petitioner filed written exceptions to the Initial Decision on June 16, 2026. On behalf of Respondent DHS, the DAG filed a timely reply to the petitioner's exceptions requesting that Respondent affirm the Initial Decision's findings and conclusions that the petitioner's actions constituted gross negligence for failing to closely supervise J.M. It is unmistakably clear from the video, documentary and testimonial evidence that Petitioner's actions constituted gross negligence and recklessness. Thus, Respondent should uphold Petitioner's placement on the Central Registry.

FINAL AGENCY DECISION

LEGAL ANALYSIS AND CONCLUSIONS OF FACT AND LAW

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, 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).]

The applicable standard to Central Registry cases is a preponderance-of-the-evidence burden. It looks at whether "it is more likely than not" that the evidence reveals abuse gross negligence or recklessness occurred. Woods-Pirozzi v. Nabisco Foods, 290 N.J. Super. 252, 266 (App. Div. 1996). Stated another way, the standard evaluates whether 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).

M.F. was a caregiver employed by Bancroft, a nonprofit corporation, that operates a group home where resident J.M. lived. (Initial Decision, p.3, hereafter ID). On February 4, 2025, J.M. stayed back at his group home residence rather than attend his scheduled day program. (Transcript of OAL March 23, 2026 hearing p.25:13-21, hereafter T). M.F. agreed to stay after her 9:00am shift with J.M. while the other staff members transported the other residents from the group home to the day program. (T146:5-21; ID, p.3-4). That morning M.F. never mentioned to Tyree Rudolph, her supervisor, that she was not feeling well. (T146:5-21). Later that morning J.M. changed his mind and informed M.F. that he wanted to attend the program. (T25:16-21; ID, p.4). M.F. reached out to Latoya Chestnut, the manager, by text message at 10:51am and asked if J.M. could still attend his day program. (T93:13-17; P-B). Shortly after the text message exchange, J.M. went through the house and entered another resident's bedroom. (T25:1-6). M.F. attempted to stop J.M. from closing the bedroom door by putting her leg in the door. (T31:19-24). J.M. pressed the door onto M.F.'s leg and was eventually successful in closing the door and barricaded himself in the room. (T31:21-24; T97:4-10). J.M. then proceeded to ingest eight batteries from a chime alarm, four batteries from a remote control and two metal hooks from the closet. (ID, p.3; T97:4-10). Shortly after Chestnut arrived, Tyree Randolph, a supervisor, arrived at the home and was able to push the furniture that was pushed up against the door out of the way allowing access to the room. (T97:19-98:4; T144:17-145:6). J.M. came out of the room and proceeded to the

living room and told Chestnut what happened. (T98:9-16). Chestnut then performed a pocket check to ensure J.M. did not have additional items in his pockets. (T98:16-99:4). J.M. was transported to the hospital by ambulance accompanied by M.F. where he underwent an esophagogastroduodenoscopy and a colonoscopy to remove the objects. (ID, p.4; T99:8-13).

After DHS conducted an investigation into the allegations arising from the incident, the agency placed Petitioner on the Central Registry for caregivers who have abused or neglected individuals with developmental disabilities. (ID, p.2). Petitioner subsequently appealed.

The Office of Administrative Law ("OAL") held a hearing on March 23, 2026, which was followed by the parties' filings of their written summations. The OAL closed the record on May 15, 2026, and issued the Initial Decision on June 5, 2026, by concluding that:

(1) "Security footage and M.F.'s own admission during the investigation demonstrate that she failed to keep J.M. physically close enough to assist him or prevent self-injury" allowing J.M. to move between floors and throughout the residence;

(2) "At several points, M.F. made no effort to keep pace; instead, she lingered behind, using her cellphone while J.M. moved between floors and throughout the residence" and on three occasions M.F. turned her back on J.M.; and

(3) "M.F.'s disregard for her training and the established safety protocols constitutes gross negligence. Her decision to remain physically distant and distracted was a conscious, voluntary omission performed in reckless disregard of her duty to J.M. and the potential consequences of his well-known pica disorder. Furthermore, her actions were reckless, and by allowing a resident with a compulsive eating disorder to move out of her sight and reach, she created a substantial and unjustifiable risk of harm and consciously disregarded that risk;" and

(4) M.F.'s failure to closely supervise J.M. constitutes both gross negligence and recklessness under N.J.S.A. 30:6D-77(b)(2), as those terms are defined under N.J.A.C. 10:44D-4.1(c)(1) and (c)(2), and that M.F.'s name must be placed on the Central Registry." (ID, pp.5-7)

Petitioner claims that the Initial Decision relied on unofficial supervision requirements. (Petitioner's Exceptions, p.3, hereafter PE). Petitioner claims that the court relied on informal expectations. Ibid. The Bancroft Behavior Support Plans ("BSP") and Individualized Service Plans ("ISP") for J.M., required staff to always provide "close supervision," which the BSP defined as "being physically close

enough to provide hands-on assistance." The ISP specifically required staff to remain close enough to prevent pica attempts and elopement. While the Plans do not use the specific term "arm's reach," the need to maintain close supervision to prevent pica attempts require that. Also, on May 20, 2024, Petitioner's manager texted her emphasizing that that staff should remain within "arms reach," noting that failure to do so would be considered a breach of supervision and constitute neglect. (ID, p.3). Not only did Petitioner fail to remain within arm's reach of J.M., she stayed on the main floor of the home as J.M. roamed a lower floor, clearly in violation of J.M.'s BSP and ISP. (R-24; R-25). The videos show Petitioner turning her back on J.M. on a number of occasions, and lingering far behind him, staring at her cell phone as he moved throughout the house. (R-24; R-25; ID, p.4). Also, this was not the first time J.M. swallowed batteries on M.F.'s watch. (R-3, T42:23-43:8). In August 2023 a similar incident occurred where M.F. was assigned to watch J.M. and he swallowed batteries. Ibid. Petitioner knew full well that she had to be close enough to J.M. to prevent him from swallowing objects and failed to do so. Therefore her claim that the specific term "within arms reach" was not contained in J.M.'s ISP or BSP, thereby proving her actions did not constitute gross negligence has no merit.

Petitioner also claims that the court failed to consider the staffing conditions in finding her actions reckless. Petitioner notes that she was the only staff member in the home while the other residents were being transported to their day program. Contrary to Petitioner's claim she was not required to stay that morning past her shift time. (T91:24-93:2). If Petitioner was not willing to stay past her shift with J.M., someone else would have taken over watching him. (T91:24-93:2). Petitioner attempts to excuse her actions claiming she "was attempting to maintain supervision of J.M. while simultaneously responding to an escalating behavioral incident and seeking additional assistance." This claim contradicts the video evidence and the manager's testimony that J.M. only sought help after J.M. was swallowing batteries. (T93:14-96:6). The evidence shows Petitioner was so preoccupied with her cell phone that she failed to properly perform her job and allowed J.M. to wander throughout the home, knowing the risk it posed to J.M. Had Petitioner stayed close behind J.M. and made an attempt to talk to him to calm him down, rather than being glued to her phone, this entire incident could have been prevented. The evidence is clear, M.F. consciously disregarded J.M.'s safety and her excuse that another individual was necessary to monitor J.M. is also without merit.

Petitioner further claims that her cell phone use was used to "communicate with management regarding J.M.'s escalating behavior and to seek additional assistance." Petitioner emailed her manager first asking if J.M. could attend his day program. (T93:14-96:6). She only sought her manager's help after J.M. barricaded himself in a bedroom and swallowed batteries. J.M.'s escalating behavior, and subsequent injury was a result of Petitioner's own making. The video shows Petitioner tagging along behind J.M., not engaging him as he wandered around the house in search of the supervisor. (T167:24-168:5). Petitioner

failed to maintain close supervision, ignoring J.M. as she stared at her phone. This was what resulted in J.M.'s "behavioral crisis". The court wrote, "At several points, M.F. made no effort to keep pace; instead, she lingered behind, using her cellphone while J.M. moved between floors and throughout the residence without close supervision." (ID, p.4). Petitioner's lackadaisical attitude and pre-occupation with her cell phone rather than doing her job is the reason she was found grossly negligent and reckless. For this reason Petitioner's exception is without merit.

Petitioner additionally claims that the record does not establish gross negligence or recklessness. Petitioner claims that the evidence shows she "remained engaged throughout the incident and took affirmative steps to protect J.M. The ALJ addressed M.F.'s claims writing,

> M.F. points to her attempt to block the bedroom door and her decision to accompany J.M. to the medical center as evidence of diligence. However, these subsequent actions do not mitigate the initial failure. Regardless of whether these actions stemmed from genuine compassion or a desire to protect her employment, the fact remains that M.F.'s inattentiveness allowed J.M. to suffer an injury requiring medical interventions. This injury could have been avoided had M.F. maintained the level of supervision required by her training and J.M.'s safety plans.
>
> [ID, p.6]

F.M.'s references her attempt to prevent J.M. from entering the bedroom. Petitioner was not maintaining a close distance to J.M. when he came up the stairs allowing him to reach the room and close the door almost completely before she was able to get part of her leg in the door. The video evidence showed that at 10:51:35-10:51:38 the video J.M. ascending the stairs with M.F. following behind him. (R-24). J.M. can be seen quickly turning the corner as M.F. appears to increase her speed but at 10:51:40 as J.M. is no longer shown on the screen, M.F. is still coming up the stairs. (R-24). J.M. proceeded to a peer's bedroom that was outside the video recording range and barricaded himself in his peer's bedroom. (T31:3-13). The video evidence shows that Plaintiff failed to maintain a close distance from J.M. Had Plaintiff remained close to J.M., that could have allowed her to reach the bedroom before he had a chance to close the door. M.F.'s claim that she sustained physical injuries attempting to keep the door open were the result of her own inattention. Also, M.F. did not "immediately call 911" and she only notified management after management inquired about what was going on in the home. (T94:25-96:23).

Petitioner also notes that she accompanied J.M. to the hospital to ensure he received appropriate

medical care. As the ALJ noted, it could have been to protect her employment, but also, while not mentioned in the decision, could have been to increase her pay by working additional hours. Petitioner alleges that her placement on the Central Registry is not warranted based on the record. (Pe, p.5). The video evidence clearly shows Petitioner ignoring J.M., following far behind him, preoccupied with her cell phone and not paying attention to J.M. despite knowing the risk. (R-24, R-25). Petitioner's actions clearly show that she abandoned her responsibilities and disregarded the substantial risk she put J.M. in knowing his past behavior and Pica diagnosis.

Petitioner lastly argues that the ALJ failed to distinguish ordinary negligence from gross negligence. The ALJ wrote, "N.J.A.C. 10:44D-4.1(c)(1) defines gross negligence as a conscious, voluntary act or omission in reckless disregard of a duty and the consequences to another party. It defines recklessness as the creation of a substantial and unjustifiable risk of harm through a conscious disregard for that risk." (ID, p.6). The judge continued to determine that Plaitiff's behavior "constitutes a substantiated finding of neglect." Ibid. The judge went on to detail why Petitioner's actions constituted gross negligence. ID, at 6-7.

Respondent has shown that the totality of the evidentiary record proved by a preponderance of the credible evidence that M.F. committed prohibited acts of neglect against service recipient J.M. with the requisite mental state sufficient to meet the legal standard required for placement of M.F. on the Central Registry. Therefore, the original decision to place M.F. on the Central Registry on July 15, 2025 was proper and in full compliance with the necessary statutory and regulatory requirements.

FINAL AGENCY DECISION ORDERS

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 AFFIRM, ADOPT AND ACCEPT the **Initial Decision** of the **ALJ** in its' entirety without modification and therefore:

I CONCLUDE AND AFFIRM that DHS has sustained its burden of proving, by a preponderance of the credible evidence, that the actions of M.F. rose to the level of Neglect as

defined in N.J.A.C. 10:44D-2.1(e), by failing to closely supervise J.M.-an act necessary for his well-being.

I CONCLUDE AND AFFIRM that DHS has sustained its burden of proving, by a preponderance of the credible evidence, that M.F. acted with recklessness by creating a substantial and unjustifiable risk of harm to J.M. with a conscious disregard for that risk., as defined by N.J.A.C. 10:44D-4.1 (c), thereby justifying the placement of M.F.'s name 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** that M.F. **shall remain** on the Central Registry of Offenders against Individuals with Developmental Disabilities.

Date: July 14, 2026

Deborah Robinson

Deborah Robinson, Director
Office of Program Integrity and Accountability