

WATCHDOG

Long awaited report on NJ group home medication death cites 'neglect'

8-minute read

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Key Points

- Katie Moronski died two days after moving into a group home run by Broadstep of an "acute intoxication due to Bupropion, Olanzapine, Fluoxetine and Lorazepam."
 - The state substantiated neglect against Broadstep, but stopped short of saying neglect was the cause of Moronski's death.
 - The report — issued nearly 18 months after Moronski's death — relies on a trio of questionable experts to draw conclusions.
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There was neglect by the company that operates the Sussex County group home where [21-year-old Katie Moronski](#) lived for just two days before succumbing to a lethal mix of prescription medication, a state investigation has found, but it stopped short of saying neglect was the cause of the autistic woman's death.

The rambling and contradictory report, obtained by NorthJersey.com, concludes that [neglect was a factor](#) in the "medical event" that resulted in Katie's hospital treatment, but that there was "insufficient evidence to support neglect was a factor" in her death.

Yet it goes on to say the finding of neglect is supported by Katie's treatment and death at a hospital emergency room.

Story continues below photo gallery.

The circular logic is one part of the 21-page confidential report issued nearly 18 months after Katie's death. It relies, in part, on a trio of questionable experts to draw conclusions — two of them state employees, one of whom said outright that he lacked the expertise to explain Katie's toxicology report in detail.

The December 2025 report also determined that the Newton group home for adults with developmental disabilities run by Broadstep — owned by the for-profit company RHA Health Services — violated its own policy and state regulations in numerous ways.

Despite those findings, the report and a letter sent to Katie's parents did not mention any penalties or corrective actions that need to be taken by the company to keep residents safe.

“My clients, beyond being disappointed with the conclusions regarding cause of death, are even more concerned about how many other disabled individuals have had their deaths determined to be not caused by neglect, when in fact, those deaths were causally related,” said Paul M. da Costa, the Moronskis' attorney.

RHA Health Services did not reply to an email requesting comment. A spokesman for the state Department of Human Services, which oversees the state's \$1.5 billion group home system, declined to comment, saying it cannot discuss individual cases or investigations.

Katie's death was first detailed in NorthJersey.com's 2025 investigative series [Hidden at Home](#), which revealed serious ongoing problems in the group home system, including the prevalence of medication errors at companies across the state and the absence of medical personnel to administer them properly.

No individual or administrator at Broadstep was cited for neglect, and all names of Broadstep employees were redacted from the report, making it difficult to follow.

Instead, the state found “administrative neglect” against the company itself — a finding levied against just eight organizations from 2018 through the end of 2025.

The state found that Broadstep did not have a nurse on site to review Katie’s medication when she was admitted to the group home — in fact, the director of nursing told an investigator she was new to the agency and there was no nursing team at the time.

The staff did not handle Katie’s medications properly — the person who signed that they had distributed medication to Katie was not the person who gave it to her. And a worker was missing the required annual training.

The investigator also raised concerns that photos showed pill packs returned to Katie’s family after her death had been opened and taped shut. Staff members told the investigator they did so to count the number of pills in the pre-sorted packs — but they admitted they didn’t know which pills were which.

The report notes that the group home did not have a pill book on site — a reference used to identify medications, side effects and drug interactions.

Katie had a complicated mix of medications — about 30 taken at varying intervals throughout the day, some on an as-needed basis. In addition to being autistic, she was bipolar and struggled with depression, as well as obsessive compulsive and attention deficit hyperactivity disorders. She had asthma and nut and dairy allergies.

Attorney general ceded investigation

Katie was excited to start a new chapter of her life at the group home in Newton near her family after seven years at a therapeutic boarding school in Massachusetts. She fell ill on the

morning of her second day, when the report says staff woke Katie at 8 a.m. and she did not want to get up.

She declined breakfast, took her medication and returned to bed. She got up to go to the bathroom again at 9 a.m. and went back to bed. She was back in the bathroom 20 minutes later, and again went to lie down.

The staff said she was so lethargic that she fell asleep on the toilet. Her mother was contacted at 10 a.m., and the staff took Katie to an urgent care facility at 10:30 a.m.

From there, Katie was rushed to a nearby hospital, where her condition quickly deteriorated.

The medical examiner ruled Katie's June 24, 2024, death an accident. The cause, according to her autopsy: "Acute intoxication due to Bupropion, Olanzapine, Fluoxetine and Lorazepam."

The first three drugs were part of Katie's regular medication regimen, which the group home was responsible for dispensing — Katie could not administer her own medication. Records show that the fourth medication listed in the autopsy report, lorazepam, was administered at the hospital in response to a seizure.

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Two of the drugs cited by the Morris County Medical Examiner's Office as contributing to Katie's death were prescribed antidepressants; a third was prescribed to treat her bipolar disorder. At least one of those drugs was in her bloodstream at a concentration in the range where there have been fatal overdoses, a toxicology report shows.

It took four months for the case to be routed to the Office of Investigations in the state Department of Human Services. The office, which conducts civil investigations,

notified the Division of Criminal Justice in the Attorney General's Office the same day. The office decided not to act until after the civil investigation was completed.

Asked why a criminal investigation would not have taken precedence, an agency spokesperson said, "The Attorney General's Office continues to work with partner agencies to ensure that any instance of possible neglect is investigated promptly. This includes regularly updating communication processes to ensure that cases move swiftly and appropriately."

The spokesperson said the office could not confirm or deny the existence of investigations when asked whether the agency would open its own inquiry into Katie's death.

Da Costa, the family's lawyer, said the Attorney General's Office has not contacted the Moronskis.

What's more, the report suggests that Broadstep did not investigate Katie's death, writing "it is of concern" that "the agency did not assess for neglect after the passing of Ms. K. Moronski."

The Moronskis have sued RHA Health Services and several of its employees. In a lawsuit filing, RHA denied allegations that negligence and recklessness led to Katie's death.

Katie's parents want the state to change the way medication is administered to group home residents. They met last year with Assemblywoman Aura Dunn, R-Morris, who introduced a bill requiring a nurse — or a certified medication aide working under the supervision of a nurse — to administer medication in group homes and supervised apartments.

The bill did not advance, and it expired. In January 2026, it was reintroduced in the state Senate.

Trio of experts

The state's experts repeatedly noted limitations in the conclusions they were able to draw given their specific medical expertise, as well as the lack of documentation they possessed in Katie's medication history.

"My clients are not putting any weight in the conclusions about the cause of death, given the lack of true experts that the state relied upon," da Costa said.

"While we have retained medical doctors who specialize in emergency medicine as well as toxicology," da Costa said, "our investigation makes it abundantly clear that the substantial cause of Katie's death was the reckless handling and administration of her prescription medications by the staff, as documented in the state's own investigation."

A forensic toxicologist consulted by the state said she could "only speak generally."

Another state medical director said he did not "have the specialized training or experience in the treatment of individuals with autism spectrum disorders" or "the expertise to comment on the post-mortem blood levels," and that his responses were based "on the limited documentation provided."

It is unclear which records the experts reviewed, though one expert noted he did not have a medication history from before Katie moved back to New Jersey, which could have provided more context.

The report does not indicate that the investigator requested medication records from Katie's former school in Massachusetts — or Katie's parents or attorney — once understanding that the documentation could be important.

"There was not any request made for records regarding Katie's prior medication history," da Costa said.

The report referred to records from five medical or psychiatric visits Katie attended dating back to 2019, but the summaries of the medical reports did not include medication lists. There is no indication any of those doctors were questioned by the state investigator.

State investigators are supposed to have registered nursing licenses with four years of experience on the job, according to the job description. However, if an investigator doesn't have a nursing license, a bachelor's degree with three years of experience in a health or human services setting can suffice.

The investigator on Katie's case does not appear to have a medical background. She has worked for the state since 1999 and has a degree in psychology and a master's degree in public administration, her résumé says.

New medical director weighs in

Late last year, the Department of Human Services hired Daniel Goldsmith — an internal medicine physician at Capital Health Regional Medical Center in Trenton — as a director to review cases with complex medical issues.

The report said, “Dr. Goldsmith agreed with the conclusion that although there were irregularities found in the [medication] documentation, it was unlikely these issues were causal in the clinical deterioration and death.”

“The existing documentation did not suggest a major dosing error on the part of administering staff, and there was also no evidence of any additional ingestion other than that what was prescribed.”

The Broadstep employees interviewed said they gave Katie and her housemate the correct medication and she never had access to the locked medication cabinet.

The investigator also spoke with Brianna Peterson, a forensic toxicologist from NMS Labs — the lab where Katie's toxicology review was conducted, though not by Peterson.

She said that generally speaking, the toxicity level Katie's report showed "would most likely occur due to extra dosage given" or "postmortem redistribution," in which concentration of drugs can increase in the bloodstream after death as they move from the organs.

Robert Eilers, medical director of the Division of Mental Health and Addiction Services — under the Human Services Department — told the investigator that multiple possibilities could be considered: Katie was given the wrong medication doses; she received her housemate's medication; if there were complications with long-term use of her medications, there would be an "environmental or a physical change that resulted in the medications becoming toxic."

Eilers said he could not explain Katie's toxicology report in detail, "nor can he comment about the cause of death being an acute medication intoxication, as this is not his area of expertise," the report noted. He also told the investigator that although he is a psychiatrist, he does not have specialized training or experience in the treatment of autism spectrum disorders — though the investigator spent three full pages on Eilers' comments.

In the state's letter to Katie's parents, an official wrote that "the investigation could not determine the cause of acute intoxication."

The official referred to postmortem redistribution and said acute intoxication can be caused by medication given over a short or long period.

The state wrote, "For these reasons, there was not sufficient clinical evidence to determine what caused or contributed to Ms. Moronski's death."