STATE OF NEW YORK
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

FINAL DETERMINATION AFTER HEARING

ADJUDICATION CASE
[redacted]

Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived

Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Thomas Parisi, Esq.

[redacted]

By: Nicole Murphy, Esq.
Fine, Olin and Anderman, LLP
39 Broadway, Suite 1910
New York, New York 10006

[redacted]

The Findings of Fact and Conclusions of law are incorporated from the Recommendations of the presiding Administrative Law Judge's Recommended Decision.

ORDERED: The request of [redacted] that the substantiated report dated [redacted], [redacted] dated [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The Subject's neglect of the service recipient constituted a Category 3 finding of neglect.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(c).

[redacted]

This decision is ordered by David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

DATED: Schenectady, New York
March 17, 2015

David Molik
Administrative Hearings Unit

STATE OF NEW YORK
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

ADJUDICATION CASE [redacted]

Before: Sharon Golish Blum
Administrative Law Judge

Held at: Adam Clayton Powell Jr. State Office Building
163 W 125th St
New York, New York 10027
On: [redacted]

Parties: Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived

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[redacted]

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] ("the Subject") for neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not the subject of a substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a "substantiated" report dated [redacted], [redacted], dated [redacted] of neglect by the Subject against a Service Recipient.

2. The initial report alleges, in pertinent part, that on or about [redacted], the Subject committed an act of neglect by leaving a Service Recipient behind at the [redacted] Pier, during a day trip from the [redacted], without leaving any staff member there to continue the search and without notifying the police. (Justice Center Exhibit 1)

3. The initial report was made to the Justice Center for the Protection of People with Special Needs (the Justice Center), separately, by all [redacted] custodians who were involved in the incident. [redacted] The report was investigated by an Internal Investigator for the Office for People With Developmental Disabilities (OPWDD).

4. On or about [redacted], the Justice Center substantiated the report against the

[redacted]

Subject for neglect.[1] The Justice Center concluded that:

Offense

> It was alleged that on [redacted], while at the [redacted] Pier during a day trip out of the [redacted], located at [redacted], while acting as a custodian, you committed neglect when, after discovering that a service recipient was missing, you left the pier and returned to the [redacted] without notifying the police or leaving a staff member at the pier to continue searching for the service recipient, who was discovered about two and one-half hours later after he had wandered away and locked himself in a portable bathroom.
>
> This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493.

5. An Administrative Review was conducted and, as a result, the substantiated report was retained.

6. [redacted], ("the facility"), located at [redacted], is a group home for people with developmental disabilities, which is operated by the New York State OPWDD, and is *a facility or provider agency* that is subject to the jurisdiction of the Justice Center.

7. At the time of the alleged neglect, the Subject, [redacted], had been employed at the facility for 11 years as a Developmental Disabilities Secure Care Treatment Aid I (DDSCTA). His regular work shift was [redacted]. (Testimony of [redacted])

8. At the time of the alleged neglect, the Service Recipient was 32 years of age and had been a resident of the facility since [redacted]. The Service Recipient is a person with a primary diagnosis of mild intellectual disability and a secondary diagnosis of schizoaffective

[1] Other staff members were also made Subjects of substantiated reports. However, those other staff members are not parties to this hearing.

[redacted]

disorder. (Justice Center Exhibit 16)

9. On Tuesday, [redacted], DDSCTA [redacted], the Subject, DDSCTA Staff [redacted] and DDSCTA Staff [redacted] took ten residents, including the Service Recipient, shopping and then to McDonalds for lunch, as a "community inclusion outing." [redacted] was responsible for driving the facility van during this outing. (Testimony of [redacted]; Subject)

10. On the way back to the facility, at approximately 2:30 p.m., the group stopped at the [redacted] Pier to allow the residents to use the bathrooms. All of the residents, except for one, exited the van and [redacted] waited in the van with that person. Staff [redacted] accompanied the other residents into the bathroom, in a building near the parking lot, and Staff [redacted] waited outside the bathroom to supervise the residents as they came out. (Justice Center Exhibit 4)

11. The residents, who had finished using the bathroom, at first just stood around outside, and then boarded the van when requested to do so. In the meantime, a dispute between two of the residents had erupted in the bathroom. One of the residents, who had been involved in the conflict, remained upset and only after some delay, did he finally agree to go back into the van. (Justice Center Exhibit 17)

12. Once the residents were in the van, [redacted] began driving the van towards the parking lot exit. Staff [redacted] performed a head count and, before they had exited the parking lot, she indicated that the Service Recipient was not in the van. The van had not gone far and [redacted] turned it around, returning to the parking area. Staff [redacted] and Staff [redacted] took two of the "higher functioning" residents with them, as "another set of eyes," and went in search of the Service Recipient, while [redacted] stayed in the van, supervising the seven other residents. (Justice Center Exhibit 17)

13. Thereafter, the staff and residents returned to the van without having located the

[redacted]

Service Recipient. Staff [redacted] attempted to telephone [redacted], DDSCTA II, in the core office and [redacted], Treatment Team Leader, but could not reach either of them. While Staff [redacted] was attempting to notify the facility of the Service Recipient's disappearance, [redacted] exited the van and conducted his own search of the area for the missing Service Recipient. After returning to the van alone, [redacted] unsuccessfully attempted to telephone Resident Unit Supervisor, [redacted]. It was then mutually decided between the staff, that they should start out in the direction of the facility, in case the Service Recipient had begun walking back. (Testimony of [redacted]; Subject)

14. While [redacted] drove, Staff [redacted] telephoned and spoke with facility Safety Officer, [redacted]. She remained speaking to him for the duration of the short return trip to the facility. (Justice Center Exhibit 4)

15. When they arrived back at the facility, Staff [redacted] and [redacted] were told by the two supervisors that they should not have left the area without the Service Recipient. [redacted] then volunteered to immediately return to the [redacted] Pier, which he did alone. At approximately 5:30 p.m., [redacted] located the Service Recipient in the area and transported him back to the facility thereafter.

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute neglect.
- Pursuant to Social Services Law § 493(4), the category of neglect that such act or acts constitute.

[redacted]

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. SSL § 492(3)(c) and 493(1) and (3). Pursuant to SSL § 493(3), the Justice Center determined that the initial report of neglect presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been made as a result of an investigation that there is a preponderance of evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3(f))

Pursuant to SSL §§ 494(1)(a)(b) and (2), and Title 14 NYCRR § 700.6(b), this hearing decision will determine: whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report, and if there is a finding of a preponderance of the evidence; whether the substantiated allegations constitute neglect; and pursuant to Social Services Law § 493(4), the category of neglect that such act or acts constitute.

The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488:

1. "Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:

    (a) "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.

    (b) "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct

or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.

(c) "Psychological abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by verbal or non-verbal conduct, a substantial diminution of a service recipient's emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor, or causing the likelihood of such diminution. Such conduct may include but shall not be limited to intimidation, threats, the display of a weapon or other object that could reasonably be perceived by a service recipient as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments or ridicule.

(d) "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

(e) "Use of aversive conditioning," which shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the absence of a person-specific authorization by the operating, licensing or certifying state agency pursuant to governing state agency regulations. Aversive conditioning may include but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.

[redacted]

(f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.

(g) "Unlawful use or administration of a controlled substance," which shall mean any administration by a custodian to a service recipient of: a controlled substance as defined by article thirty-three of the public health law, without a prescription; or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article thirty-three of the public health law, at the workplace or while on duty.

(h) "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject(s) committed the act or acts of abuse and/or neglect alleged in the

[redacted]

substantiated report that is the subject of the proceeding and that such act or acts constitute the category of abuse and/or neglect as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493:

4. Substantiated reports of abuse or neglect shall be categorized into one or more of the following four categories, as applicable:

    (a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:

        (i) intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur;

        (ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;

        (iii) threats, taunts or ridicule that is likely to result in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

        (iv) engaging in or encouraging others to engage in cruel or degrading treatment, which may include a pattern of cruel and degrading physical contact, of a service recipient, that results in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

(v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;

(vi) any conduct that is inconsistent with a service recipient's individual treatment plan or applicable federal or state laws, regulations or policies, that encourages, facilitates or permits another to engage in any conduct in violation of article one hundred thirty of the penal law, with a service recipient;

(vii) any conduct encouraging or permitting another to promote a sexual performance, as defined in subdivision one of section 263.00 of the penal law, by a service recipient, or permitting or using a service recipient in any prostitution-related offense;

(viii) using or distributing a schedule I controlled substance, as defined by article thirty-three of the public health law, at the work place or while on duty;

(ix) unlawfully administering a controlled substance, as defined by article thirty-three of the public health law to a service recipient;

(x) intentionally falsifying records related to the safety, treatment or supervision of a service recipient, including but not limited to medical records, fire safety inspections and drills and supervision checks when the false statement contained therein is made with the intent to mislead a person investigating a reportable incident and it is reasonably foreseeable that such false statement may endanger the health, safety or welfare of a service recipient;

(xi) knowingly and willfully failing to report, as required by paragraph (a) of subdivision one of section four hundred ninety-one of this article, any of the conduct in subparagraphs (i) through (ix) of this paragraph upon discovery;

(xii) for supervisors, failing to act upon a report of conduct in subparagraphs (i) through (x) of this paragraph as directed by regulation, procedure or policy;

(xiii) intentionally making a materially false statement during an investigation into a report of conduct described in subparagraphs (i) through (x) of this paragraph with the intent to obstruct such investigation; and

[redacted]

(xiv) intimidating a mandated reporter with the intention of preventing him or her from reporting conduct described in subparagraphs (i) through (x) of this paragraph or retaliating against any custodian making such a report in good faith.

(b) Category two is substantiated conduct by custodians that is not otherwise described in category one, but conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Category two conduct under this paragraph shall be elevated to category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged in category two conduct. Reports that result in a category two finding not elevated to a category one finding shall be sealed after five years.

(c) Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a category three finding shall be sealed after five years.

(d) Category four shall be conditions at a facility or provider agency that expose service recipients to harm or risk of harm where staff culpability is mitigated by systemic problems such as inadequate management, staffing, training or supervision. Category four also shall include instances in which it has been substantiated that a service recipient has been abused or neglected, but the perpetrator of such abuse or neglect cannot be identified.

If the Justice Center proves the alleged abuse and/or neglect, the report will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the act of abuse and/or neglect cited in the substantiated report constitutes the category of abuse and/or neglect as set forth in the substantiated report.

If the Justice Center did not prove the abuse and/or neglect by a preponderance of evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has established by a preponderance of evidence that [redacted] committed the neglect as alleged in the substantiated report. Specifically, the evidence establishes that [redacted] drove a van with two staff members and nine residents away from the [redacted] Pier, after discovering that the Service Recipient had become missing there, without

notifying the police and without leaving a staff member at the pier to continue searching for the Service Recipient, as was alleged in the Notice of Substantiated Finding.

failure to immediately contact facility safety personnel or other facility staff actions also represents a breach of his duty as a custodian and, therefore, constitutes neglect as defined in SSL § 488(1)(h). The category of the affirmed substantiated neglect that such act constitutes is Category 3.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-17) The investigation underlying the substantiated report was conducted by OPWDD Internal Investigator, , who was the only witness who testified at the hearing on behalf of the Justice Center. testified on his own behalf and provided no other evidence.

The facts of this case are, by and large, not in dispute. The Justice Center relied upon that portion of the facility *Policy and Procedure Manual* under the topic: *Missing Consumers*. The four page document clearly sets out the responsibilities of the various facility staff members when a consumer is found to be missing. The responsibility of *"Any Staff"* is the directive that is applicable to the custodians in this case, including . It states that any staff:

> "1. *Will immediately report missing consumer to the Safety Department, consumer's unit and Clinical Control Unit*." (Justice Center Exhibit 5)

The policy does not require staff to contact the police or to remain at the last location that a consumer was seen, when a consumer is found to be missing, both of which are elements of the substantiated finding. However, the policy does contain an important reporting requirement that was not strictly followed by .

By his own testimony, admitted that, other than attempting to reach one person, Resident Unit Supervisor, , did not endeavor to notify the

[redacted]

facility safety department or the other relevant facility staff. The evidence indicates that, once [redacted] became aware that the Service Recipient was not in the van, he participated in the search effort, together with the other staff members, by looking for the Service Recipient at the [redacted] Pier. It was also established that [redacted] and Staff [redacted] had attempted to contact their supervisors by cell phone from the [redacted] Pier but were unable to reach them. (Testimony of [redacted]; Subject)

[redacted] testified that, while they were all back in the van after conducting some physical search of [redacted] Pier, it was thought that the Service Recipient may have started walking back to the nearby facility. It was at that point that the staff members mutually decided that the search for the Service Recipient should continue by checking along the walkway that is parallel to the [redacted] Parkway, which is in the direction of the facility. [redacted] then drove the van away from the [redacted] Pier, without the Service Recipient and without making ***all*** of the telephone calls as required by the policy. (Testimony of [redacted]; Subject)

Although, [redacted] had unsuccessfully attempted to telephone a supervisor, there is no evidence that he complied fully with the duty to "*...immediately report missing consumer to the Safety Department, consumer's unit and Clinical Control Unit*." It was not until after the van had left the pier, that Staff [redacted] contacted the facility safety office. (Justice Center Exhibit 4)

[redacted] hearing testimony was that he could not remember ever having seen the Policy and Procedure Manual, nor could he recall having received a copy of the entire Policy Manual. The Justice Center did not provide evidence, such as [redacted] signature, that he had been given a copy of either the whole manual or any portion thereof. In any case, despite the absence of evidence that [redacted] was familiar with the written policy or was otherwise chargeable with notice of the policy, [redacted] good judgment and basic responsibility to

[redacted]

be diligent should have been enough for him to know that he had a duty to notify the facility of the missing Service Recipient before leaving the pier as he did. (Testimony of [redacted]; Subject)

[redacted] testified that he had never received any training related to the procedure to be followed in the case of a missing resident and the Justice Center did not provide any evidence to the contrary. (Testimony of [redacted]; Subject)

The audio interrogations of Staff [redacted] and Staff [redacted] are consistent with [redacted] testimony on this point, as they also reveal that they had received no training related to the procedure to be followed in the case of a missing resident. In fact, it was apparent from the three audio interrogations, that none of the three custodians had a clear concept of what to do when the Service Recipient disappeared. (Justice Center Exhibit17)

Again, even though there was no evidence of training, [redacted] intrinsic duty as a custodian was not obviated. It was clear from all of the evidence that [redacted] did not take all reasonable, common sense steps available to him to ensure the Service Recipient's safety.

Upon cross examination, [redacted] testified that he had not even thought of leaving one of the staff behind as he "...really needed the two staff in the van." There were nine residents that required supervision while he drove and the two residents who had been quarrelling at the pier were still engaged in their dispute in the van. (Testimony of [redacted]; Subject)

While the need for adequate staffing in the van was a legitimate safety concern, [redacted] still should not have abandoned the Service Recipient at the [redacted] Pier, without having notified anyone at the facility, without having contacted the police for assistance or without leaving a staff member there, at the last place that the Service Recipient had been seen.

[redacted] testified that the leaving of the [redacted] Pier was only for the purpose of continuing the search for the Service Recipient. He stated that once Staff [redacted] was speaking to the facility Safety Officer, [redacted], after the van left the pier parking lot, he was seeking instructions from her as he drove the van along the [redacted] Parkway, while looking for the Service Recipient. Because Staff [redacted] was so busy answering [redacted] questions, she did not provide any guidance as to what he should do and he just wound up taking everyone back to the facility. He further testified that he "... had not intended to go back to the [redacted]... [and that while he was driving]... when he asked two or three times what safety was saying, Staff [redacted] kept gesturing to just keep going." (Testimony of [redacted]; Subject)

[redacted] cannot blame the actions of Staff [redacted] for the fact that he drove the van back to the facility without the Service Recipient having been found. He should not have driven away from the [redacted] Pier as he did. Because [redacted] was the one in control of the van, he had the ability to insist that they not leave the pier until proper notifications were made and instructions received.

When the Service Recipient was found by [redacted] walking around at the [redacted] Pier, at approximately 5:30 p.m. that day, the Service Recipient revealed that he had entered a portable bathroom earlier and that, for some time, he had mistakenly thought that he was locked in. Eventually, the Service Recipient realized that he could get out and when he exited the bathroom, he found himself alone and began walking around the area looking for a familiar face until he was found by [redacted]. This explanation underscores the reasonableness of the expectation that the search for the Service Recipient should have continued uninterrupted until he was found. (Justice Center Exhibit 4)

In the final analysis, based on all of the evidence, it is concluded the Justice Center has

[redacted]

met its burden of proving by a preponderance of the evidence that [redacted] committed the neglect as alleged in the substantiated report. By leaving the Service Recipient alone at the [redacted] Pier, without notifying the police or leaving one of the staff members behind to continue the search, [redacted] breached his duty as a custodian, which may very well have resulted in "physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient" as set out in SSL § 488(1)(h).

Furthermore, [redacted] breached his duty as a custodian when he left the Service recipient at the [redacted] Pier without having made the required notifications as set out in the facility policy, which also constitutes an act of neglect. The substantiated report will not be amended or sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated allegation constitutes the category of neglect as set forth in the substantiated report**.** Category 3 is the least serious Category of neglect in the legislation and it is appropriate under these circumstances.

A substantiated Category 3 finding of abuse or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to NY SSL § 496 (2). This report will be sealed after five years.

DECISION: The request of [redacted] that the substantiated report [redacted], [redacted] dated [redacted] be amended

[redacted]

and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The Subject's neglect of the service recipient constituted a Category 3 finding of neglect.

This decision is recommended by Sharon Golish Blum, Administrative Hearings Unit.

DATED: March 9, 2015
Plainview, New York