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** **Adjud. 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: Todd M. Sardella, Esq.

[redacted]
By: Patricia M. Curtin, Esq.
Levene, Gouldin & Thompson, LLP
PO Box F-1706
Binghamton, New York 13902-0106

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

The substantiated report is properly categorized as a Category 3 act.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be retained in part 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: July 24, 2015
Schenectady, New York

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

Adjud. Case #: [redacted]

Before: Jean T. Carney
Administrative Law Judge

Held at: NYS Justice Center
401 State Street
Schenectady, NY 12305
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
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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for abuse and/or neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the 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 report substantiated on [redacted], dated and received on [redacted] of neglect by the Subject of a Service Recipient.

2. The Justice Center substantiated the report against the Subject. The Justice Center concluded that:

Offense 1

> It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to investigate a door alarm, which permitted a service recipient to leave the [redacted] unsupervised.
>
> This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493.

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

4. The facility, [redacted], is a residential facility operated by [redacted] and licensed by the Office for People With Developmental Disabilities [hereinafter OPWDD]. It

[redacted]

is a facility or provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged abuse and/or neglect, the Subject was employed by [redacted] since [redacted] 2013, as a Direct Service Provider (DSP) (Justice Center Exhibit 3, Hearing testimony of Subject).

6. At the time of the alleged abuse and/or neglect, the Service Recipient had been a resident of the facility since shortly after it opened in [redacted]. The Service Recipient is a male born in 1986 (Justice Center Exhibit 12). He has been diagnosed with profound intellectual disability, type I diabetes, paronychia autism, and generalized anxiety disorder (Justice Center Exhibit 3).

7. On [redacted], the Subject was working the evening shift, 5:00 p.m. to 11:00 p.m. (Justice Center Exhibit 9, Hearing testimony of Subject). No staff assignments had been made, so the Subject volunteered to assist the Service Recipient in eating his dinner (Justice Center Exhibits 2, 3, Hearing testimony of Subject, Hearing testimony of Assistant Director (AD) [redacted]).

8. After eating his dinner, the Service Recipient ran toward his bedroom, normal behavior for him, and the Subject went into the kitchen to clean the dishes (Justice Center Exhibits 3, 12, and Hearing testimony of Subject). The Subject heard the front door alarm sound, and observed DSP [redacted] enter the residence (Hearing testimony of Subject). A few minutes later the Subject heard two other staff members, DSP [redacted] and DSP [redacted], discuss DSP [redacted] having found the Service Recipient outside the residence by the lamppost at the end of the driveway (Hearing testimony of Subject).

9. The Subject did not hear any other door alarms during that shift (Hearing testimony of Subject, Justice Center Exhibits 2, 3, and 5). DSP [redacted] was the only

staff on duty that evening who heard another door alarm go off as she entered the residence after her break (Hearing testimony of AD , Justice Center Exhibits 3, and 5).

10. DSP had taken another resident to the emergency room. Upon her return, she saw the Service Recipient at the end of the driveway, so she parked the van, made sure he was safe and supervised by other staff, and went into the residence through the front door (Justice Center Exhibits 3 and 7). She saw DSP and told her about finding the Service Recipient (Justice Center Exhibits 3 and 7).

11. Each entrance to the residence is equipped with a door alarm consisting of a buzz or chime sound as well as a voice announcing which door is open. The residence had opened months prior to the incident and maintenance had not reported any problems or issues with the door alarms malfunctioning. During the course of the investigation, , the Assistant Director of Quality Assurance who investigated the incident, tested the door alarms and found no problems (Hearing testimony of AD , Justice Center Exhibit 3, and Subject Exhibit B).

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 abuse and/or neglect.
- Pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

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

[redacted]

Justice Center determined that the initial report of abuse and 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 the 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 abuse and/or neglect; and pursuant to Social Services Law § 493(4), the category of abuse and/or 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.

(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

[redacted]

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 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).

[redacted]

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

(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.

[redacted]

(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 the Subject committed a prohibited act, described as "Offense 1" in the substantiated report. The act committed by the Subject constitutes neglect.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation (Justice Center Exhibits 1-13). The investigation underlying the substantiated report was conducted by AD [redacted], who testified at the

[redacted]

hearing on behalf of the Justice Center. Team Leader (TL) [redacted] also testified in support of the Justice Center.

The Subject testified on her own behalf and presented several documents (Subject Exhibits A, B, and C).

The Justice Center proved by a preponderance of the evidence that the Subject committed neglect by failing to pay attention to the door alarms and investigating when the door alarms sounded. This breach allowed the Service Recipient to leave the residence unattended, and placed him at risk of harm. Social Services law §488(1)(h) defines neglect as "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." In this case the Subject was so inured to the door alarms going off that she did not pay attention to the door alarm sound. This lack of attention enabled the Service Recipient to leave the residence unnoticed. Due to this Service Recipient's documented inability to protect himself when in the community, it is very likely that he could have been harmed during the time he was unsupervised (Justice Center Exhibits 12 and 13).

The Subject testified that while she was cleaning up after dinner, she heard the front door alarm. She saw DSP [redacted] come in the front door and did not investigate further. The Subject also testified that she did not hear any other door alarms after that. Several minutes later she heard DSP [redacted] and DSP [redacted] talking about the Service Recipient being found outside.

The Subject posits that because she did not hear the hallway door alarm, it probably malfunctioned. Indeed, at least two other staff, DSP [redacted] and DSP [redacted], were also in the residence and did not hear the hallway door alarm. However AD [redacted]

[redacted]

and TL [redacted] performed tests on the doors to determine what would happen if two doors were opened simultaneously. Their tests showed that both door alarms sounded and announced that they were open (Hearing testimony of TL [redacted], Hearing testimony of AD [redacted], Subject Exhibit B). In addition, AD [redacted] checked with maintenance and found that there were no reported issues with the door alarms (Hearing testimony of AD [redacted]). Thus the weight of the evidence does not bear this theory out.

However, the most compelling evidence supporting the Justice Center's case comes from the Subject. She never heard the front door alarm go off when DSP [redacted] entered the residence through the front door after finding the Service Recipient outside (Hearing testimony of Subject, Justice Center Exhibit 3). DSP [redacted] had transported another resident to the emergency room, so she was not in the residence when the Service Recipient eloped. When she returned, she came in through the front door to alert staff that the Service Recipient had gotten outside (Justice Center Exhibits 3 and 7). It is uncontroverted that the front door alarm was functioning properly; the Subject had heard it minutes before when DSP [redacted] came back from her break. Therefore it is likely that she did not hear the hallway door alarm when the Service Recipient left the residence; as opposed to the alarm not sounding.

The Service Recipient has been diagnosed with profound intellectual disability. He has a history of wandering he may "bolt if he sees something of interest" and has no safety awareness (Justice Center Exhibit 12). The likelihood of this Service Recipient coming to harm if allowed in the community unsupervised is great. Therefore the need to be vigilant in monitoring the door alarms cannot be stressed enough. Both AD [redacted] and TL [redacted] testified as to how staff can become so used to the alarms going off during their shift; that they stop processing the sound. One witness compared it to living near a train track and not hearing the trains after a

[redacted]

while. For that reason, they stress the importance to staff to remain vigilant and attentive to the door alarms so that they will not neglect to investigate the source of the alarm. In this instance, that training failed, resulting in the Subject breaching her duty to the Service Recipient.

Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged. 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 report constitutes the category of abuse or neglect set forth in the substantiated report**.** Social Services Law §493(4)(c) defines Category 3 as "abuse or neglect by custodians that is not otherwise described in categories one and two." Accordingly, based upon the totality of the circumstances, the evidence presented and the testimony given, it is determined that the substantiated report is properly categorized as a Category 3 act.

A substantiated Category 3 finding of 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 SSL §496(2). This report will be sealed for five years.

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

[redacted]

The substantiated report is properly categorized as a Category 3 act.

This decision is recommended by Jean T. Carney, Administrative Hearings Unit.

DATED: July 1, 2015
Schenectady, New York