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 AND ORDER AFTER HEARING

Adjud. Case #: [redacted]

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

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

[redacted]

[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] 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 by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(c).

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: May 20, 2016
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: Mary Jo Lattimore-Young
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
Administrative Hearings Unit
1200 East and West Road
West Seneca, New York 14224
On: [redacted]

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

Administrative Appeals Unit
New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Robert DeCataldo, Esq.

[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 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 "substantiated" report dated [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:

Allegation 1

> It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you and a co-worker left the [redacted] together during your shift to smoke, during which time the service recipients were not provided with proper supervision.
>
> This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

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

4. The facility, located at [redacted], is an [redacted] that provides twenty-four hour supervision for people with various developmental disabilities. The facility is operated by [redacted], which is a

not-for-profit corporation certified by NYS Office for People With Developmental Disabilities (OPWDD). The provider agency is subject to the jurisdiction of the Justice Center. The [redacted] facility has two bedrooms on the first floor, three bedrooms upstairs and a basement. The [redacted] also has a driveway located on the right side of the house and a detached garage in the back of the house. (Hearing testimony of [redacted] Specialist/Investigator)

5. At the time of the neglect, which allegedly occurred on [redacted], the Subject had been employed by [redacted] as a Direct Support Professional (DSP). On that date, the Subject was assigned to work the afternoon shift from 11:30 a.m. until 9:30 p.m., along with another DSP (Staff Member A) who was assigned to work at the [redacted] from 8:30 a.m. until 8:30 p.m. (Justice Center Exhibit 8, page 19 and Justice Center Exhibit 10) Generally, the DSPs' duties include, among other things, supervising the service recipients in accordance with their Individualized Plans of Protective Oversight (IPOPs) and assisting the service recipients with cooking, laundry, hygiene care, medical appointments, home maintenance, and outings. (Hearing testimony of [redacted] Specialist/Investigator and Justice Center Exhibit 13, pages 1-5)

6. The Subject has been employed in the human services health field for over ten years. Prior to his employment at [redacted], the Subject had been employed at another company where he worked with disabled individuals for over five years. (Hearing testimony of the Subject and Justice Center Exhibit 2)

7. At the time of the alleged neglect, there were five adult male service recipients that resided at the facility who ranged in ages from approximately 45 to 55 years old. Each of the service recipients had various ranges of disabilities and diagnoses. All of the service

recipients have IPOPs, which contain mandated supervisory levels that are to be performed by staff. (Justice Center Exhibit 8, pages 15- 16 and Justice Center Exhibit 13)

8. Among the directives contained in Service Recipient 1's IPOP, is the requirement that, while he is in the facility, staff is to observe him every thirty minutes. He is able to ambulate independently with the use of Canadian crutches and is verbal. However, Service Recipient 1 has diagnoses of moderate intellectual disability, Schizophrenia with auditory hallucinations, anxiety, Cerebral Palsy with congenital Diplegia (paralysis) and other medical conditions. His IPOP further provides that he is able to recall and report information, even though his ability to accurately recount the exact time an event occurred is limited. (Justice Center Exhibit 8, page 15 and Justice Center Exhibit 13, page 4)

9. Service Recipient 2's IPOP also requires that staff is to observe him every thirty minutes while he is in the [redacted]. He is able to ambulate independently and is verbal. He can understand verbal directions and clearly communicate his wants and needs. Service Recipient 2's diagnoses are mild to moderate intellectual disability, Seizure Disorder/Epilepsy, behavior disorder (intermittent explosive disorder, anxiety NOS), pervasive developmental disorder as well as other medical conditions. It is further noted in his IPOP that he is able to recall and report information but may not always be truthful, especially when he is exhibiting anxious behaviors.[1] Additionally, Service Recipient 2 may not always accurately report the exact time when an event occurred. (Justice Center Exhibit 8, page 15 and Justice Center Exhibit 13, page 2)

10. Among the directives contained in Service Recipient 3's IPOP is the requirement that staff provide proper supervision of Service Recipient 3 by conducting observations of him

[1] At the hearing, [redacted] Specialist/Investigator testified that when she interviewed Service Recipient 2 on [redacted] he did not exhibit such behaviors.

every ten minutes when he is alone on the first floor of the [redacted]. However, if staff is cooking food and Service Recipient 3 is nearby, then staff is mandated to be within arm's reach of him to ensure his safety. He is able to ambulate independently and is non-verbal. Service Recipient 3 has diagnoses of profound intellectual disability, impulse control disorder and many other medical conditions. (Justice Center Exhibit 8, page 16 and Justice Center Exhibit 13, page 5)

11. Among the directives contained in Service Recipient 4's IPOP are the requirements that staff provide observation of him every ten minutes while he is in the residence and that there are two staff members working in the [redacted] at all times, except overnight. He can ambulate independently and is able to make his wants and needs known through his limited vocabulary in conjunction with facial expressions. It is also noted in his IPOP that he cannot recall past events. Service Recipient 4 has diagnoses of severe intellectual disability, Autism, behavior disorder, impulse control disorder and other medical conditions. (Justice Center Exhibit 8, page 15 and Justice Center Exhibit 13, page 3)

12. Among the directives contained in Service Recipient 5's IPOP is the requirement that staff observe him every ten minutes when he is in the [redacted]. He lacks the capability of being left in the facility alone at any time. He is able to ambulate independently and, although he is verbal, he does not always communicate with staff what he wants or needs. It is also noted in Service Recipient 5's IPOP that he cannot accurately recall past events. Although he can recall current events, his recollection is not specific as to time. Service Recipient 5 has diagnoses of Down Syndrome, moderate intellectual disability, Dementia (early stages) / Alzheimer's, impulse control disorder, mild to moderate hearing loss and other medical conditions. (Justice Center Exhibit 8, pages 15-16 and Justice Center Exhibit 13)

13. On [redacted], between the hours of 6:00 p.m. and 7:00 p.m., while

attempting to make a delivery of medications for the residents, a pharmacy delivery person drove up to the [redacted] and parked his vehicle in the driveway, then walked to the door of the [redacted]. The driver rang the doorbell, then knocked on the door several times. (Justice Center Exhibit 8, page 17)

14. At some point, Service Recipient 1, who had been in his bedroom on the second floor, saw through his window that the Subject and Staff Member A were outside by the garage smoking cigarettes. Upon hearing the pharmacy driver knocking on the door of the IRA, Service Recipient 1 came to the door to open it then allowed the driver to enter the [redacted]. The pharmacy driver asked if staff was there and Service Recipient 1 responded by saying "[t]hey're not here." (Justice Center Exhibit 8, page 17) Because the pharmacy driver saw that no staff was present, he leaned down the basement stairs and yelled "hello" twice, but got no response. Service Recipient 2, who was in his bedroom on the first floor underneath Service Recipient 1's bedroom, heard the pharmacy driver yell for staff.[2] The pharmacy driver then left the [redacted] without delivering the medication and reported the situation to the pharmacy supervisor. (Justice Center Exhibit 8, page 17) Later that evening, the pharmacy supervisor called the [redacted] to ensure that a staff person would be present at the house to accept a re-delivery of the medications. The medications were successfully delivered after a second delivery attempt was made at the [redacted] at approximately 10:30 p.m. that same day. Staff Member B had accepted the second delivery. (Justice Center Exhibits 9 and 14)

15. On [redacted], [redacted] staff reported the incident to the facility's Residential Manager (RM) when he came to the [redacted] the following morning. Thereafter, the RM spoke to Service Recipient 1 about what had happened. Service Recipient 1 told the RM that on the

[2] During the course of the investigation, Service Recipient 2 told [redacted] Specialist/Investigator that the pharmacy driver left because staff was outside. He knew staff went outside because the Subject and Staff Member A told him they were headed outside for a smoke. (Justice Center Exhibit 8, page 16)

previous day there was a knock at the door. Service Recipient 1 further explained that he opened the door for the driver who had entered the facility then yelled out for staff assistance. Service Recipient 1 further reported that when no-one responded to the calls from the pharmacy driver, the pharmacy driver asked him where staff was and that he told the driver that staff was out back by the garage. (Justice Center Exhibit 8, pages 4, 9 and 16; and Justice Center Exhibit 9)

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 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 the evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3(f))

The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1)(h). Under SSL §488(1)(h)(i),

> "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.

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 3, which is defined under SSL § 493(4)(c) as follows:

> 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.

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

If the Justice Center proves the alleged 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 neglect cited in the substantiated report constitutes the category of neglect as set forth in the substantiated report.

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

DISCUSSION

The Justice Center has established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 1" in the substantiated report. The record shows that

the Subject committed neglect when he and his co-worker, Staff Member A, being the only staff working at the time of a pharmacy delivery, were both on a smoking break outside of the [redacted], leaving the service recipients alone and unsupervised for a period of time. The pharmacy was unable to deliver the service recipients' medications to [redacted] staff because there was no staff present in the residence at the time of the attempted delivery, further evincing a level of neglect.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1- 15) The investigation underlying the substantiated report was conducted by [redacted] Specialist/Investigator, who was the only witness to testify at the hearing on behalf of the Justice Center.

The Subject testified in his own behalf and provided no other evidence.

The evidence presented by the Justice Center is found to be credible. The Justice Center's main evidence consists of the investigation interviews of the detailed eyewitness accounts of Service Recipient 1, Service Recipient 2 and the pharmacy driver as reported to his supervisor.

Service Recipient 1's second floor bedroom window faces the back yard and garage area of the [redacted]. Service Recipient 1 said he saw the Subject and Staff Member A outside by the garage smoking at the time the pharmacy driver made his first delivery to the [redacted]. Service Recipient 1's view of the back yard and garage from his bedroom window was confirmed by [redacted] Specialist/Investigator during the course of her investigation. (Hearing testimony of [redacted] Specialist/Investigator and Justice Center Exhibit 8, pages 16 - 17)

During his investigative interview, Service Recipient 2 stated that the Subject and Staff

Member A told him that they were going outside for a smoke. Service Recipient 2 further related that none of the other staff members go outside together and he did not like it when the Subject and Staff Member A went outside of the [redacted] at the same time. (Justice Center Exhibit 8, pages 16 - 17)

Service Recipient 1's compelling eyewitness account is consistent with his report to the RM the following morning, his statement to [redacted] Specialist/Investigator during the course of her investigation, and the eyewitness account of Service Recipient 2. Additionally, the two service recipients' accounts of events were corroborated by the pharmacy driver's eyewitness account of what happened when he arrived at the [redacted] to try to make the first delivery and found no staff present to accept the delivery. (Justice Center Exhibit 8, pages 4 and 16 – 17)

The Subject's actions, of leaving the service recipients alone in the [redacted] for a period of time[3] while he went outside of the [redacted] with the only other staff person on duty at the time of the pharmacy's first delivery, constituted a breach of his custodial duty. The Subject's actions were likely to have resulted in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the service recipients. It is clear from the record that the policy of [redacted] does not allow for the facility to be unstaffed for any period of time. (Hearing testimony of [redacted] Specialist/Investigator) The [redacted] is mandated to provide twenty-four hour supervision to the service recipients who all required various periodic observations by staff when the Service Recipients are inside of the residence. Additionally, it is mandated in Service Recipient 5's IPOP that he is to be never left alone in the residence at any time. (Justice Center Exhibit 13)

At the hearing, the Subject offered very little to explain what, if anything, occurred that

[3] The record is unclear as to how long the Subject and Staff Member A were outside of the [redacted]. However, the amount of time is immaterial to the decision in this case.

day. The Subject testified that on the day in question he was assigned to administer medications from the medication room located in the upstairs hallway that has a window overlooking the driveway. The Subject claims that from this position he would have seen the pharmacy driver's vehicle in the driveway and that he did not. The Subject further claims that this incident never happened and that the pharmacy never delivered medications to the house during his shift. He stated that even if he had been outside at the time of the delivery, he still would have heard or seen the driver's vehicle in the driveway.

During the Subject's testimony, he denied that he was outside with Staff Member A and left the service recipients alone and unsupervised in the [redacted]. The Subject also testified that, although there is no set schedule for breaks, staff usually coordinated break times. Additionally, the Subject claims as a defense that he does not smoke and that he may have kiddingly said that he was going outside for a smoke. Yet, his claim is controverted by Staff Member A's interrogation statement when Staff Member A told the investigator that the Subject did indeed smoke. (Justice Center Exhibit 8, page 19) As a further defense, the Subject argued that if these allegations against him were true, then [redacted] would have fired him immediately instead of allowing him to work the rest of the week. However, the Subject presented no evidence to support his claim that his continued employment was based on a finding by his employer that the allegations were not substantiated. The remaining defenses raised by the Subject are not sufficiently supported by the record and therefore lack merit for consideration.

Accordingly and given the state of the record, 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 neglect set forth in the substantiated report**.** Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, 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 NY SSL § 496 (2). This report will be sealed after five years.

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

This decision is recommended by Mary Jo Lattimore-Young, Administrative Hearings Unit.

DATED: May 12, 2016
West Seneca, New York