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: Juliane O'Brien, Esq.

[redacted]
By: [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 granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

NOW, THEREFORE, IT IS DETERMINED that the record of this report shall be amended and sealed by the Vulnerable Persons' Central Register, pursuant to SSL § 493(3)(d).

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: June 3, 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: Louis P. Renzi
Administrative Law Judge

Held at: Adam Clayton Powell State Office Building
163 West 125th Street
New York, New York 10027
On: [redacted]

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

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

[redacted]
By: [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 scheduled in accordance with the requirements 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] 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 failed to supervise a service recipient and he eloped from the residence for a period of time.
>
> 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, [redacted] located at [redacted] is an [redacted] operated by [redacted] and is certified by the Office for People With Developmental

Disabilities (OPWDD), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center. [redacted] began operation in [redacted]. On [redacted], the date of the alleged neglect ("the incident"), [redacted] had six residents. Residents were transported each day to and from their day habilitation program. (Hearing testimony of [redacted]; hearing testimony of [redacted], Behavior Intervention Specialist (BIS) [redacted]; Justice Center Exhibit 2)

5. At the time of the incident, the Subject was working at [redacted] as a direct care Program Specialist. She had worked for [redacted] for 4 months. (Hearing testimony of Subject; Justice Center Exhibits 3, 4, 16, 17 and 18)

6. At the time of the incident, the Service Recipient was a twenty-one year old male who had resided at [redacted] since [redacted], 2013. The Service Recipient had a diagnosis of autism and functioned within the moderate range of intellectual functioning. (Hearing testimony of BIS [redacted]; Justice Center Exhibits 3 and 4; Subject Exhibits G, H and I)

7. The Service Recipient's Behavior Support Plan (BSP), effective [redacted], noted his history of elopement and indicated that he needed to be closely supervised and kept within staff's line of sight. (Justice Center Exhibit 20; Subject Exhibits G, H and I)

8. On [redacted], approximately two weeks prior to this incident, the Service Recipient eloped from the [redacted] residence through an exit door in the basement. That door was located near the computer which was in the basement hallway of the residence, and out of staff's line of sight. The Service Recipient returned to [redacted] on his own four hours later. (Justice Center Exhibits 4 and 12)

9. On [redacted], a meeting was held to review the [redacted] elopement. Protective

measures were recommended and included, *inter alia*, installing door alarms and cameras, relocating the computer to a more visible area of the residence and away from the exit, giving the Service Recipient an alternative activity when the computer is not available and retraining staff on proper procedures in transferring ("handing off") individual assignments. On the date of the incident, the computer had not been moved and remained in the basement hallway. (Justice Center Exhibits 4, 12, 23, 24, 25 and 26; Subject Exhibit I)

10. Alarms were installed at [redacted] so there was one on each of the floors to announce service recipients coming and going. Video cameras were installed on the basement doors and the front door. (Justice Center Exhibits 4 and 23; Subject Exhibits H and I)

11. The development of an elopement protocol was discussed but not finalized at the [redacted] meeting. (Justice Center Exhibit 24)

12. On [redacted], the Subject worked the 7 a.m. to 3 p.m. shift. That shift was staffed by the Subject and three other employees. Program Manager [redacted] was the supervisor on duty but was not on site. The shift assignment sheet assigned the Subject to the Service Recipient plus three other service recipients. The remaining two service recipients each had staff assigned to them with one-to-one supervision. (Justice Center Exhibits 4 and 5)

13. On the morning of the incident, Program Manager [redacted] called [redacted] before the residents left for their day programs and spoke with the Subject to confirm which staff were on duty. During that call, [redacted] changed the staff assignments for the morning shift. The most significant change was to the Subject's shift assignment, from the Service Recipient and three others to a one-to-one assignment with service recipient "B". The Service Recipient and three others were re-assigned to Program Specialist [redacted] (Hearing testimony of Subject; Justice Center Exhibits 4, 7, 17)

14. During the day, all service recipients were out of [redacted] and at their day programs. That afternoon, the Subject drove the Program Manager and [redacted], a Shift Supervisor who was not on duty, to a meeting at the [redacted] Central Office in [redacted]. (Hearing testimony of Subject; Justice Center Exhibit 4)

15. After the [redacted] meeting, the Program Manager asked [redacted] to go with the Subject to pick up the Service Recipient and service recipient "B" (who required one-to-one supervision) from their day program and return them to [redacted] as two employees were required in the vehicle. The Program Manager further asked [redacted] to go to [redacted] and create the shift assignments for the afternoon shift. The Program Manager also asked the Subject to work the next shift from 3p.m. to 11p.m. as additional staff was required. The Subject agreed to do so. (Hearing testimony of Subject; Justice Center Exhibits 4, 7, 8 and 17)

16. The Subject, [redacted], the Service Recipient and service recipient "B" returned to [redacted] at approximately 2:55p.m. After they entered [redacted], the Subject took service recipient "B" to his second floor room so he could change his clothes. Then, on the way to taking service recipient "B" to the basement for a snack, the Subject stopped at the first floor office where [redacted] was making staff assignments for the afternoon shift and asked what her assignment would be. [redacted] told the Subject she would be responsible for four service recipients, including the Service Recipient, during the afternoon shift. During this exchange, the Service Recipient entered the office and asked [redacted] if he could use the office computer. [redacted] told the Service Recipient to go to the basement and use the computer there. The Subject then brought service recipient "B" to the basement where the kitchen was located. At that point in time, all of the service recipients, except for the Service Recipient in question, were in the basement kitchen having their snack. (Justice Center Exhibits 2, 3, 4, 6, 8, 16 and 17;

Subject Exhibits H and I)

17. For the afternoon shift, service recipient "B" was to be assigned to Program Specialist [redacted]. Program Specialist [redacted] was late for her shift and arrived at approximately 3:07 p.m. to 3:10 p.m. The Subject remained with one-to-one service recipient "B" until Program Specialist [redacted] arrived. After transferring service recipient "B" to Program Specialist [redacted], the Subject began to look for the Service Recipient but could not locate him. (Justice Center Exhibits 3, 4, 5, 6, 13, 14, 16, 17, 18, 22 and 30; Subject Exhibits H and I)

18. Assistant Program Manager [redacted] arrived at 3:10 p.m. He met with [redacted], who debriefed him on the planned schedule for the afternoon shift. The Subject entered the office and asked about her assignment and the whereabouts of the Service Recipient. (Justice Center Exhibits 4 and 12)

19. At approximately 3:15 p.m., a search of the facility and the surrounding area was commenced by staff. Ten minutes later, a call was placed to 911. At 5:15 p.m., the Subject found the Service Recipient near a local train station and returned him to [redacted]. The Service Recipient was medically evaluated; no new marks or bruises were found. (Justice Center Exhibits 3, 4, 6, 13, 14, 16, 17, 18, 22 and 30; Subject Exhibits H and I)

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 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))

The neglect of a person in a facility or provider agency is defined by SSL § 488 (1)(h):

> (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.

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

> (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.

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).

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 the evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center did not establish by a preponderance of the evidence that the Subject committed the prohibited act as described in "Allegation 1" in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation, (Justice Center Exhibits 1-30), and three witnesses. [redacted], [redacted], testified in place of the original investigator, [redacted], who was no longer employed by [redacted] at the time of the hearing. Also called to testify by the Justice Center were [redacted], Behavior Intervention Specialist [redacted], and [redacted], [redacted] Assistant Program Director. The Subject testified in her own behalf and presented a number of documents (Subject Exhibits A–D and F–I).

The hearing evidence, once fully distilled, revealed a timeline containing four connected

and partially overlapping series of events which inform this conclusion:

1. The Service Recipient successfully eloped twice during the month of [redacted], approximately two weeks apart. It is clear and uncontroverted that the requirement for the Service Recipient to be supervised closely and within eyesight of staff at all times due to his prior elopement history was embodied in his Behavior Plan, dated and effective [redacted] (Justice Center Exhibit 20), which pre-dates either of his elopements on [redacted] and [redacted]. The incident now before us concerns the second of the two elopements. As custodians, staff and management have a duty to know - and are charged with knowing - this kind of information, without regard to whether formal "training" in such specifics had been given. While one could easily conclude on this record that the staff and management of this residential program were somehow unaware of the supervision requirements for this Service Recipient, that argument put forth by the Subject is neither a defense nor really relevant to the allegation here.
2. What is relevant here, and uncontroverted on this record, is that on the morning of the incident, Program Supervisor [redacted] phoned the residence and changed the staffing assignments, diverting the Subject away from the Service Recipient for what became the remainder of the shift and beyond, up to and including the point of this elopement. The Program Supervisor's written statement confirmed that she clearly remembered reassigning staff, including the Subject, but had no recollection of which staff members she had assigned to which service recipients. (Justice Center Exhibit 7)
3. The Subject testified consistently with her earlier written statements and other

evidence in the record, that she was re-assigned by [redacted] to a one-to-one service recipient for the remainder of the morning shift, and was thus required to remain with that service recipient beyond the 3:00 pm shift change because her relief staff was late in arriving to work. At the point of shift change, Program Specialist [redacted], the staff member who had been assigned during the morning to the Service Recipient and three other service recipients, had already left the residence. The evidence showed that no one knew for certain who had taken the "hand off" of the Service Recipient at or about 3:00 p.m., but it was not and could not have been the Subject, since her relief had not yet arrived. (Justice Center Exhibit 4)

4. At or about 3:00 p.m., Shift Supervisor [redacted] was occupied with creating last-minute staff assignments for the afternoon shift. The Subject, who had agreed to work a double shift, was being assigned to take over supervision of the Service Recipient and others for the 3-11 p.m. shift, according to those assignments. The Subject was temporarily prevented from doing so, as noted above. At the same time, [redacted] directed the Service Recipient to use the basement computer, out of sight of any staff and clearly without ascertaining that he would be properly supervised once he left their presence. The Service Recipient then left the supervisor's office, went to the basement and – according to the timeline outlined in the Investigative Report - promptly eloped, exiting through the basement door near the computer, repeating his elopement of two weeks prior. When the Subject was relieved of her one-to-one assignment a few moments later, she went to find the Service Recipient only to discover that he had

eloped. (Justice Center Exhibits 4 and 8)

The Subject has claimed in her own defense that, at the time of the elopement, she was not yet responsible for the Service Recipient and could not have been, due to the tardy arrival of her relief staff. The Subject concludes that the elopement was caused by factors other than Subject's lack of attention to a duty owed to the Service Recipient. The Subject's claim is adequately supported by this record.

Despite the recommendations for an elopement protocol for the Service Recipient after the [redacted] elopement, those measures were not put in effect until after the incident at issue here. (Justice Center Exhibits 4, 21, 23, 24, 25 and 26; Subject Exhibits H and I)

Staff assignments were changed during the shift. Staff was not given proper notice of changes. Measures that were recommended for safety included a working alarm and video system, line of sight supervision for the Service Recipient, relocating the computer and redirecting the Service Recipient to alternate activities. These measures were not properly or timely implemented. Staff was not adequately trained in supervision and elopement protocols. The record indicates that the door alarms either did not sound, or were not heard. No video evidence from the cameras was presented. Additionally, the supervisor, not the Subject, directed the Service Recipient to proceed unsupervised to an area of the residence from where he had previously managed to elope undetected. Based upon the hearing record, it is not at all clear who was responsible for supervising the Service Recipient at the time he eloped. Nevertheless, given the simultaneous activities taking place in the residence at the time of elopement, as developed by the [redacted] Investigator [redacted] (Justice Center Exhibit 4) and testified to during the hearing, this record supports the conclusion that it was not the Subject.

Other possible causes have been discussed, and clearly many missteps were made on the

day of the incident and during the prior two weeks. Considering all of the evidence presented, this record does not contain a preponderance of evidence pointing directly to the Subject as the cause of the Service Recipient's second elopement on [redacted].

Accordingly, it is determined that the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged. The substantiated report will be sealed.

Based upon that finding, there is no need for further inquiry as to the category level assigned to the report.

DECISION: The request of [redacted] that the substantiated report [redacted], [redacted] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

This decision is recommended by Louis P. Renzi, Administrative Hearings Unit.

DATED: June 1, 2016
Schenectady, New York

Louis P. Renzi, ALJ