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: Theresa Wells, Esq.

[redacted]

By: Jason Jaros, Esq.
Jaros & Jaros
8207 Main Street, Suite 13
Williamsville, New York 14221

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] 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: November 16, 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: Gerard D. Serlin
Administrative Law Judge

Held at: Administrative Hearing Unit
New York State Justice Center for the Protection of People with Special Needs
200 East & West Road
West Seneca, New York 14228
On: [redacted]

Parties: Vulnerable Persons' Central Register
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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 [redacted] 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 provide proper supervision to the service recipient, during which time he eloped from the residence and was in the community unsupervised.
>
> 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], and is operated by the Office for People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the

jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the Subject was employed by the OPWDD. The Subject worked as a Direct Support Assistant (DSA). (Hearing testimony of the Subject and Justice Center Exhibit 6) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

6. At the time of the alleged neglect, the Service Recipient was twenty years of age. (Justice Center Exhibit 6, first page) The Service Recipient was a person with various mental health diagnoses, who was intellectually high functioning, could read and write, was capable of ambulating without difficulty and communicated verbally without difficulty. (Hearing testimony of OPWDD Investigator [redacted] and Justice Center Exhibit 6, sixth page)

7. On [redacted] the time of the alleged neglect, there was no supervisor on duty during the Subject's shift, and the Subject was assigned in the "Staff-A" role. (Hearing testimony of the Subject) The Subject's duties included medication administration, accounting for money, confirming door alarm functionality, policing the grounds and checking water temperature before showers. When there was no supervisor on duty at the facility, Staff-A was the functional equivalent of the shift supervisor. (Hearing testimony of the Subject) The Subject and three other staff members worked the evening shift. (Hearing testimony of OPWDD Investigator [redacted])

8. The Service Recipient had a number of challenging behaviors including a history of shoplifting, eloping and routinely urinating in bottles and then throwing the urine-filled bottles out of his bedroom window. The Service Recipient's bedroom window was secured to prevent him from throwing the bottles out of the window. However, even so, the Service Recipient continued to urinate in bottles and secret them in his bedroom. (Justice Center Exhibits 6, 8, 9 and

10) The Service Recipient was not allowed to leave the facility unsupervised, but he had previously enjoyed the privilege of unsupervised time in the community. The Service Recipient lost this privilege after he engaged in theft and elopement. (Hearing testimony of OPWDD Investigator [redacted] Hearing testimony of the Subject and Justice Center Exhibit 6, sixth page) The Service Recipient also had a history of engaging in assaultive behaviors that resulted in the police being called to the facility on numerous occasions. (Hearing testimony of the Subject)

9. Because of the Service Recipient's propensity to urinate in bottles, if the Service Recipient was in his bedroom with the door closed, his room was subject to extensive inspection every two hours in an effort to uncover the secreted bottles containing urine. (Hearing testimony of OPWDD Investigator [redacted] Justice Center Exhibits 9 and 10) The inspections of the Service Recipient's bedroom included flipping his mattress, looking under furniture and checking the closet. (Hearing testimony of the Subject) If the Service Recipient was in a common area, he was subject to supervision checks every five minutes. (Justice Center Exhibit 8) There was no dictated protocol for the supervision level of the Service Recipient while he was in his bedroom, if his bedroom door remained open. (Hearing testimony of OPWDD Investigator [redacted] and Justice Center Exhibits 9 and 10)

10. Most doors in the facility, but more specifically the Service Recipient's bedroom door and the doors from inside of the facility to an adjacent facility carport, as well as the front door of the facility were equipped with some type of alarm system. Every door alarm could, however, be disarmed at the door by the simple touch of a button. Any time an alarm-armed door was opened or closed there was an audible tone made at an annunciator panel located in the common area. The alarm would not continue to sound if a door was left open, but the annunciator panel that serviced the second floor bedrooms, including the Service Recipient's bedroom,

provided a visual signal of any alarmed door that was left open. (Justice Center Exhibit 6, tenth page).

11. However, there was no distinction in the audible alarm for each door, so as multiple doors were opened and closed, the alarm would ring but it was not possible to determine which door in the facility had been opened and or closed based solely on the audible alarm. (Hearing testimony of OPWDD Investigator [redacted] and Justice Center Exhibit 6, eighth page)

12. On [redacted] at the time of alleged neglect, there were four staff working at the facility. (Justice Center Exhibit 6 and Hearing testimony of the Subject) At approximately 6:00 p.m., two staff took five service recipients on a fishing outing. (Justice Center Exhibits 14 and 21) At approximately the same time, another service recipient who was authorized to have independent community privilege signed out of the facility and exited via the door between the residence and the carport. When he exited the facility, that service recipient likely left the door leading from the residence to the carport open. (Justice Center Exhibit 14) The Service Recipient noticed this open door when he looked out of his bedroom window. (Justice Center Exhibit 6, ninth page) After the various service recipients had exited the facility, neither the Subject nor Staff-1, who both remained in the facility, confirmed that the carport door was closed. (Justice Center Exhibit 6, tenth page)

13. At the time that the service recipients were leaving the facility, the Service Recipient was initially sitting on the couch located in the first floor living room watching television with the Subject and another service recipient. (Justice Center Exhibit 21). However, the Subject observed the Service Recipient walk toward the stairs to the second floor. (Justice Center Exhibit 6, tenth page) At approximately 6:00 p.m., the Service Recipient went to his bedroom on the second floor, gathered his book bag, and walked downstairs and through the first floor common

area where the Subject, Staff-1 and two service recipients were seated watching television. The Service Recipient then exited the facility unnoticed. (Justice Center Exhibit 6, ninth page). The alarm on the door between the facility and the carport had been disabled by someone. (Justice Center Exhibit 17) The alarm on the front door had likewise been disabled. (Justice Center Exhibit 6, first page) The record was unclear as to which door the Service Recipient used when he exited the facility.

14. The Service Recipient, who was not allowed to be unsupervised in the community, walked about one-half mile to a retail area. At approximately 8:30 p.m., the Service Recipient returned to the facility. (Hearing testimony of OPWDD Investigator [redacted] and Justice Center Exhibits 6, 7 and 17).

15. During the time when the Service Recipient was absent from the facility, the Subject presumed that the Service Recipient was inside his second floor bedroom. (Hearing testimony of the Subject and Justice Center Exhibit 6, tenth page) The Subject did not confirm that the Service Recipient was in his bedroom, and/or whether the bedroom door was open or closed.

16. During the period of the Service Recipient's elopement, both Staff-1 and the Subject were at times monitoring phone calls for two other service recipients, which necessitated that they sit and listen to the service recipients as they made phone calls. This was done to ensure that the service recipients did not make calls to persons whom the service recipients were restricted from calling. (Hearing testimony of the Subject and Justice Center Exhibit 6) The two service recipients remaining in the residence were subject to range of scan supervision, which means that staff was required to have both of the service recipients within their line of sight during waking hours. (Hearing testimony of the Subject)

17. After the Service Recipient returned to the facility at approximately 8:30 p.m., the Service Recipient was subjected to a body check for injuries and was searched for potentially shoplifted items. The body check was negative for injuries and no stolen items were found on the Service Recipient's person. (Hearing testimony of OPWDD Investigator [redacted] and Justice Center Exhibit 22) The remaining service recipients and the other two staff who had gone on the fishing outing returned to the residence at 8:40 p.m. (Justice Center Exhibit 20)

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

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-23) The investigation underlying the substantiated report was conducted by OPWDD Investigator [redacted]; however, as he was unavailable to appear and testify at the hearing, [redacted], Internal Investigator 2 - OPWDD, testified at the hearing on behalf of the Justice Center.

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

The Service Recipient's rights and restrictions were memorialized in his Rights Restoration/Intrusive Intervention Fading Plan. (Justice Center Exhibit 10) The plan was fluid and documented amendments were made to the plan at various times, as milestones were met. The every two-hour bedroom check was implemented on [redacted] and as of the date of the incident, the Service Recipient had not progressed past Step-1 of the rights restoration process and, as a result, every two-hour bedroom checks were still required when the Service Recipient was in his room and his bedroom door was closed. (Justice Center Exhibit 10 and Hearing testimony of OPWDD Investigator [redacted]

Though not material to the outcome, there was evidence that the sounds made by multiple alarmed doors were indistinguishable from one another and, therefore, there was no way to differentiate which door had been opened from the sounding of the doors' audible alarms. (Justice Center Exhibit 6) When the Subject heard the door alarms sounding at around 6:00 p.m., she assumed, based on the events of the evening, that the numerous service recipients who were exiting

the facility were sounding the alarms, and she did not consider that the Subject, whom she had seen go toward the second floor stairs, had eloped.

The Subject claimed during the investigation that she was in the living room when heard the alarms sounding. (Hearing testimonies of OPWDD Investigator [redacted] and the Subject and Justice Center Exhibits 6, and 23) Whether or not the alarms ever sounded when the Service Recipient eloped from the facility was not developed in the record. Indeed, the evidence was that the alarms were easily disabled and had, at some point during the relevant period been disabled, and that at least one egress door had been left open.

The significant issues of factual dispute are whether the Subject was sitting on the living room couch when the Service Recipient walked through the living room and eloped unnoticed or whether she was attending to medication duties in the medication room when the Service Recipient likely eloped, as she told the Investigator during her interrogation. (Justice Center Exhibit 23) The Subject has no specific recollection of the Service Recipient eloping and therefore she cannot say where she was or what she was attending to when the Service Recipient eloped. Additionally, there is credible evidence in the record from both the Service Recipient and other staff which supports the conclusion that the Subject was in the living room sitting on the couch watching television at the time of the Service Recipient's elopement and that the Service Recipient escaped the facility by walking right through the living room undetected by both the Subject and Staff-1. (See Justice Center Exhibits 6, ninth page and Exhibit 21)

After considering all of the evidence, it is concluded that at the time when the Service Recipient eloped, the Subject was sitting on the couch in the living room watching television.

The Justice Center's proof also focused on the stipulation that the Service Recipient was subject to bedroom searches when his bedroom door was closed, and that none were performed.

Neither the Plan of Protective Oversight nor the Behavior Support Plan contains the stipulation that the Service Recipient was only subject to searches of his bedroom when the door was closed. (Justice Center Exhibits 9 and 10) However, OPWDD Investigator [redacted] testified that the expectation was that the Service Recipient's bedroom was to be searched every two hours only when the Service Recipient's bedroom door was closed, and that there was no set protocol dictating room searches, or supervision of the Service Recipient when he was in his bedroom and the door was open. The Subject argued that there was a gap in the supervision protocol of the Service Recipient in that if he was in his room with door open he was considered independent. (See Justice Center Exhibit 9) The Subject argued that once she observed the Service Recipient heading up the stairs, assumedly to his bedroom, that she had no obligation to supervise the Service Recipient. This argument is unconvincing. The Subject never confirmed that the Service Recipient made it to his bedroom; the Subject had an obligation to determine whether the Service Recipient's bedroom door was open or closed in order to comply with the every two-hour room search. However, the Subject did not do so, and did not delegate that task to Staff-1.

The OPWDD Investigator who conducted the investigation did not make a factual finding as to whether the Service Recipient's bedroom door was closed. (Hearing testimony of OPWDD Investigator [redacted] However, none of the staff reported during the investigation that the annunciator panel located on the first floor visually illustrated that the Service Recipient's door or any door on the second floor was open. (Hearing testimony of OPWDD Investigator [redacted]

It is clear from the evidence in the record that at no time during the over two-hour period when the Service Recipient was absent did the Subject confirm whether the Service Recipient's bedroom was open or closed. If she had done so, the Subject would likely have discovered that the Service Recipient was not in his room.

The proof and theory of the failure of supervision by the Subject offered by the Justice Center focused both on the failure of supervision in the first instance which allowed the escape and continued failure of supervision post-escape, which ultimately led the Subject to be completely unaware of the Service Recipient's absence for over two hours.

The preponderance of the evidence established that the Service Recipient walked through the living room and out of the facility unnoticed as the Subject sat watching television on the couch.

The preponderance of the evidence also established that Service Recipient's bedroom door was closed during his absence, and the Subject had a duty to either search the bedroom thoroughly or delegate that task to Staff-A, in her capacity as the de facto shift supervisor, and also to ensure that the task was completed by Staff-A. While the two service recipients who remained in the facility were subject to range of scan supervision, nothing prevented one staff from providing supervision to both service recipients, so that the other staff could confirm whether the Service Recipient's bedroom door was open or closed. Had the Subject fulfilled this obligation, or ensured that it was completed, the absence of the Service Recipient would have been discovered. The Subject failed to properly supervise the Service Recipient in that she failed to follow the provider agency Plan of Protective Oversight or the Behavior Support Plan for the Service Recipient and failed to complete her required "Staff A" duties. The Subject's inaction or lack of attention breached the Subject's duty to the Service Recipient as a custodian.

Considering the Service Recipient's history of criminality, physical violence and mental health issues, the Subject's actions or inactions were likely to have resulted in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

The Justice Center proved by a preponderance of the evidence that the Subject's inaction or lack of attention breached the Subject's duty to the Service Recipient and constitutes neglect of the Service Recipient.

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. Substantiated Category 3 findings 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). The report will be sealed after five years.

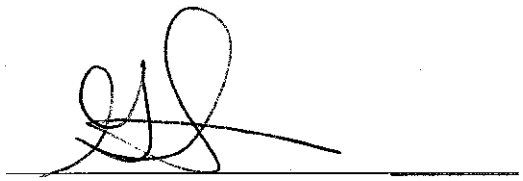
DECISION: The request of [redacted] that the substantiated report dated [redacted] be amended and sealed is denied.

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 Gerard D. Serlin, Administrative Hearings Unit.

DATED: November 9, 2016
Schenectady, New York



Gerard D. Serlin, ALJ