

**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

**AMENDED 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: Todd Sardella, Esq.

[REDACTED]
[REDACTED]
[REDACTED]

By: Jacob Korder, Esq.
Raff & Becker, LLP
470 Park Avenue South, 3rd Floor North
New York, New York 10016

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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 ██████████ that the substantiated report dated ██████████
██████████ of neglect by the Subject of a
Service Recipient be amended and sealed is denied. The Subject has been
shown by a preponderance of the evidence to have committed neglect.
However, the category of that act is reduced to a Category 3.

The category of the substantiated report is reduced to 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: December 28, 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

██████████

Pursuant to § 494 of the Social Services Law

**AMENDED
RECOMMENDED
DECISION
AFTER
HEARING**

Adjudication Case #:

██████████

Before:

Sharon Golish Blum
Administrative Law Judge

Held at:

Administrative Hearings Unit
New York State Justice Center for the Protection
of People with Special Needs
125 East Bethpage Road, Suite 104
Plainview, New York 11803
On: November 16, 2016

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

New York State Justice Center for the Protection
of People with Special Needs
161 Delaware Avenue
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By: Todd Sardella, Esq.

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By: Jacob Korder, Esq.
Raff & Becker, LLP
470 Park Avenue South, 3rd Floor North
New York, New York 10016

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 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 she¹ failed to provide proper supervision to a service recipient during which time he ingested unknown food items, causing him to become ill.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(b).

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

4. The facility, [REDACTED] located at [REDACTED], is ten bed residential [REDACTED] for people with acute developmental disabilities, which is operated by [REDACTED]

¹ The allegation contains a typographical error.

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██████████. ██████████ is certified by the New York State Office for People With Developmental Disabilities (OPWDD) and licensed by the New York State Office of Children and Family Services (OCFS), both of which are provider agencies that are subject to the jurisdiction of the Justice Center. (Hearing testimony of Investigator ██████████)

5. At the time of the alleged neglect, the Subject had been employed by the facility as a Developmental Support Professional (DSP) since ██████████. On ██████████ the Subject's regular assigned shift was overnights from 11:00 p.m. until 9:00 a.m., but at the time of the incident, the Subject was working an overtime day shift. (Hearing testimony of the Subject) 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 a fifty-three year old non-verbal ambulatory male with diagnoses which included profound developmental disability and maladaptive behaviors. One of the Service Recipient's maladaptive behaviors was pica, the compulsion to eat inedible substances. (Justice Center Exhibit 8)

7. The Service Recipient's Behavioral Strategy dated ██████████ indicates that, due to his pica behavior, several measures were undertaken, including that staff be assigned to provide the Service Recipient with constant line of sight supervision at all times, and the requirement that should the Service Recipient's assigned staff need to transfer supervision of him to another staff, that staff must make a verbal request for a replacement and ensure that another staff assumes the responsibility to provide line of sight supervision, before discontinuing supervision of the Service Recipient. (Justice Center Exhibits 15 and 16)

8. Other measures to address the Service Recipient's pica behavior had been implemented after a 2006 incident, which included documentation in a Hand Off Log whenever supervisory responsibility for the Service Recipient was transferred, and that a designated lanyard necklace be worn by the staff who was currently providing the Service Recipient's line of sight

supervision. (Hearing testimony of Investigator [REDACTED] and Justice Center Exhibit 10)

9. After implementation of those measures in 2006, there had been little, if any, training of facility staff regarding the Service Recipient's Hand Off Log and the travelling lanyard necklace. At the time of the alleged neglect, despite the fact that these measures remained in effect, the facility management did not ensure that these measures were consistently employed. (Hearing testimony of the Subject and Justice Center Exhibits 11, 12 and 14)

10. At the time of the alleged neglect, all ten service recipients were present in the facility together with four DSPs and the house manager. (Hearing testimony of Investigator [REDACTED])

11. On the morning of [REDACTED] the Subject was assigned to provide the Service Recipient with line of sight supervision and to supervise service recipient A. At approximately 10:15 a.m., the Subject, who was in the kitchen while supervising the Service Recipient, who was sitting within her line of sight at the dining room table, was reminded by Staff X to prepare service recipient A for his home visit. At that time, Staff Y, who was assigned to supervise three service recipients, was in the kitchen preparing breakfast for a service recipient. At that time, Staff Z, who had been walking back and forth between the kitchen and the dining room, attending to her three assigned service recipients, exited the kitchen to assist one of her assigned service recipients with showering. The Subject then announced that she was going to assist service recipient A with showering and exited the kitchen, without specifically requesting that another staff take over supervision of the Service Recipient or ensuring that another staff had assumed responsibility for the supervision of him. (Justice Center Exhibits 2, 11 and 14)

12. Shortly thereafter, the Service Recipient, who was then unsupervised, entered the kitchen undetected and gained access to the refrigerator and freezer. While in the kitchen, the Service Recipient ate some bread and/or crackers and scattered the torn packages and the food on

the counter and floor. (Justice Center Exhibit 10)

13. It was subsequently determined that the Service Recipient did not suffer injury or ill effects as a result of the incident. (Justice Center Exhibit 8)

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 allegation constitutes 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):

"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...

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4). Category 2 is defined as follows:

(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.

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The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject 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 has established by a preponderance of the evidence that the Subject committed the act described as Allegation 1 in the substantiated report.

In support of its substantiated findings, the Justice Center presented evidence obtained during the investigation. (Justice Center Exhibits 1-17) The investigation underlying the substantiated report was conducted by ██████████ Investigator ██████████, who testified on behalf of the Justice Center.

The Subject testified at the hearing on her own behalf and submitted two documents as evidence. (Subject Exhibits A and B)

A finding of neglect requires, in part, that a preponderance of the evidence establishes that the Subject engaged in conduct that breached her duty to the Service Recipient. In this case, the Subject had a duty to the Service Recipient to ensure that another staff assumed the responsibility

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of providing the Service Recipient with line of sight supervision, prior to discontinuing her own assigned supervision of him. (Justice Center Exhibit 16)

The evidence in the record is clear that the Subject did provide verbal notice to at least one other staff that she was going to shower service recipient A for his home visit before she exited the kitchen. The Subject's ██████████ signed statement (Justice Center Exhibit 14) indicates that, at the relevant time, the Subject told other staff that she was going to get service recipient A ready for his home visit, but it also states that the Subject did not specifically ask Staff Y or X to take over line of sight supervision of the Service Recipient when she left the room. Staff Y's signed statement (Justice Center Exhibit 11) corroborates that, while she was supervising her assigned service recipients in the kitchen, she heard the Subject say that she was going to shower service recipient A.

The Subject's undated handwritten request for amendment of the substantiation (Justice Center Exhibit 2), which is date stamped received on ██████████ indicates that, at the relevant time, the Subject "gave a verbal" to the other staff that she had to get service recipient A ready and "to watch" the Service Recipient. In this version, the Subject alleged that she took the further step of directing other staff to watch the Service Recipient. However, even if this version were true, the Subject's admitted actions still fell short of meeting the requirement of ensuring that another staff actually assumed line of sight supervision of the Service Recipient.

The Subject testified at the hearing that when she announced that she was going to shower service recipient A, she did ask Staff X and Y to watch the Service Recipient and that Staff Y responded by saying "I got him," which the Subject interpreted as an affirmation that Staff Y was assuming the required line of sight supervision of the Service Recipient.

The Subject's testimony on this material point is a significant departure from her initial contemporaneously signed statement. (Justice Center Exhibit 14) That fact, together with the fact

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that none of the four other DSPs who provided signed statements corroborated the Subject's testimony, but did corroborate her signed statement (Justice Center Exhibit 14) severely weakens the credibility of the Subject's testimony. Upon considering and evaluating the Subject's hearing testimony, it is determined that the entirety of the Subject's hearing testimony on this material issue is not credited evidence.

The explanation provided by the Subject in her initial contemporaneously signed statement (Justice Center Exhibit 14) is credited evidence and it is concluded that, at the relevant time, the Subject did not request that other staff supervise the Service Recipient, nor did she ensure that another staff was, in fact, providing line of sight supervision to him when she left the room.

While there was testimony from both Investigator ██████████ and the Subject regarding the existence of a Hand Off Log, in which all supervision transfers of the Service Recipient were to be recorded, and a necklace which was supposed to be transferred simultaneously with supervisory responsibility of the Service Recipient, the Subject testified that they were not regularly used and, in any event, the facts and circumstances surrounding the protocol regarding these measures were not material to the outcome of the case.

The Subject testified that the house manager had instructed facility staff that "verbal tradeoffs" of supervision assignments were allowed because the Hand Off Log was not working. That may be true, however, a "tradeoff," by definition, involves an exchange, meaning that when the Subject made her "verbal tradeoff" of the Service Recipient's supervision, another staff had to have accepted it, which did not occur in this case. Accordingly, it is concluded that the Subject breached her duty to provide the Service Recipient with proper supervision when she failed to ensure that another staff had assumed responsibility of the Service Recipient's supervision prior to discontinuing her own assigned line of sight supervision of him.

A finding of neglect also requires that the Subject's breach of duty resulted in or was likely

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to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. In this case, the allegation indicates that the Service Recipient ingested unknown food items, causing him to become ill, which would have met the test of physical injury or serious or protracted impairment of the Service Recipient's physical condition. However, the Justice Center did not prove, as alleged, that the Service Recipient became ill. Despite the fact that the Justice Center did not establish that the Service Recipient suffered any adverse effects as a result of the Subject's breach of duty, such evidence is not necessary for a finding of neglect.

As a result of the Subject's breach of duty, the Service Recipient, who was required to be directly supervised at all times due to his pica behavior, was left unsupervised. It was fortunate that, while unsupervised, the Service Recipient had only eaten some food. Nonetheless, considering that the Service Recipient had a history of consuming inedible and potentially harmful substances and that he was unsupervised for a sufficient period of time to enter the kitchen, gain access to the refrigerator and consume some amount of food, there is a preponderance of the evidence in the record to conclude that the Subject's breach of duty was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

Accordingly, it is concluded that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect under SSL § 488(1)(h), as alleged in Allegation 1 of the substantiated report. The report will remain substantiated.

The next issue to be determined is whether the substantiated report constitutes the category of neglect set forth in the substantiated report. Under 14 NYCRR § 700.6(a), the Administrative Law Judge has discretion to amend the findings of the substantiated report since it is the subject matter of the hearing, namely "whether the findings of the report should be amended." Section 700.6(b) specifically sets forth the category of abuse or neglect as one of the three issues to be

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determined at the hearing. In this case, the Subject's conduct was substantiated as a Category 2 act, however, the Justice Center did not establish by a preponderance of the evidence that the Subject's neglect seriously endangered the health, safety or welfare of the Service Recipient. Accordingly, the category of neglect is hereby amended to 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 ██████████ that the substantiated report dated ██████████
██████████ of neglect by the Subject of a
Service Recipient 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 hereby reduced to a Category 3 act.

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

DATED: December 5, 2016
Plainview, New York


Sharon Golish Blum, Esq.
Administrative Law Judge