

**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]

[REDACTED]

[REDACTED]

By: Danielle K. Blackaby, Pro Bono Scholar
Legal Services of Central New York
221 South Warren Street, Suite 300
Syracuse, New York 13202

██████████

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 ██████████
██████████ ██ 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: October 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

**RECOMMENDED
DECISION
AFTER
HEARING**

Adjud. Case #:

██████████

Before:

Louis P. Renzi
Administrative Law Judge

Held at:

New York State Justice Center for the Protection
of People with Special Needs
401 State Street
Schenectady, New York 12305
On: ██████████

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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By: Danielle K. Blackaby, Pro Bono Scholar
Legal Services of Central New York
221 South Warren Street, Suite 300
Syracuse, New York 13202

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], [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 properly supervise a service recipient by leaving him home, alone and unsupervised, while you took other service recipients for an outing.

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] where ten (10) adult service recipients reside in a 24-hour, seven day a week supervised setting. The [REDACTED] is operated by Project Independence, Inc. which is certified

by the Office for People With Developmental Disabilities (OPWDD), a facility or provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the Subject had been employed as a Residence Counselor since [REDACTED], 2012. There were two other Residence Counselors on duty at the [REDACTED] with the Subject at all times relevant to this matter.

6. At the time of the alleged neglect, the Service Recipient was a 47-year old male who had been diagnosed with Type I, insulin dependent diabetes and autism and had been a resident of the facility since at least [REDACTED] 2004. (Justice Center Exhibits 4, 14)

7. On the day of the alleged neglect, nine service recipients were scheduled to attend an outing at [REDACTED] to celebrate one of the service recipient's birthday. The Subject left earlier than the other two Residence Counselors, as the Subject was scheduled to drop off the tenth service recipient to meet his family on the way to the outing. The Subject took a total of three service recipients with her in her personal car. At least one of the two remaining Residence Counselors was aware that the Subject had taken three service recipients with her. (Hearing Testimony of Subject; Justice Center Exhibits 2, 8, 14)

8. At the time that the Subject departed the [REDACTED] six service recipients remained at the [REDACTED], including the Service Recipient at issue, with two Residence Counselors present. As the two Residence Counselors were preparing to leave, they became distracted as one of the service recipients began exhibiting negative behavior. Neither of the Residence Counselors performed a house sweep and/or a head count prior to leaving the [REDACTED] to attend the outing. (Justice Center Exhibits 2, 7, 11)

9. On the way to the outing, one of the service recipients asked the Residence Counselors where the Service Recipient was. The two Residence Counselors stopped their

vehicles in order to converse. Neither knew where the Service Recipient was and one of the Residence Counselors telephoned the Executive Director of the [REDACTED]. The Residence Counselors proceeded to the outing and when the Subject arrived, they questioned her as to whether she had taken the Service Recipient. The Subject replied that she had not, and drove back to the [REDACTED] to retrieve the Service Recipient. (Hearing Testimony of Subject; Justice Center Exhibit 7)

10. On the day of the alleged neglect, Recreational Supervisor [REDACTED] arrived at the [REDACTED] at approximately 5:30 pm. She noted that the security alarm was going off and that the Service Recipient came running out of the [REDACTED] saying that he was lost. No staff were present at the [REDACTED] at this time. (Justice Center Exhibit 7)

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 neglect.
- Pursuant to Social Services Law § 493(4), the category of 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 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 not established by a preponderance of the evidence that the Subject committed an act, described as “Allegation 1” in the substantiated report. Specifically, the evidence does not establish that the Subject committed neglect by failing to properly supervise a service recipient by leaving him home, alone and unsupervised, while she took other service recipients for an outing.

In order to prove neglect as set forth by Social Services Law § 488(1)(h), the Justice Center must prove that a custodian breached a duty owed to a service recipient, and that such breach resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Here, a preponderance of the evidence does not establish that the Subject breached a duty owed to the Service Recipient.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-19) The investigation underlying the substantiated report was conducted by House Manager [REDACTED], who was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and presented one document. (Subject Exhibit A)

The evidence clearly indicates that when the Subject left the [REDACTED] she left the Service Recipient in the care of the two Residence Counselors that were on shift at the facility. At least one of the Residence Counselors admitted in her written statement that she knew the Subject was transporting three service recipients (leaving seven behind). This statement is consistent with the hearing testimony of the Subject. (Hearing Testimony of Subject; Justice Center Exhibit 8)

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All staff members are responsible for all service recipients, as a general obligation. (Hearing Testimony of House Manager ██████████; Justice Center Exhibit 15) Nevertheless, when staff necessarily divide duties as to certain service recipients, and further, when such division physically separates them, as happened here, then all staff cannot reasonably be held responsible for those service recipients who are no longer within their purview. The investigative report states that a house sweep should have been performed prior to leaving the ██████████ to ensure that all service recipients were accounted for. (Justice Center Exhibit 7)

In contrast, House Manager ██████████ testified that the Subject did not need to do a house sweep when she left the ██████████ as she was not the last staff to leave the facility. House Manager ██████████ further testified that it was the remaining two Residence Counselors who should have performed a house sweep and a head count prior to leaving the ██████████ to ensure that no service recipient was left behind.

When interviewed, Residence Counselor ██████████ stated that when they were ready to leave, she began to check the house when a service recipient became agitated and the Residence Counselors had to calm the service recipient down. After calming the service recipient down twice, the Residence Counselors left the facility en route to the outing. In her written statement, Residence Counselor ██████████ writes: “There is no excuse for this. I should have check[ed] the bedrooms.” (Justice Center Exhibits 7, 11)

House Manager ██████████ testified that there was a lack of communication on the Subject’s part as she did not inform the other two Residence Counselors which service recipients she was taking with her. The Subject credibly testified that both Residence Counselors saw the Subject walk out with the three Service Recipients. However, even if the Subject’s testimony was not credited, Residence Counselor ██████████ statement admits that the Subject left with three service

recipients. Thus, even if the Residence Counselors were not sure exactly which service recipients the Subject took with her, they knew that she had three, and had they simply performed a head count and/or a house sweep before leaving themselves, they would have ensured that the Service Recipient was not left behind. (Justice Center Exhibit 8)

The Subject did not leave the Service Recipient home, alone and unsupervised. The Subject properly left the Service Recipient in the care of the two Residence Counselors on duty at the [REDACTED]. Since the threshold element of a breach of duty owed by the Subject to the Service Recipient has not been met, no further inquiry or discussion regarding injury to the Service Recipient, or the likelihood of such injury, is necessary.

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 amended and sealed.

DECISION:

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.

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

DATED: October 4, 2016
Schenectady, New York



Louis P. Renzi, ALJ