

**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

**FINAL
DETERMINATION
AND ORDER
AFTER HEARING**

Adjud. Case #:

██████████

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.

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By: Constance R. Brown, Esq.
Associate Counsel
CSEA, Inc.
143 Washington Avenue
Capitol Station Box 7125
Albany, New York 12224

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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 ██████████ ██████████ 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: July 21, 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 Id#:

██████████

Before: Gerard D. Serlin
Administrative Law Judge

Held at: New York State Justice Center for the Protection
of People with Special Needs
333 East Washington Street
Syracuse, New York 13202
On: ██████████

Parties: Vulnerable Persons' Central Register
New York State Justice Center for the Protection
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Capitol Station Box 7125
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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 of a Service Recipient.
2. After investigation, the Justice Center substantiated the report against the Subject.

The Justice Center concluded that:

Allegation 1

It was alleged that on various dates, including [REDACTED], at the [REDACTED], located at [REDACTED], while acting as a custodian you committed neglect when you failed to follow a service recipient's Individual Plan of Protective Oversight and Behavioral Guidelines by not securing and requiring staff at the residence to secure the facility's van keys in the office, instead of in an unsecure location that was accessible to the service recipient.

This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493.

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

4. The facility, the [REDACTED], located at [REDACTED], is an [REDACTED] operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is a provider agency that is subject

██████████ to the jurisdiction of the Justice Center. Approximately ten individuals resided at the ██████████ at the time of the report. (Hearing testimony of OPWDD Investigator ██████████)

5. At the time of the alleged neglect, the Subject had been employed by the ██████████ ██████████ for 25 years. The Subject was employed as a Direct Assistant-2 (DA-2) and was the supervisor of the ██████████. The Subject had been employed at the ██████████ for four years. (Hearing testimony of OPWDD Investigator ██████████; Justice Center Exhibit 7: audio interrogation of the Subject and Hearing testimony of the Subject)

6. At the time of the alleged neglect, the Service Recipient was twenty-three years of age and had been a resident of the facility for approximately four months. The Service Recipient was a person who was high functioning with a diagnosis of traumatic brain injury and seizure disorder. Because the Service Recipient was so high functioning, he had far less rights restrictions than the normative ██████████ resident did. (Justice Center Exhibit 6¹ and Hearing testimony of ██████████ DA ██████████)

7. On or about² ██████████, while the Subject was absent from work due to medical leave, the Service Recipient arrived at the ██████████. (Justice Center Exhibit 7: audio interrogation of the Subject) ██████████, a psychologist employed by the ██████████, drafted Behavioral Guidelines for the Service Recipient. (Justice Center Exhibit 4, p. 4) The Behavioral Guidelines required that the keys to all ██████████ vehicles were to be secured on a staff person or locked in the ██████████ office. This directive did not change, and was not modified at any time during the period relevant to this case. (Justice Center Exhibit 4 and Hearing testimony of ██████████ DA ██████████)

¹ Justice Center Exhibit 6 was labeled as such, but was ultimately admitted at the request of the Subject's counsel and on consent of the Justice Center attorney.

² The exact date of the Service Recipient's arrival was not clear in the record, but it was approximately this date.

8. After her return to the [REDACTED] from medical leave on [REDACTED], the Subject spoke with [REDACTED], (Hearing testimony of the Subject and Justice Center Exhibit 5: audio interrogation of the Subject) who advised her that the Service Recipient was on parole³ and was a known arsonist. Their conversation focused primarily on the Subject being vigilant about securing flammables. (Hearing testimony of the Subject)

9. The Subject initiated her review of the Service Recipient's Behavioral Guidelines the week of her return, possibly during the [REDACTED] meeting. A copy of the document was stored at the [REDACTED] and was available for all [REDACTED] staff to read. (Hearing testimony of Subject, Justice Center Exhibit 4, p. 4, and Justice Center Exhibit 7: audio interrogation of the Subject) The Service Recipient's Behavioral Guidelines included the requirement that "staff should ensure that the house vehicle keys be secured on their person or locked in the office at all times." (Justice Center Exhibit 4, p. 2 of the Behavioral Guidelines)

10. As of the time of the Subject's return to the [REDACTED] on [REDACTED], the van keys were secured in a locked drawer in the [REDACTED] kitchen and had been secured in this manner since the Service Recipient came to reside at the [REDACTED] in [REDACTED]. (Justice Center Exhibit 7: audio interrogation of the Subject and Hearing testimony of the Subject) The Service Recipient had access to the kitchen area of the [REDACTED]. The [REDACTED] staff office was located on the second floor of the [REDACTED]. The door to that office was capable of being locked. (Hearing testimony of the Subject) The Subject was required to ensure that her subordinate staff followed the requirements of the Behavioral Guidelines. The Subject was aware that the keys were secured in a locked drawer and the Subject deemed this acceptable. (Hearing testimony of the Subject)

³ There was other evidence in the record that the Service Recipient was on probation, and was not on parole but the distinction is without a difference in the context of this case. (See Justice Center Exhibit 11, last page)

11. On or about,⁴ [REDACTED], [REDACTED] conducted a training for [REDACTED] staff on the specific and unique needs of the Service Recipient. During this training, the [REDACTED] staff members were also trained on the Service Recipient's Behavioral Guidelines. The Behavioral Guidelines included specific language that indicated that the Service Recipient was at significant risk for elopement and physical aggression without warning. (Justice Center Exhibit 4)

12. The Subject was not present at this training, as the Subject was on vacation.⁵ However, [REDACTED] noted on the relevant training sheet that the Subject had actually conducted the training, when she had not. (Justice Center Exhibit 5) [REDACTED] also incorrectly documented the training as having occurred on [REDACTED], and not [REDACTED], which is the date when the training most likely occurred.

13. During the overnights of [REDACTED] and [REDACTED], before commencement of the investigation, one or more OPWDD owned vans were stolen from the [REDACTED]. (Justice Center Exhibit 7: audio interrogation of the Subject and Hearing testimony of the Subject) The Subject did not work at the [REDACTED] on [REDACTED]. The Subject worked a partial shift on [REDACTED], but did not operate any [REDACTED] owned van during that shift. (Hearing testimony of the Subject) [REDACTED] DSA, [REDACTED] was the last [REDACTED] staff to use a van on [REDACTED]. She returned the van to the [REDACTED] about 9:00 p.m. on that date. After returning the van, [REDACTED] DSA, [REDACTED], locked the keys in a drawer in the kitchen of the residence.⁶ (Justice Center Exhibit 11)

⁴ The date of this training was never definitively established in the record.

⁵ The Subject testified that she went on vacation on [REDACTED] and did not return to work until [REDACTED]. (Hearing testimony of the Subject, Justice Center Exhibit 5 and Justice Center Exhibit 13)

⁶ During the investigation by police, the Subject told police that she noticed on [REDACTED] that the lock on the drawer where the keys were secured no longer functioned and she was not sure if the lock had ever worked. The Subject questioned whether [REDACTED] staff might have erroneously believed that the drawer was locking when it was not. (Justice Center Exhibit 11) On [REDACTED], the Subject reported to the OPWDD investigator that the Service Recipient had shown the police that he could open the "locked drawer" in the kitchen with a knife, or even his fingernail. (Justice Center Exhibit 3)

14 During the early morning of [REDACTED], a van owned by the [REDACTED] was located a few blocks from the residence by [REDACTED] Police. The van had struck a utility pole, splitting the pole and causing it to lean to one side. The police recovered a cell phone from inside the van, which was later determined to belong to the Service Recipient. The keys to the van were found inside the vehicle. After hitting the utility pole, the driver of the van fled the scene on foot. (Justice Center Exhibits 10 and 11)

15. Ultimately, the Service Recipient was developed as a suspect by law enforcement personnel. During an interview with law enforcement, the Service Recipient reported that he stole the van while staff slept during the overnight. This disclosure culminated in an unsubstantiated finding, after investigation by the Justice Center, regarding the allegation that [REDACTED] staff members were sleeping during the overnight shift. (Hearing testimony of OPWDD Investigator: [REDACTED])

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(s) 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 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 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 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 a prohibited act, described as “Allegation 1” in the substantiated report. The act committed by the Subject constitutes 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 OPWDD Investigator [REDACTED], who testified at the hearing on behalf of the Justice Center. The Subject testified in her own behalf and provided six exhibits, Subject Exhibits A, B, C, D, E and F. Additionally, [REDACTED] DSA [REDACTED] testified on behalf of the Subject.

The Subject initially testified, unconvincingly, that when she read the Behavioral Guidelines on [REDACTED], it contained no requirement that vehicle keys were to be locked in the office, and that this provision was added after the van was stolen on [REDACTED]. The Subject further testified that as of [REDACTED], the only requirement concerning storage of the vehicle keys was that they were to be secured. (Hearing testimony of the Subject) However, DSA [REDACTED] testified that the Behavioral Guidelines included the requirement (that the keys were to be secured in the locked staff office) since the inception of the Behavior Guidelines. The Subject conceded in her hearing testimony that the testimony of DSA [REDACTED] was likely accurate.

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The Subject then provided some waffling testimony on the issue of whether she had ever completed her reading of the Behavioral Guidelines. In any event, the Subject acknowledged that at some point during the ██████████ she read language in the Behavioral Guidelines regarding securing vehicle keys.

The Subject testified that she was required to ensure that her subordinate staff followed the requirements of the Behavioral Guidelines, and that she was aware that the keys were actually being secured by the staff in a locked drawer in the kitchen of the residence, a practice that the Subject deemed acceptable.

The Service Recipient had a well-documented elopement risk and was known to become explosively violent without warning. Considering these facts specifically, the totality of the circumstances, and the entirety of the evidence and testimony presented, the failure of the Subject to secure the van keys in a manner consistent with the Behavioral Guidelines constitutes a lack of attention on the part of the Subject, which breached the Subject's duty and 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 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.

Moreover, based upon the totality of the circumstances, the evidence and testimony presented, it is determined that the category of the affirmed substantiated neglect that such act constitutes was properly substantiated as a Category 3 act. A substantiated Category 3 finding of abuse and/or 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, or should be categorized as a Category 3.

This decision is recommended by Gerard D. Serlin, Administrative Hearings Unit.

DATED: June 23, 2016
Schenectady, New York



Gerard D. Serlin, ALJ