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: Jared R. Mack, Esq
Levene, Gouldin & Thompson, LLP
450 Plaza Drive
Vestal, New York 13850

[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 denied. The Subject has been shown by a preponderance of the evidence to have committed abuse (obstruction of reports of reportable incidents) and 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 26, 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 Hearings Unit
New York State Justice Center for the Protection of People with Special Needs
333 East Washington Street
Syracuse, New York 13202
On: [redacted]

Parties: Vulnerable Persons' Central Register
New York State Justice Center for the Protection of People with Special Needs
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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for abuse and 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 abuse and 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 provide proper supervision to a service recipient, during which time he arrived at the residence and was without staff supervision for an undetermined amount of time.

This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law§ 493(4) (c)

Allegation 2

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed abuse (obstruction or reports of reportable incidents) when you failed to report a reportable incident involving a service recipient being without staff supervision.

This allegation has been SUBSTANTIATED as Category 3 abuse (obstruction of reports of reportable incidents) 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 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.

5. At the time of the alleged abuse and neglect, the Subject was employed by the [redacted], and was so employed for eleven years. The Subject worked as a Direct Support Assistant (DSA). The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

6. At the time of the alleged abuse and neglect, the Service Recipient had been a resident of the facility for approximately two years. The Service Recipient is a person with a diagnosis of mild mental retardation, anxiety and a plethora of other significant medical issues. (Hearing testimony of OPWDD Investigator [redacted])

7. At the time of the alleged abuse and neglect, the facility provided residential services to eleven service recipients. (Hearing testimony of OPWDD Investigator [redacted]) On [redacted], the minimum day shift staffing requirements dictated that one staff member was to be at the facility between 7:00 a.m. and 3:00 p.m. (Hearing testimony of OPWDD Investigator [redacted] and Justice Center Exhibit 9, third page)

8. At the time of the alleged abuse and neglect, all eleven service recipients who resided in the facility attended a day program or similar program on each weekday. The Service Recipient was picked up at 8:10 a.m. for transport from the facility to his day program every weekday. Typically, the Service Recipient returned to the facility at 2:10 p.m. (Hearing testimony

of OPWDD Investigator [redacted])

9. The Service Recipient's Safeguards Individual Plan of Protective Oversight required a supervision ratio for the Service Recipient of one staff to five service recipients while in the facility. (Justice Center Exhibit 12) It was permissible for the Service Recipient to be out of eyesight supervision for up to thirty-minutes and he was also authorized to be on the porch or in the backyard of the facility, without supervision, for as long as thirty minutes. However, it was a requirement that whenever the Service Recipient was on facility grounds, at least one staff was required to be present at the facility. (Hearing testimony of the Subject)

10. On [redacted], the Subject began her shift at 1:30 p.m., a ten-hour shift that was scheduled to conclude at 11:30 p.m. As the Subject's shift began, the facility was also staffed by Staff A and Staff B. (Hearing testimony of the Subject) Staff B began her shift the evening before, at 11:00 p.m. However, because she had been mandated to work overtime the following morning beginning at 7:00 a.m., Staff B was still on duty at the facility when the Subject reported to work on [redacted]. (Hearing testimony of the Subject)

11. On that day, two service recipients needed to be retrieved from their day programs at 2:10 p.m. One of these two service recipients required one-to-one staff supervision while riding in an automobile and it was necessary for two staff members to assist in the pickup of the two service recipients. Consequently, two staff members needed to commit to the process of retrieving the two service recipients.[1] (Hearing testimony of OPWDD Investigator [redacted] and the Subject)

12. Staff B stated that she did not want to stay at the facility any longer. (Hearing

[1] There was conflicting testimony as to why two staff members were needed to retrieve the service recipients, but there was no disagreement that both Subject and Staff A did need to work together to retrieve the two service recipients.

Testimony of the Subject) The Subject and Staff A attempted to contact other staff to come to the facility to bridge the potential gap in coverage, as they anticipated that the Service Recipient would be returning to the facility at 2:10 p.m. (Hearing Testimony of the Subject) Pursuant to provider agency protocol, the Development Assistant (DA-3), which is a supervisor level staff, should have been the first person contacted regarding the shortage of staff. However, the Subject did not contact the DA-3. (Hearing Testimony of the Subject)

13. Finding no success, the Subject and Staff A left the facility at approximately 1:50 p.m., which was earlier than they typically left the facility to retrieve the two service recipients. The process usually took no more than ten to fifteen minutes for a round trip. (Hearing testimony of the Subject)

14. Staff B briefly remained at the house when the Subject and Staff A left the facility. However, neither the Subject nor Staff A requested that Staff B remain at the facility and Staff B left the facility at approximately 2:15 p.m. (Hearing testimony of the Subject and Justice Center Exhibit 10)

15. The Subject and Staff A encountered a delay at the pickup site when they arrived to retrieve the two service recipients, consequently they did not return to the facility until 2:20 p.m. At that time, they discovered the Service Recipient alone on the front porch of the facility. No staff was present at the facility. (Justice Center Exhibit 18: Audio interrogation of the Subject and Hearing testimony of the Subject)

16. Neither the Subject nor Staff A noted in the facility Staff Observation Notes that the Service Recipient was found unsupervised on the porch. (Justice Center Exhibit 11) The Subject did not immediately report the incident to the VPCR.

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 abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1) (f) and (h), to include:

> (f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.
>
> (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 has established by a preponderance of the evidence that the Subject committed the acts described in Allegations 1 and 2 of the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-18[2]) The investigation underlying the substantiated report was conducted by OPWDD Investigator [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 provided no other evidence.

The Subject testified that the Service Recipient was allowed to be out of visual supervision for up to thirty minutes and could be on the facility porch or in the facility back yard, without direct supervision, for as long as thirty minutes. However, on cross-examination the Subject conceded that, irrespective of whether the Service Recipient was allowed to be in the yard or on the porch without immediate supervision, at least one staff was required to be present at the facility, whenever the Service Recipient was there.

Additionally, OPWDD practice dictates that it is permissible to allow a service recipient to be unsupervised at a facility - meaning to be at a residence without a staff person or in the community without a staff person - only when the service recipient's Individual Plan of Protective Oversight explicitly states that such independence is allowed. This Service Recipient had no such privilege stated in his Individual Plan of Protective Oversight. (Hearing testimony of OPWDD Investigator [redacted])

On the date of the incident, the Subject telephoned the facility supervisor and other staff in an attempt to obtain coverage. The Subject was unsuccessful in reaching any staff. The Subject

[2] Including Justice Center Exhibit 12 A.

testified that she and Staff A left the facility to pick up the two service recipients at 1:50 p.m. and the entire trip normally took five to ten minutes. However, there was an unanticipated delay and the process took longer than usual.

Additionally, the Subject testified that she and Staff A left early to pick up the two service recipients in order to ensure that they were back at the facility when the Service Recipient returned to the house from program. The Subject also testified that she assumed that Staff B would remain at the house because Staff B was mandated to work overtime and that this mandate was automatic without supervisor approval or direction. However, the Subject testified that she could not personally mandate Staff B to stay at work, because she and Staff B were the same grade level. The fact that the Subject and Staff A planned to return to the house early enough to ensure they were there when the Service Recipient returned, indicates that they knew that Staff B would not be there when the Service Recipient returned.

Further, the Subject acknowledged in her testimony that she never asked Staff B to remain at the facility until their return to the facility. Having had an opportunity to observe and consider the Subject's hearing testimony, specifically her testimony that she and Staff A reasonably believed that Staff B would remain at the facility until their return, the Subject's testimony is not credited evidence.

Allegation 1: <u>Neglect</u>

The Justice Center proved by a preponderance of the evidence that the Subject committed neglect. Specifically, the evidence establishes that on the afternoon [redacted], the Subject and at least one other staff, while having a duty to do so, failed to take adequate measures to ensure that one staff was present at the facility to supervise the Service Recipient when he returned to the facility from his day program. Although the Service Recipient did not require visual supervision,

the Service Recipient was never to be without staff supervision while he was at the residence. Although this breach did not result in actual injury, the likely result of such breach was 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.

Allegation 2: Abuse (Obstruction of Reports of Reportable Incidents)

The uncontradicted evidence in the record establishes that the Subject is a custodian, and as a result, necessarily a mandated reporter. A mandated reporter is required to report allegations of reportable incidents to the VPCR immediately upon discovery.

On [redacted], the Subject discovered a reportable incident, namely, the Service Recipient was at the facility without any staff present. This was a clear violation of provider agency policy and a breach of custodial duty. The Subject, being aware that Staff A had failed to ensure adequate supervision of the Service Recipient, was obligated to immediately report the incident to the VPCR. However, the Subject did not report the incident to the VPCR.

The Subject also argued that Staff B remained at the house when she and Staff A left the facility just after 2:00 p.m. and that Staff B, who was working an overtime shift, should have stayed until 3:00 p.m. The Subject argued that she and Staff A expected Staff B to remain at the facility until 3:00 p.m., even though she did not ask Staff B to do so. For reasons discussed previously, the Subject's testimony on this issue is not credited evidence. However, assuming for the sake of argument that Staff B was neglectful in leaving work before 3:00 p.m., or the Subject believed that Staff B violated her duty to remain at the facility, the Subject should have reported to the VPCR

that Staff B left the facility before her shift ended, effectively leaving the Service Recipient unsupervised. The Subject acknowledged in her hearing testimony that she did not make such a report to the VPCR.

The Justice Center proved by a preponderance of the evidence that the Subject failed to report a reportable incident immediately upon discovery. Accordingly, it is determined that the Justice Center proved by a preponderance of the evidence that the Subject committed the act of abuse (obstruction of reports of reportable incidents). The substantiated report will not be amended or sealed.

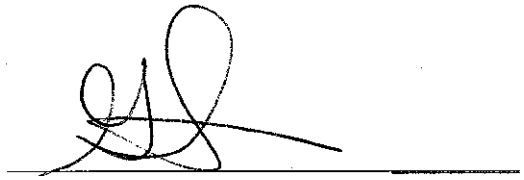
Based on the finding that the Subject committed the acts as alleged in Allegations 1 and 2 of the substantiated report, the report will remain substantiated, and the next question to be decided is whether the substantiated report constitutes the category of neglect and abuse (Obstruction of Reports of Reportable Incidents) set forth in the substantiated report**.** Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated Allegations are properly categorized as Category 3 acts.

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 abuse (obstruction of reports of reportable incidents) and neglect.

The substantiated report is properly categorized as a Category 3 act.

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

DATED: July 7, 2016
Schenectady, New York



Gerard D. Serlin, ALJ