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]

The attached Recommended Decision After Hearing (Recommended Decision) is incorporated in its entirety including but not limited to the Findings of Fact, Conclusions of Law and Decision section.

ORDERED: The attached and incorporated Recommended Decision is hereby adopted in its entirety.

ORDERED: The Vulnerable Persons' Central Register shall take action in conformity with the attached Recommended Decision, specifically the Decision section.

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 1, 2017
Schenectady, New York

David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[redacted], Subject

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: Elizabeth M. Devane
Administrative Law Judge

Held at: Administrative Hearings Unit
New York State Justice Center for the Protection of People with Special Needs
11 Perlman Drive
Spring Valley, New York 10977
On: [redacted]

Parties: New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Laurie Cummings, Esq.

[redacted]

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 the 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 a custodian, you committed neglect when you failed to provide proper supervision to the service recipient, during which time he was left unattended in the residence.

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, the [redacted], located at [redacted], is an Individualized Residential Alternative (IRA) for adults with developmental disabilities and is operated by [redacted], which is certified by the Office for People With Developmental

Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of [redacted] Chief Program Officer [redacted]; Justice Center Exhibit 6)

5. At the time of the alleged neglect, the Subject had been employed at the IRA for an undisclosed amount of time in a direct care position as a Residence Counselor. The Subject's duties included supervision and support of service recipients as well as transportation of service recipients to activities. (Hearing testimony of [redacted] Chief Program Officer [redacted]; Hearing testimony of the Subject; Justice Center Exhibit 7)

6. At the time of the alleged neglect, the male Service Recipient was 54 years old, had been receiving services from [redacted] for over 40 years and had resided in a [redacted] residence for "decades." The Service Recipient's diagnoses included autism and developmental disability. He was somewhat verbal, was ambulatory and his behaviors of concern included agitation and anxiety, with incidents of aggression and property destruction. The Service Recipient required 24-hour supervision in the residence, as stated in his Plan of Protective Oversight. The Service Recipient was very particular about his choice of activities and consistently chose not to attend arts and crafts. (Hearing testimony of [redacted] Chief Program Officer [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 7, 8, 9 and 16)

7. On [redacted], the Subject worked the evening shift from 3:30 p.m. to 11:00 p.m. along with one additional direct care staff (DC-1). There were eight service recipients at the IRA. Four service recipients were scheduled to attend arts and crafts that evening, one was to attend martial arts and another was to do errands in the community, including paying a bill and buying a gift. Two service recipients, including the Service Recipient, were not assigned to any activity. (Hearing testimony of [redacted] Chief Program Officer [redacted];

Hearing testimony of the Subject; Justice Center Exhibits 7, 8, 9, 10, 12, 13 and 15)

8. At approximately 6:30 p.m., the Subject went to the medication room, informed DC-1 that "I have two and I am out," then left the IRA with two service recipients. Shortly thereafter, DC-1 left the IRA with five service recipients, four who were going to arts and crafts and one who was going to martial arts. (Hearing testimony of [redacted] Chief Program Officer [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 7, 8, 9, 10, 11, 12 and 13)

9. At 8:22 p.m., the Service Recipient called his sister and said he was alone in the IRA. The Service Recipient's brother-in-law arrived at the IRA at 8:45 p.m., found the Service Recipient in the IRA alone, and took him out for a ride. The Service Recipient's sister contacted the IRA's Assistant Director who contacted the Subject, DC-1 and the Residence Director. (Hearing testimony of [redacted] Chief Program Officer [redacted]; Hearing testimony of the Subject; Hearing testimony of Unit Manager [redacted]; Justice Center Exhibits 7, 8, 9, 14 and 15a)

10. Administrative staff provided emotional support to the Service Recipient that evening after he returned to the IRA. The day after the incident, the Service Recipient stated to [redacted] that "no one was here," "why the staff not here?" and "I'm sorry that staff was not here." (Hearing testimony of [redacted] Chief Program Officer [redacted]; Justice Center Exhibits 7, 8, 14 and 18)

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 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) as:

> "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 neglect shall be categorized into categories, including Category 3 pursuant to SSL § 493(4)(c), which is defined as follows:

> 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 of neglect alleged in the substantiated report that is the subject of the proceeding and that such act constitutes 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 proved by a preponderance of the evidence that the Subject committed neglect as described in "Allegation 1" in the substantiated report.

In support of its substantiated findings, the Justice Center presented several documents obtained during the investigation (Justice Center Exhibits 1 – 20). The investigation underlying the substantiated report was conducted by [redacted] Chief Program Officer [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 no other evidence.

To sustain an allegation of neglect, the Justice Center must prove that the Subject was a custodian who owed a duty to the Service Recipient, that she breached that duty, and that her breach either resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. (SSL § 488(1)(h))

The Subject argued that when she left the IRA, DC-1 was at the IRA with the Service Recipient and therefore she was not the custodian of, or responsible for, the Service Recipient during the time he was alone in the IRA. This argument is not persuasive.

The evidence established that the Service Recipient required 24-hour supervision and that it is the responsibility of direct care staff at the IRA to be familiar with and follow the supervision requirements of all service recipients in the IRA. (Hearing testimony of [redacted] Chief Program Officer [redacted]; Justice Center Exhibit 16). At the time of the alleged neglect, the Service Recipient was not assigned to any specific activity. DC-1 was responsible for taking service recipients who were assigned to arts and crafts to that activity. It was well known, and the Subject was aware, that the Service Recipient consistently chose not to participate in arts and crafts activities. The Service Recipient was not on the list to attend, nor did he pay to participate in, the arts and crafts activity scheduled that evening. (Hearing testimony of [redacted] Chief Program Officer [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 7, 8, 9 and 15) The Subject testified that she and DC-1 did not discuss what the Service Recipient would be doing that evening. (Hearing testimony of the Subject)

When DC-1 was in the medication room, the Subject said "I have two and I am out." (Hearing testimony of [redacted] Chief Program Officer [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 7, 12 and 13) However, the Subject failed to provide the names of the two service recipients she was taking. Knowing the Service Recipient's preferences, and that he was not signed up for arts and crafts, DC-1 assumed that the Subject took the Service Recipient with her when the Subject left the IRA. The Service Recipient was left alone at the IRA from 6:30 p.m. until 8:45 p.m. (Hearing testimony of [redacted] Chief Program Officer [redacted]; Justice Center Exhibits 7, 8 and 9) The Subject and DC-1 were

responsible for all service recipients at the IRA. If not for the Subject's lack of clear communication, then the Service Recipient would not have been left behind alone at the IRA.

The weight of evidence in the record and hearing testimony support a finding by a preponderance of the evidence that the Subject was a custodian of the Service Recipient as that term is defined in Social Services Law § 488(2), that the Subject breached her duty by failing to adequately communicate with DC-1 and that, as a result, the Service Recipient was left alone at the IRA without proper supervision in violation of his Plan of Protective Oversight.

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. The Service Recipient was to be supervised at all times while in the IRA. The Service Recipient also had a history of agitation, anxiety and aggression. The Service Recipient called his sister and told her that he was alone and scared. Administrative staff provided emotional support to the Service Recipient that evening after the incident. (Justice Center Exhibit 18) The day after the incident, the Service Recipient said to [redacted] that "no one was here," "why the staff not here?" and "I'm sorry that staff was not here." (Justice Center Exhibit 14)

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 and sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of neglect 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 report is properly categorized as a Category 3 act. A substantiated Category 3 finding 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 as a Category 3 act.

This decision is recommended by Elizabeth M. Devane, Administrative Hearings Unit.

DATED: November 6, 2017
Schenectady, New York

Elizabeth M. Devane
Administrative Law Judge