STATE OF NEW YORK
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS

In the Matter of the Appeal of [redacted]	**FINAL DETERMINATION AND ORDER AFTER HEARING**
Pursuant to § 494 of the Social Services Law	**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 12, 2017
Schenectady, New York

David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
Administrative appeals Unit
[redacted], Subject
Constance Borwn, Esq.

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

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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], [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 a custodian, you committed neglect when you failed to provide proper supervision, during which time a service recipient was left unattended at the IRA when the residence was evacuated.

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, an Individualized Residential Alternative (IRA), is a residential facility for developmentally disabled individuals, which is operated by the Office for People With Developmental Disabilities (OPWDD), which is provider agency that is subject to the jurisdiction

of the Justice Center.

5. At the time of the alleged neglect, the Subject was employed by the Facility in the capacity of Developmental Support Aide (DSA), and had been employed in that capacity for 14 years. (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 40-year-old male who was partially ambulatory, though he required continuous supervision when walking. (Hearing testimony of the Subject) The Service Recipient had numerous underlying conditions and diagnoses, including intermittent explosive disorder and trichotillomania, a compulsive disorder characterized by pulling one's hair out. The Service Recipient was prone to pulling out his chest hair and had a history of elopement. (Justice Center Exhibit 13 and Hearing testimony of the Justice Center Investigator)

7. When attending his day program, the Service Recipient's level of supervision was not required to be continuous, but instead observation by staff at fifteen minute intervals. While in a motor vehicle and while in the community, the Service Recipient was subject to constant field-of-vision supervision. (Justice Center Exhibit 12)

8. On the date of the alleged neglect, there were six service recipients at the Facility. A bed bug or bed bugs were found at the Facility and staff were directed to evacuate the service recipients, including the Service Recipient, to a local day habilitation program (the evacuation site). (Hearing testimony of the Justice Center Investigator) The Facility's emergency response plan dictated, in pertinent part, that the "Lead Staff" person was "responsible for doing a head count" of the service recipients at the time of departure. (Justice Center Exhibit 17)

9. On the date of the alleged neglect, the Service Recipient was largely confined to a

wheel chair but could ambulate with assistance, particularly for short distances. There was no requirement that the Service Recipient was to be transported in his wheelchair while in a motor vehicle. (Hearing testimony of the Subject) The Facility had two vans, one capable of transporting the wheelchair, and one not. (Hearing testimonies of the Justice Center Investigator and the Subject)

10. On the date of alleged neglect, the Subject arrived at the Facility for her shift at 7:00 a.m. At that time, Staff 1 and 2 were both present. The Subject was assigned the Lead Staff role. Shortly thereafter, Staff 2 left as her shift ended. Sometime early in the Subject's shift, or perhaps before, bedbugs were discovered. The Subject called her supervisor and asked for additional support staff to assist with packing and evacuating the service recipients from the Facility, but the request was denied. (Hearing testimony of the Subject)

11. On the date of the alleged neglect, Staff 1, a relatively new employee, and the Subject were experiencing some tension between themselves. Staff 1 had been mandated to work overtime as her shift had ended at 7:00 a.m. The Subject had an issue with the amount of time that Staff 1 spent on the phone, and Staff 1 said some "inappropriate things" to the Subject. (Hearing testimony of the Subject)

12. On the date of the alleged neglect, the Subject oversaw medication administration, and the decision was made to administer morning medication before evacuation. Service recipient 1 acted out and exhibited negative behaviors. Generally, it was a priority to keep service recipient 1 calm as she could become violent when escalated. Service recipient 1 required arm's length supervision. (Hearing testimony of the Subject)

13. As the evacuation unfolded, the Subject escorted and/or assisted service recipients 1, 2 and 3 to the van. The Subject assumed that Staff 1 had, or would, evacuate the Service

Recipient from the house. (Hearing testimony of the Subject)

14. While in the driveway, the Subject, who was standing about twenty-feet from Staff 1, told Staff 1 that she (the Subject) was departing for the evacuation site. Staff 1 may not have acknowledged what the Subject said to her, as Staff 1 was not talking much to the Subject that day. When the Subject departed, Staff 1 was still loading her van and at least one service recipient was sitting in Staff 1's van. (Hearing testimony of the Subject)

15. The trip to the evacuation site took between fifteen and twenty minutes. (Hearing testimony of the Subject) The Subject arrived at the evacuation site before Staff 1 and attempted to gain access. Staff 1 arrived at the evacuation site about 10 minutes after the Subject arrived. At that time, the Subject discovered that the Service Recipient had not been evacuated from the Facility. (Hearing testimony of the Subject)

16. At 11:46 a.m., Staff 1 called her supervisor to report that the Service Recipient had been left at the Facility. A staff member responded to the Facility and arrived at 11:56 a.m., whereupon the staff member located the Service Recipient unharmed. (Justice Center Exhibit 15) The Service Recipient was left unsupervised at the Facility for a minimum of 25 minutes, but may have been left for a longer period.

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 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), 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 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 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 established by a preponderance of the evidence that the Subject committed the act described in Allegation 1 of the substantiated report.

In support of its substantiated findings, the Justice Center presented many documents obtained during the investigation. (Justice Center Exhibits 1-19) The investigation underlying the substantiated report was conducted by Justice Center 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.

A finding of neglect requires that a preponderance of the evidence establishes that the Subject engaged in conduct that breached her duty to the Service Recipient and that the breach of duty 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.

At the hearing, the Subject argued that once she had loaded Service Recipients 1, 2 and 3 into the van, she could not return to the house to ensure the proper evacuation of the remaining

service recipients, including the Service Recipient, because she would have left the service recipients in her van unsupervised. This argument is not convincing.

The Subject was assigned to supervise the Service Recipient on the date of the alleged neglect and, in her capacity of lead staff, she was responsible for ensuring that all service recipients were accounted for at the time of departure from the Facility. The Subject failed to effectively communicate with Staff 1. While in the driveway before departing, the Subject failed to verify that Staff 1 knew that she was departing. The Subject also failed to verify that all the service recipients were evacuated. The Subject could have remained in the driveway and confirmed that all service recipients had been evacuated, and could have done so without compromising supervision of the service recipients that she was immediately responsible for. Clearly, in failing to account for the Service Recipient during the evacuation, the Subject breached her duty to the Service Recipient.

The Service Recipient was subject to fifteen-minute check supervision in some instances and constant supervision in others, while in the car, or in the community. During the day and while in the Facility, the Service Recipient was subject to one-time per hour visual checks. (Justice Center Exhibit 12) However at the time of alleged neglect the Service Recipient was left completely unattended in the Facility for at least 25 minutes. The Service Recipient had a history of elopement and, while he used a wheel chair most of the time, the Service Recipient was capable of self-ambulation for a short distance, although not safely. Additionally, the Service Recipient was prone to engaging in the behavior of pulling his own chest hair out.

After considering all the evidence, the Justice Center has established by a preponderance of the evidence 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 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.

The report will remain substantiated and 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 should properly be categorized as a Category 3 act.

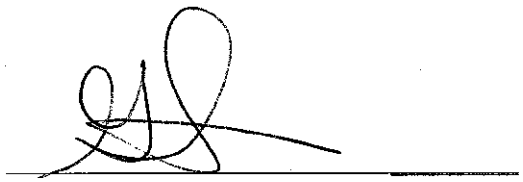
A substantiated Category 3 finding of neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to NY SSL § 496(2). This report will be sealed after five years.

DECISION: The request of [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 Gerard D. Serlin, Administrative Hearings Unit.

DATED: November 10, 2017
Schenectady, New York



Gerard D. Serlin, ALJ