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: April 27, 2018
Schenectady, New York

David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[redacted], Subject
Lawrence H. Schaefer, 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: Keely D. Parr
Administrative Law Judge

Held at: Administrative Hearings Unit
New York State Justice Center for the Protection of People with Special Needs
9 Bond Street – 3rd Floor
Brooklyn, New York 11201
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: Kevin McGuckin, Esq.

[redacted]
By: Lawrence H. Schaefer, Esq.
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54 State Street, Suite 1001
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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. 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 a service recipient, during which time her whereabouts were unknown.
>
> 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], offers inpatient and outpatient treatment for adults with mental illness. The facility is licensed by the Office of Mental Health (OMH), a provider agency that is subject to the jurisdiction of the Justice Center.

(Justice Center Exhibit 8)

5. At the time of the alleged neglect, the Subject had been employed by OMH as a Social Worker for 16 years and had been in the facility for the same amount of time. Part of the Subject's job responsibility was to facilitate groups. (Hearing Testimony of Subject; Justice Center Exhibit 29)

6. At the time of the alleged neglect, the Service Recipient was a 36-year old female, with a long history of schizophrenia and poor compliance with medications. The Service Recipient was admitted to the facility on [redacted] 2015. (Justice Center Exhibit 12)

7. At the time of the alleged neglect, the Subject was leading a group entitled "Where do I belong?" on the [redacted] floor, and the Service Recipient was assigned to that group. The process in the facility was for all of the service recipients to line up in the hallway of the ward where a head count was taken prior to the service recipients boarding the elevators to go to the treatment mall where all of the groups were held. The treatment mall was located on the [redacted] and [redacted] floors of the facility. Each service recipient had a program card which told them which group they were in and also alerted the staff as to whether the service recipients needed to be escorted to their rooms or could go alone. The Service Recipient had a white card, indicating that she had to be escorted to off-ward destinations and could not go by herself. (Hearing Testimony of Subject; Justice Center Exhibits 21 and 29)

8. At the time of the alleged neglect, there were four elevators in use to take the service recipients to the treatment mall, however there were only two mental health therapy aides (MHTA) and one registered nurse (RN) available to escort the service recipients in the elevator. The service recipients were responsible for getting themselves to the right treatment mall. Once the service recipients exited the elevator, a staff member was supposed to let them in through a door where

they dispersed into their respective rooms. Once inside their rooms, the program leader would take attendance. (Hearing Testimony of Investigator; Justice Center Exhibits 8 and 29)

9. At the time of the alleged neglect, the Subject had a co-leader assigned to his group, however, the co-leader never appeared. The Subject had 16 lower-functioning service recipients assigned to his group. The Subject took attendance at the end of the class in the event that one of the service recipients came in late. The Subject marked the Service Recipient and one other service recipient absent and entered the information into the facility's computer system. (Hearing Testimony of Subject; Justice Center Exhibit 29)

10. When the service recipients finished their group, they rode back down the elevator to the ward. The service recipients then gathered in the dining room, where a head count was taken. The Service Recipient was marked present by Staff [redacted]. When the RN called out to the Service Recipient to administer her medication, she did not respond. The RN sent a staff member to look for the Service Recipient, however she could not be found. Staff [redacted] called the safety dept. who found the Service Recipient alone on the treatment mall on floor [redacted]. The Service Recipient was examined and found to be unharmed. (Justice Center Exhibits 8, 10 and 29)

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 neglect of a person in a facility or provider agency is defined by SSL § 488(1) as:

> (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 as found in 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 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 did not establish that the Subject committed neglect when the Subject failed to provide proper supervision to the Service Recipient, during which time her whereabouts were unknown.

In order 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 he breached that duty, and that his 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))

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-28) The Justice Center also presented audio recordings of all interrogations and interviews. (Justice Center Exhibit 29) 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 his own behalf and provided no other evidence.

The Subject testified that the group that he was leading was located in the kitchen and that there were no telephones or other communication devices in that room. The only way that he would have been able to use the telephone to call the treatment mall manager would have been to leave the classroom and go to the telephone far down the hallway. However, the Subject testified that he could not leave the service recipients alone and endanger them as once the service recipients entered his classroom he was responsible for them. The treatment mall manager herself acknowledged that a leader without a co-leader was not supposed to leave the service recipients in the classroom by themselves. Had there been a co-leader in the classroom, the Subject testified that he would have sent him or her to see if the Service Recipient was in a different room. The Subject further testified that when he led a group at night there was usually no co-leader present. (Hearing Testimony of Subject; Justice Center Exhibit 29)

The Subject testified that there was a pillar that would block his view of the room once he left, so he could not step outside to see if a MHTA was in the hallway. In addition, there was quite a distance between the kitchen and the hallway, so it was not as simple as sticking his head outside of the door of the classroom. The Subject further testified that there could have been any number of reasons for the Service Recipient not to be in his class, including her right to refuse to attend, an appointment at the clinic, being placed under psychiatric observation, etc. and that there was no procedure in place to alert him to this information. (Hearing Testimony of Subject; Justice Center Exhibit 29)

Although the treatment mall manager was supposed to visit the classrooms to ensure that everything was ok and inquire as to whether any service recipient was not in class, the Subject

testified that she did not come into his classroom at all that evening, nor did she take the attendance sheet. The Subject entered the data from the attendance sheet into the facility's computer system, at the end of the class. In addition, a mall report evidencing, inter alia, that a service recipient was not in class was not filled out by the treatment mall manager that night. (Hearing Testimony of Subject, Justice Center Exhibit 29)

The Subject's primary duty was to the 15 service recipients in his classroom and had the Subject left the room to alert staff that the Service Recipient was not in his class and something happened to one or more of the 15 service recipients, he would have been charged with another offense. The Subject could not be in two places at the same time. The duty to the Service Recipient was breached by the facility by not having proper procedures in place, not ensuring that staff followed the policies that were in place, especially with regard to patient escorts, and by not having adequate staffing, including ensuring that co-leaders are present in the evening, e.g. for the Subject's group. There was no head count taken once the service recipients exited the elevators to go to the treatment mall nor a check performed to ensure that the service recipients exited the elevator on the correct floor for their group, notwithstanding that the treatment mall was on two different floors, that there were multiple classrooms on each floor and that the service recipients were at the facility due to diminished mental ability! Having the service recipients be responsible for getting themselves to the right treatment mall resulted in a lack of accountability, where no staff member interviewed could explain how the Service Recipient was able to access and remain alone in the treatment mall where she was not assigned. (Hearing Testimony of Subject; Justice Center Exhibits 8 and 29)

The evidence did not establish that the Subject committed neglect when the Subject failed to provide proper supervision to the Service Recipient, during which time her whereabouts were

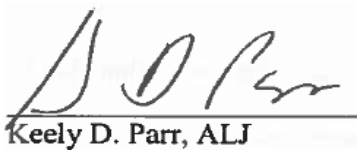
unknown.

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] 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 Keely D. Parr, Administrative Hearings Unit.

DATED: April 10, 2018
Brooklyn, New York



Keely D. Parr, ALJ