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

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]

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], of abuse (obstruction of reports of reportable incidents) 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 a custodian, you committed abuse (obstruction of reports of reportable incidents) and/or neglect when you failed to provide proper supervision to a service recipient by falsely documenting her presence on the ward, during which time her whereabouts were unknown.
>
> These allegations have been SUBSTANTIATED as Category 3 abuse (obstruction of reports of reportable incidents) and 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 abuse and/or neglect, the Subject was employed by OMH as a Mental Health Therapy Aide (MHTA) and was assigned to the Service Recipient's ward. (Justice Center Exhibit 29)

6. At the time of the alleged abuse and/or 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 Exhibit12)

7. At the time of the alleged abuse and/or neglect, the Subject had taken a head count in the hallway of the ward at 5:45 p.m. and marked the Service Recipient present. 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 Subject then proceeded to the elevator with service recipients to the [redacted] floor where he was leading a group on anger management. The Service Recipient was not on the elevator with the Subject nor was she assigned to his classroom. When the Subject finished the group, he proceeded downstairs in the elevator and returned to the ward with the service recipients that attended his group. (Hearing Testimony of Subject; Justice Center Exhibits 19 and 29)

8. All service recipients from all of the groups assembled in the dining room on the ward where a head count was taken by the Subject. The Subject was not assigned this duty but took it upon himself to perform the head count as the facility was short-staffed and the service recipients were getting restless. The Subject marked the Service Recipient present at 7:00 p.m.

(Hearing Testimony of Subject; Justice Center Exhibits 8 and 29)

9. 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. The Subject called the safety dept. who found the Service Recipient alone on the treatment mall on floor [redacted], at approximately 8:45 p.m. 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 abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1) as:

> (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 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 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 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 acts 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 neglect by a preponderance of the evidence, the substantiated report must be amended and sealed.

DISCUSSION

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.

Allegation of Abuse (Obstruction of Reports of Reportable Incidents)

The Justice Center has established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 1" in the substantiated report. Specifically, the evidence establishes that the Subject committed abuse (obstruction of reports of reportable incidents) when the Subject failed to provide proper supervision to the Service Recipient by falsely documenting her presence on the ward, during which time her whereabouts were unknown.

In order to sustain an allegation of abuse (obstruction of reports of reportable incidents), the Justice Center must prove that the Subject was a custodian whose conduct impeded the discovery, reporting or investigation of the treatment of the Service Recipient by falsifying records

related to the safety, treatment or supervision of the Service Recipient. (SSL § 488(1)(f))

On the day of the alleged abuse, the Subject was employed as a MHTA by OMH and was acting as a custodian as that term is defined in Social Services Law § 488(2). 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 Subject had taken a head count in the hallway of the ward at 5:45 p.m. and marked the Service Recipient present. The Subject then proceeded to the elevator with service recipients to the [redacted] floor where he was leading a group on anger management. The Service Recipient was not on the elevator with the Subject nor was she assigned to his classroom. When the Subject finished the group, he proceeded downstairs in the elevator and returned to the ward with the service recipients that attended his group. (Hearing Testimony of Subject; Justice Center Exhibits 19 and 29)

Subsequently, all service recipients from all of the groups assembled in the dining room on the ward where a head count was taken by the Subject. The Subject was not assigned this duty but testified that he took it upon himself to perform the head count as the facility was short-staffed and the service recipients were getting restless. (Hearing Testimony of Subject)

The Subject testified that he marked the log, showing the Service Recipient as present in the dining room, when he performed the headcount at 7:00 p.m. even though he had not seen her when he returned from leading his group. The Subject additionally testified that he did not know why he did so. The Subject admitted that it was necessary to see a service recipient before marking them present in the log. By marking her present at 7:00 p.m., the Subject impeded the investigation into the Service Recipient's whereabouts by falsifying records related to the safety, treatment and

supervision of the Service Recipient. The Service Recipient was not found by the safety dept. until approximately 8:45 p.m., almost two hours after the falsification of the log, additional time where the Service Recipient was left alone and unsupervised. Had the Subject reported the Service Recipient missing at 7:00 p.m. instead of marking her as present in the dining room, the Service Recipient would have been found much sooner, reducing the amount of time that she was in harm's way. (Hearing Testimony of Subject; Justice Center Exhibits 15 and 29)

The evidence establishes that the Subject committed abuse (obstruction of reports of reportable incidents) when the Subject failed to provide proper supervision to the Service Recipient by falsely documenting her presence on the ward, during which time her whereabouts were unknown.

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 abuse alleged. The substantiated report will not be amended or sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of abuse 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 of abuse is properly categorized as a Category 3 act. Substantiated Category 3 findings 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 SSL § 496(2). The report will be sealed after five years.

Allegation of Neglect

The Justice Center has established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 1" in the substantiated report. Specifically, the evidence establishes that the Subject committed neglect when the Subject failed to provide proper supervision to the Service Recipient by falsely documenting her presence on the ward, 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))

On the day of the alleged neglect, the Subject was employed as a MHTA by OMH and was acting as a custodian as that term is defined in Social Services Law § 488(2). Although the Subject was not assigned to perform the head count at 7:00 p.m., once the Subject undertook to perform that task, the Subject had a duty to perform the headcount accurately. The Subject breached his duty to the Service Recipient by falsely reporting her presence in the dining room at 7:00 p.m. When asked during his interrogation whether he remembered seeing the Service Recipient on the ward at 7:00 p.m., the Subject answered that he did not. (Justice Center Exhibit 29)

The Subject testified that he did not know why he marked the Service Recipient present when she was not there and further testified that the facility was short-staffed and as a result, mistakes happen. However, had the Subject accurately reported that the Service Recipient was missing at 7:00 p.m. she would not have been left alone unsupervised and in harm's way until eventually being found at 8:45 p.m. that evening. (Hearing Testimony of Subject)

Although no physical injury was observed, there was a likelihood that the Subject's breach could result in the serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. The Service Recipient was relatively new to the facility and must have been frightened to be up on a floor alone with no way out. Staff [redacted] stated that once the treatment mall was closed and the Service Recipient was left on the floor by herself, she needed a key to call the elevator, which she did not possess, and therefore there was no way for her to return to the ward via the elevator. Indeed, the Service Recipient's individual crisis prevention plan shows one of her triggers as feeling lonely. Accordingly, being left alone on a floor all by herself was likely to result in the protracted impairment of the mental and emotional condition of the Service Recipient. (Justice Center Exhibits 8, 11 and 29)

The evidence establishes that the Subject committed neglect when the Subject failed to provide proper supervision to the Service Recipient by falsely documenting her presence on the ward, during which time her whereabouts were unknown.

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.

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 of neglect is properly categorized as a Category 3 act. Substantiated Category 3 findings 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.

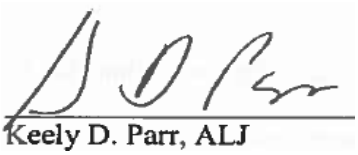
However, the report remains subject to disclosure pursuant to SSL § 496(2). The report will be sealed after five years.

DECISION: The request of [redacted] that the substantiated report dated [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 Category 3 acts.

This decision is recommended by Keely D. Parr, Administrative Hearings Unit.

DATED: April 13, 2018
Brooklyn, New York



Keely D. Parr, ALJ