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: August 24, 2018
Schenectady, New York

David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[redacted], Subject
Hugh Reid, 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: Amanda Smith, Esq.

[redacted]
By: Hugh E. Reid, Esq.
186 Montague Street, 4th Floor
Brooklyn, New York 11201

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 Service Recipients.

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][1], while a custodian, you committed neglect when you failed to ensure the residence was adequately staffed prior to leaving your shift, during which time the service recipients were not properly supervised.
>
> 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], is an individualized residential alternative (IRA) operated by [redacted]

[1] As stated in the allegation.

[redacted] and certified by the Office for People With Developmental Disabilities (OPWDD), a provider agency that is subject to the jurisdiction of the Justice Center. (Justice Center Exhibit 6)

5. At the time of the alleged neglect, the Subject had been employed by the [redacted] as a Direct Support Professional (DSP) since [redacted] 2012. The Subject had worked double shifts (8:00 a.m. – 4:00 p.m. and 4:00 p.m. – 12:00 a.m.) and was assigned to the first floor of the IRA. (Hearing Testimony of Subject; Justice Center Exhibit 2)

6. At the time of the alleged neglect, there were four Service Recipients residing on the first floor of the IRA and four Service Recipients residing on the second floor. All of the Service Recipients operated within the profound range of intellectual disability. DSP #1 was assigned to the second floor of the IRA, and had also worked double shifts. (Justice Center Exhibit 6)

7. At approximately 11:45 p.m. on the date of the alleged neglect, DSP #2 arrived at the IRA and told the Subject that she was going to be on the first floor. The Subject walked her through the first floor and checked that all Service Recipients were safe, dry and asleep. The Subject walked DSP #2 over to the medication cabinet to show her the keys, as the Subject had been the last one to administer the medication on the first floor. DSP #2 began completing the laundry that the Subject and DSP #3 had begun. (Hearing Testimony of Subject; Justice Center Exhibits 2 and 6)

8. A short time later, DSP #3 told DSP #2 that herself and the Subject were ready to leave. DSP #2 told them that they could go and that DSP#2 would staff the first floor and wait for the other overnight staff to arrive. The Subject called up to the second floor to inform DSP #1 that she was leaving. The Subject clocked out at 11:57 a.m., leaving the IRA with DSP #1 on the

second floor and DSP #2 on the first floor. (Hearing Testimony of Subject; Justice Center Exhibits 2, 6 and 20)

9. At approximately 11:59 p.m. DSP #1 left the IRA without checking to ensure that there was sufficient staff on both floors. The staffing ratio at the IRA was three staff to the eight Service Recipients. DSP #1 was not aware that before leaving she should check to ensure that there was sufficient staff on both floors. DSA #2 was left alone in the IRA to cover both floors. DSP #2 did not remember until four hours after the alleged incident that she should call the assistant program coordinator about staffing. (Justice Center Exhibits 6, 7 and 20)

10. The schedule for the facility at the time of the incident, showed DSA #4 on floors #1 and #2 at the same time with the word "open" above the name. DSA #4 did not recall being called into work on the day of the alleged incident and therefore never arrived at the facility. (Justice Center Exhibits 6 and 18)

11. No harm came to the Service Recipients as a result of the alleged neglect. (Justice Center Exhibit 6)

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.

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 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))

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-33) The investigation underlying the substantiated report was conducted by [redacted] Quality Assurance Training Coordinator (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 Justice Center's case is predicated on the fact that the weekly schedule shows DSP #2's name on the second floor and therefore the Justice Center argues that she was there to relieve

DSP #1 and not the Subject. However, above DSP #2's name is the word "floater" meaning that she floats between floors as the need arises. (Hearing Testimony of Subject and Investigator; Justice Center Exhibit 18)

The Subject credibly testified that at approximately 11:45 p.m. on the date of the alleged neglect, DSP #2 arrived at the IRA and told the Subject that she was going to be on the first floor. The Subject walked her through the first floor and checked that all Service Recipients were safe, dry and asleep. The Subject walked DSP #2 over to the medication cabinet to show her the keys, as the Subject had been the last one to administer the medication on the first floor. The Subject testified that she had to be relieved by a permanent staff member and could not be relieved by someone from the staffing agency, as they could not administer medication. DSP #2 began completing the laundry that the Subject and DSP #3 had begun. (Hearing Testimony of Subject and Investigator; Justice Center Exhibits 2, 6 and 18)

A few minutes prior to the end of the shift, DSP #3 told DSP #2 that herself and the Subject were ready to leave. DSP #2 told them that they could go and that DSP#2 would staff the first floor and wait for the other overnight staff to arrive. Although DSP #2 said in her statement that she was there to relieve DSP #1, her actions clearly indicated otherwise. (Hearing Testimony of Subject; Justice Center Exhibits 2, 6 and 21)

Prior to exiting the facility, the Subject called up to the second floor to inform DSP #1 that she was leaving. The Subject left the IRA with DSP #1 on the second floor and DSP #2 on the first floor, clocking out at 11:57 p.m. (Hearing Testimony of Subject; Justice Center Exhibits 2, 6 and 20)

At approximately 11:59 p.m. DSP #1 left the IRA without checking to ensure that there was sufficient staff on both floors. DSP #2 was left alone in the IRA to cover both floors. (Justice

Center Exhibits 6 and 20)

What is clear from the record is that the staff were not properly trained in shift hand over protocol. DSP #1 in her statement stated that she was not aware that before leaving she should check to ensure that there was sufficient staff on both floors. DSA #2 told DSP #3 and the Subject that they could go home without the authority to do so. DSA #2 did not remember until four hours after the alleged incident that she should call the assistant program coordinator about staffing. The Subject believed that having one staff on each floor was adequate coverage for the facility and testified that if DSP #1 had left before her, that she would not have been able to leave when she did. In fact, the investigative report recommended that the staff be in-serviced on shift hand over protocol. (Hearing Testimony of Subject; Justice Center Exhibits 6, 7, 18 and 25)

The schedule for the time of the alleged neglect shows DSA #4 on floors #1 and #2 (at the same time) with the word "open" above the name. According to the Subject's testimony "open" means not confirmed. In fact, when DSA #4 was interviewed, he could not recall being called to work on the day of the alleged incident and therefore never arrived at the facility for the shift. Therefore, the schedule itself did not reflect the proper staffing ratio for the facility for the time of the alleged neglect, as only two staff members were confirmed to work, one of which, a person from the staffing agency, could not relieve the Subject as they could not administer medication. According to the assistant program coordinator, during the overnight shift there was to be three staff on duty. According to the Subject's testimony, the manager prepared the schedule. Although the investigative report refers to shift hand over protocol and staff to individual ratios for each shift, no documents were presented that reflect the facility's policies in this regard nor was any evidence presented that show that the Subject received the necessary trainings. (Hearing Testimony of Subject; Justice Center Exhibits 6, 7, 18 and 25)

The evidence did not establish that the Subject committed neglect when the Subject failed to ensure the residence was adequately staffed prior to leaving her shift, during which time the Service Recipients were not properly supervised. 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: August 13, 2018
Brooklyn, New York

Keely D. Parr, ALJ