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 Elizabeth M. Devane, ALJ, of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

Dated: January 25, 2019
Schenectady, New York

Elizabeth M. Devane

Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Erin Gise, Esq.
[redacted], Subject, Pro se

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: Susanna Requets
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: Erin B. Gise, 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], 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], in an agency vehicle parked outside the [redacted], located at [redacted], while a custodian, you committed neglect when you failed to provide proper supervision to the service recipient by leaving him unattended.
>
> 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 Intermediate Care Facility (ICF) with ten service recipients. The facility is operated by [redacted] and certified by the New York State Office for People

With Developmental Disabilities (OPWDD), which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of the [redacted] Director of Quality Assurance [redacted] [Director])

5. At the time of the alleged neglect, the Subject was employed by the facility as a Clinical Liaison Officer (CLO) and had been employed by the facility for two years. The Subject worked as a Direct Service Professional for one year and received a lateral promotion as a CLO the following year. The Subject scheduled clinic appointments for the service recipients, ensured that their medication was up to date, and drove the facility van to bring the service recipients from and to their clinic appointments. (Hearing testimony of the Subject; Justice Center Exhibit 6) The Subject was a custodian as that term is defined in Social Services Law § 488(2).

6. At the time of the alleged neglect, the Service Recipient was a forty-year-old non-verbal male with diagnoses of profound intellectual impairment and autism. The Service Recipient needed assistance with his activities of daily living, such as showering, toileting and self-care. (Hearing testimony of the Director; Justice Center Exhibit 10)

7. The Service Recipient exhibited two self-injurious behaviors (SIB) in [redacted] and [redacted], which resulted in one tooth falling out during one incident and another tooth having to be removed a few days later in another incident. Because of the increased intensity of his SIB, the Service Recipient was assigned 1:1 staff. The Service Recipient could move independently in the facility with his assigned staff making visual contact with him every ten minutes. If the Service Recipient engaged in vocalizations, staff were required to increase supervision to ensure his safety. The Service Recipient could exhibit SIB with or without a vocal precursor. (Hearing testimonies of the Director and the Subject; Justice Center Exhibit 6)

8. On [redacted], the Subject worked from [redacted] The Subject

was assigned as the Service Recipient's 1:1 and helped the Service Recipient prepare for a presurgical dental appointment at [redacted] Hospital [redacted]. The Subject drove the facility van with two staff and five service recipients, including the Service Recipient, to the day habilitation program operated by [redacted] and located on [redacted] (day program). The Subject left the day program at approximately 9:30 a.m. with the Service Recipient to go to his medical appointment. (Hearing testimonies of the Director and the Subject; Justice Center Exhibits 14, 20 and 21)

9. Before parking the van at [redacted], the overnight Supervisor[1] called the Subject on his personal cell phone because Service Recipient 2's (SR 2) specialized diet lunch was left in the facility and needed to be provided to the day program. The Subject agreed to pick up SR 2's lunch before taking the Service Recipient back to the day program. (Hearing testimony of the Subject; Justice Center Exhibits 2, 6 and 14)

10. At 11:56 a.m., the Subject parked at the facility, exited the van and entered the facility leaving the Service Recipient alone inside the van. (Justice Center Exhibits 2, 14, 22 and 23) The Subject could not locate SR 2's lunch and told the Director of Nursing[2] and the Residence Manager[3] that the Service Recipient's lunch was misplaced. (Hearing testimony of the Subject; Justice Center Exhibit 14)

11. At approximately 12:00 p.m., the Group Leader[4] of the day program classroom called and asked the Director of Nursing when the Service Recipient was expected to come back to the day program because his class was waiting for him to participate in a shopping trip. (Justice Center Exhibits 18, 20 and 21) The Subject lied and told the Director of Nursing that he had

[1] The Supervisor was [redacted].
[2] The Director of Nursing was [redacted].
[3] The Residence Manager was [redacted].
[4] The Group Leader was [redacted].

dropped the Service Recipient with the Receptionist[5] at the day program. (Justice Center Exhibits 14, 15, 17, 18, 20 and 21)

12. The Group Leader called the Director of Nursing again stating that the Service Recipient was never dropped off with the Receptionist. The Subject confirmed with the Residence Manager that he followed a "proper transfer of care procedure" when he left the Service Recipient with the Receptionist. (Justice Center Exhibits 15 and 21)

13. Approximately thirteen minutes and twenty seconds after first exiting the van, the Subject went back to the van without SR 2's lunch[6]. (Hearing testimonies of the Director and the Subject; Justice Center Exhibits 2, 6, 22, 23 and 24)

14. Meanwhile, the day program Group Leader, Qualified Intellectual Disability Professional (QIDP[7]) and the Adult Operations Coordinator (AOC[8]) initiated the [redacted] missing persons protocol. [redacted] staff conducted an immediate search of the vicinity. The QIDP arranged a soft lock-down and supervised the exit doors to ensure that no one left the day program unnoticed. Since the Service Recipient was not located within five minutes, the Adult Operations Coordinator called 911. (Justice Center Exhibits 6, 17, 19 and 21)

15. Ten to fifteen minutes later, the Subject arrived at the day program with the Service Recipient. The Registered Nurse (RN[9]) assessed the Service Recipient and found no injuries. (Justice Center Exhibits 12, 19, 20 and 21)

16. All [redacted] employees were required to review [redacted] Programs Vehicle Use Policies and Procedures Employee Handbook (the Handbook) prior to driving the agency's van.

[5] The Receptionist was [redacted].
[6] SR 2's lunch was found at the day program later that afternoon.
[7] The QIDP was [redacted].
[8] The Adult Operations Coordinator was [redacted].
[9] The RN was [redacted]

The Handbook states, in pertinent part, that "participants should never be left unattended in a vehicle." (Hearing testimony of the Director; Justice Center Exhibit 13)

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 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 follows:

> "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 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 established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 1" in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1 through 3 and 5 through 21) The

Justice Center submitted three visual only videos of the exterior of the facility, which was extremely helpful and illuminating evidence with respect to the allegations. (Justice Center Exhibits 22 through 24) The investigation underlying the substantiated report was conducted by the Director of Quality Assurance [redacted] (Director), who testified at the hearing on behalf of the Justice Center.

The Subject testified in his own behalf and presented no other evidence.

In order to prove neglect, the Justice Center must establish by a preponderance of the evidence that the Subject's action, inaction or lack of attention breached a duty that 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 Recipients. (SSL § 488(1)(h))

The credible evidence establishes that the Subject had a duty to never leave the Service Recipient unattended in the van. (Justice Center Exhibit 13) The Subject breached his duty when he admittedly left the Service Recipient alone in the van for thirteen minutes. (Hearing testimonies of the Director and the Subject; Justice Center Exhibits 2, 10, 14, 22, 23 and 24)

The Subject's defense that additional staff should have accompanied the Service Recipient to the medical appointment is unpersuasive. While additional staff may have been helpful, it was neither required nor necessary. (Hearing testimony of the Director) The Subject was able to drive and accompany the Service Recipient to his medical appointment without incident. (Hearing testimony of the Subject; Justice Center Exhibits 2, 6 and 14)

After the medical appointment, the Subject had at least three options that would have resulted in compliance with the Handbook without necessitating an additional staff member: (i) the Subject could have brought the Service Recipient with him inside the facility while looking for SR 2's lunch; (ii) the Subject could have left the Service Recipient in the office with the Director

of Nursing and Residence Manager while looking for SR 2's lunch; or (iii) the Subject could have called the facility and asked staff to go outside and bring SR 2's lunch to him. (Hearing testimony of the Director) Instead, the Subject deliberately left the Service Recipient alone in the van for thirteen minutes. (Justice Center Exhibits 14, 22, 23 and 24)

The Subject's claim that he did not anticipate looking for SR 2's lunch for thirteen minutes is not an excuse for his conduct. The Subject failed to take any affirmative action to ensure that the Service Recipient was provided proper supervision, including asking the Director of Nursing or Residence Manager to assist him in the care of the Service Recipient. (Hearing testimony of the Subject) The Subject then caused pandemonium in the day program when he deliberately lied to the Director of Nursing, the Residence Manager and Group Leader by falsely claiming that he left the Service Recipient with the Receptionist. (Justice Center Exhibits 6, 17, 19 and 21)

Although the Service Recipient did not sustain any injures, the credible evidence demonstrates that the Subject's breach of duty was likely to cause physical injury or a serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. The Subject had a responsibility to comply with the facility policies and procedures when driving the Service Recipient in the facility van. (Justice Center Exhibit 13) The Subject's disregard of his duties was likely to result in self-harm by the Service Recipient considering that he experienced two severe SIBs requiring extensive dental surgery during the two months preceding the neglect. (Hearing testimony of the Director; Justice Center Exhibits 6 and 10)

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.

Since 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.

Substantiated Category 3 findings 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 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 neglect.

The substantiated report is properly categorized as a Category 3 act.

This decision is recommended by Susanna Requets, Administrative Hearings Unit.

DATED: January 22, 2019
Brooklyn, New York

Susanna Requets

Susanna Requets, ALJ