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: May 24, 2019
Schenectady, New York

Elizabeth M. Devane

Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Holly Moynihan, Esq.
Heidi S. Gregory, 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: John T. Nasci
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
2165 Brighton Henrietta Town Line Road
Rochester, New York 14623
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: Holly Moynihan, Esq.

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By: Heidi S. Gregory, Esq.
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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 between [redacted] and [redacted], at the [redacted], located at [redacted], while a custodian, you committed neglect when you failed to provide adequate oversight and monitoring of a service recipient's care and/or of staff responsible for his care, following a drug relapse.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(b).

3. An Administrative Review was conducted and, as a result, the substantiated report was retained.

4. The [redacted], located at [redacted], is a [redacted] which provides residential and counseling services for people who have been referred to [redacted] from

twenty-four hour supervision community houses or half-way houses and are transitioning to self-sufficiency. [redacted] is licensed by the New York State Office of Alcoholism and Substance Abuse Services (OASAS), and is an agency that is subject to the jurisdiction of the Justice Center. (Justice Center Exhibit 43: audio recording of Justice Center interview of the Subject, and Hearing testimonies of [redacted], Justice Center Investigator (Investigator) and the Subject)

5. At the time of the alleged neglect, the Subject was employed by [redacted] as a Program Manager (PM) and had been employed by the facility since [redacted] 2016. The Subject held the accreditation of Credentialed Alcoholism and Substance Abuse Counselor (CASAC). As PM, the Subject was responsible for the day-to-day clinical operation and management of [redacted] sixty to seventy-two bed treatment apartment program, and provided routine supervision of her staff, including four counselors with and without the CASAC accreditation and support staff. (Justice Center Exhibits 42 and 43: audio recording of Justice Center interview of the Subject, Subject Exhibit A and Hearing testimony of the Subject) 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 male Service Recipient was twenty-four years old, and had been a resident of the facility for approximately five months. The Service Recipient had diagnoses of anxiety disorder unspecified and polysubstance dependence. (Justice Center Exhibits 10 and 18)

7. [redacted] was required by New York State regulations to develop and provide comprehensive treatment plans for habilitative and rehabilitative services for service recipients in the [redacted] and to document case conferences, case reviews, reports and other evaluations. [redacted] was also required to schedule clinical interaction with each service recipient a minimum of one time per week as support in assisting them to maintain abstinence and reduce risk of relapse.

(Justice Center Exhibit 40)

8. As PM, the Subject held weekly staff meetings with all her counselors during which they discussed the program's service recipients, policies and procedures. The purpose of the meetings was to keep the Subject informed of the status of service recipients in the program and to provide guidance to the counselors in a group setting. The Subject also held biweekly supervision meetings with her counselors individually in which she reviewed the counselor's individual cases, discussed the counselor's performance and due dates, and assisted the counselor with his or her needs. (Justice Center Exhibit 6: audio recording of [redacted] investigator interview of Subject; Justice Center Exhibits 42 and 43: audio recording of Justice Center interview of the Subject; and Hearing testimony of the Subject)

9. Residents at the [redacted] remained in the [redacted] residential program for six to ten months and were required to spend a minimum of twenty hours per week in recovery related activities. The service recipients were screened for alcohol and/or drug use one time per month. (Justice Center Exhibit 6: audio recording of [redacted] investigator interview of the Subject and Justice Center Exhibit 37)

10. Service recipients in the [redacted] were placed on various levels of contracts, in the event that they violated the rules of the program, for the purpose of preventing recurrence of the violations. The lowest level of contract was a support contract for minor violations of program rules. A service recipient who relapsed by using alcohol or drugs was placed on a Preliminary Notice Of Discharge (PNOD) in which drug screens were increased to one time per week. As part of the PNOD, a relapse prevention program (RPP) was to be developed by the counselor and the service recipient. In the event of a second relapse, a service recipient was placed on a Final Notice Of Discharge (FNOD). (Justice Center Exhibits 2 and 6: audio recording of [redacted]

[redacted] investigator interviews of [redacted], Counselor (Staff A), [redacted], [redacted] Counselor (Staff B) and the Subject; Justice Center Exhibit 43: audio recording of Justice Center interview of the Subject; and Hearing testimony of the Subject)

11. After admission into the [redacted] residential program, the Service Recipient was assigned to and moved into one of the program's apartments with a male roommate. On [redacted], the Service Recipient was placed on a support contract for violating certain program rules that prohibited him from having overnight guests and engaging in under-the-table employment. On [redacted], the Service Recipient reported to his counselor, Staff A, that he had used cocaine and heroin on [redacted]. As a result of the Service Recipient's drug use admission, he was given a drug urine screening in which he tested positive for opiates, THC, amphetamines, benzo, buprenorphine and cocaine. The Service Recipient was also placed on a PNOD by his counselor, which required him, among other things, to comply with weekly drug screens and to work with his counselor to create a RPP. (Justice Center Exhibit 6: audio recording of [redacted] investigator interviews of Staff A and the Subject; Justice Center Exhibits 16, 17, 18, 19, 20, 21, 25 and 43: audio recording of Justice Center interview of the Subject; and Hearing testimony of the Subject)

12. Although the PNOD was initiated on [redacted], no written RPP was developed, no reassessment of the Service Recipient's level of care occurred and no further drug screens were conducted. (Justice Center Exhibit 30)

13. On [redacted], the Service Recipient was found deceased in his apartment by his roommate. The cause of the Service Recipient's death was attributed to the combined effects of heroin and cocaine. (Justice Center Exhibits 16, 19, 22 and 26)

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 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 2, which is defined as follows:

> (b) Category two is substantiated conduct by custodians that is not otherwise described in category one, but conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Category two conduct under this paragraph shall be elevated to category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged in category two conduct. Reports that result in a category two finding not elevated to a category one 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 5, 7 through 12, 14 through

26, 28 through 33 and 35 through 42[1]) The Justice Center also presented audio recordings of [redacted] Investigator's interview of witnesses and the Justice Center Investigator's interview of witnesses (Justice Center Exhibit 6), and the Justice Center Investigator's interview of the Subject (Justice Center Exhibit 43). The investigation underlying the substantiated report was conducted by [redacted] Quality Assurance Director [redacted] and Justice Center Investigator [redacted] (Investigator). The Investigator was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and presented one document which was admitted into evidence. (Subject Exhibit A)

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 Recipient. (SSL § 488(1)(h))

The Justice Center contends that the Subject had a duty to provide adequate oversight of her subordinate counselors, that the Subject breached her duty by failing to provide adequate oversight of Staff A concerning Staff A's monitoring of the Service Recipient's care, and that the Subject's breach of duty resulted in the Service Recipient's [redacted] drug relapse and overdose and/or was likely to result in physical injury or serious or protracted impairment of the Service Recipient's physical, mental or emotional condition.

The Subject argues that she provided adequate supervision of Staff A as required by [redacted] policies and New York State regulations both of which governed the operation of [redacted].

The record reflects that as PM, the Subject was responsible for "ensur[ing] adherence to

[1] Justice Center Exhibits 13, 27 and 34 were not offered.

state certification regulations … and other applicable regulations, policies and procedures governing the program and facility" and for "manag[ing] employee performance." (Justice Center Exhibit 38) The record also reflects that the Subject was "responsible for the day-to-day clinical operation of each residence and provide routine supervision for the staff" and was required to conduct "Clinical supervision of all staff bi-weekly." (Justice Center Exhibit 42)

The record reflects that the Subject held biweekly staff supervision meetings with each of her subordinate counselors and that she made and kept a record of the meetings on Supervision Notes. In the biweekly supervision meetings, the Subject and her subordinate counselor would discuss the counselor's individual service recipients' cases, any performance issues with the counselor and the counselor's due dates or deadlines. (Justice Center Exhibit 6: audio recording of [redacted] investigator interview of Subject; Justice Center Exhibits 23 and 43: audio recording of Justice Center interview of the Subject; and Hearing testimony of the Subject)

The record reflects that the Service Recipient reported his [redacted] relapse to his counselor, Staff A, on [redacted] during a counseling session between the Service Recipient and Staff A. As a result of the Service Recipient's admission, Staff A implemented a PNOD which required, among other things, that the frequency of the Service Recipient's drug screening increase from monthly to weekly and that Staff A and the Service Recipient develop a written RPP. The record also reflects that the Service Recipient was not screened for drugs after [redacted] and that no written RPP was developed.

While the Subject's Supervision Notes dated [redacted], reflect that the Service Recipient relapsed and was placed on a PNOD, the only subsequent Supervision Note in the record, on [redacted], does not reflect any discussion between the Subject and Staff A concerning the Service Recipient's PNOD or a RPP. (Justice Center 23)

The Subject admitted in her Justice Center interview that as Program Manager she was responsible for her subordinate counselors completing their work and that it was her "ultimate responsibility, at the end of the day to make sure [her] staff are doing what they are supposed to be doing." The Subject also admitted in the Justice Center interview that she did not identify that Staff A was not performing more frequent urine screens on the Service Recipient and that she should have inquired of Staff A about the increased urine screens during her biweekly supervision meetings. (JC43: audio recording of Justice Center interview of the Subject)

The weight of the evidence in the record establishes that the Subject had a duty to properly and adequately supervise her subordinate counselors by ensuring that each counselor properly performed the responsibilities the job, and that the Subject's duty included inquiring of the counselor at the biweekly supervision meetings about the administration of increased urine screens and the status of a PNOD. The weight of evidence also establishes that the Subject breached this duty between [redacted], when the Service Recipient's PNOD was implemented, and [redacted], when the Service Recipient passed away from a drug overdose, by failing to inquire of Staff A about the status of the Service Recipient's PNOD, and specifically about the status of the increased urine screens and development of a written RPP.

Although the Justice Center contends that the Subject's breach of duty resulted in the Service Recipient's death, the Justice Center's evidence does not address how the Subject's breach of duty caused the Service Recipient's overdose and death. Consequently, the evidence does not sufficiently establish that the Service Recipient's death by drug overdose was the result of or the likely result of the Subject's failure to adequately supervise Staff A. Therefore, the Justice Center has not established that the Subject's breach of duty resulted in or was likely to result in the Service Recipient death.

However, the evidence in the record does establish that the Subject's breach was likely to result in serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Among the responsibilities of the [redacted] was to provide support for service recipients' continued sobriety. Among the tools for that support was the PNOD which included increased drug urine screening and a RPP. The failure of the Subject to ensure that her Counselor provide the increased drug urine screens and RPP as parts of the PNOD deprived the Service Recipient of essential support tools. Without these essential support tools, the Service Recipient's recovery was likely hindered. Consequently, the Subject's failure to properly supervise Staff A was likely to result in 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 be not 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 or neglect set forth in the substantiated report. Category 2 conduct is defined as conduct in which the Subject seriously endangered the health, safety or welfare of the Service Recipient. (SSL § 493(4)(b)) The Subject's failure to properly supervise her subordinate counselors resulted in the Service Recipient being without tools essential for his addiction recovery, which placed the Service Recipient in jeopardy of relapse. Consequently, the absence of increased drug screens and the RPP seriously endangered the Service Recipient's health safety and welfare. Therefore, 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 2 act.

A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

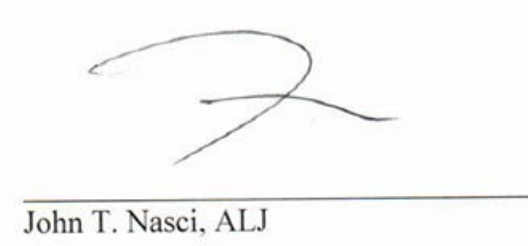
DECISION: The request of [redacted], that the substantiated report dated [redacted] be amended and sealed, is denied.

The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized, as a Category 2 act.

This decision is recommended by John T. Nasci, Administrative Hearings Unit.

DATED: May 13, 2019
Schenectady, New York



John T. Nasci, ALJ