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: October 10, 2019
Schenectady, New York

Elizabeth M. Devane

Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Alliah Rozan, 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: Alliah Rozan, 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 or about [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 he eloped.
>
> 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 Individual Residential Alternative (IRA). The facility is operated by [redacted] and is 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 [redacted] Quality Assurance Investigator [redacted] [Investigator])

5. Nine service recipients resided in the facility, which consisted of three floors. The kitchen, dining room, living room, bathroom and several bedrooms were located on the first floor. Additional bedrooms, a living room, bathroom and medical room were on the second floor. The managerial offices (Program Director[1], Assistant Program Director[2] and Shift Supervisor[3]), employee lounge, two bathrooms and a nurse's office were located on the third floor. The offices on the third floor contained landline telephones. A landline telephone was also located in the first-floor hallway between the dining room and the living room. (Hearing testimonies of the Investigator and Subject; ALJ Exhibit 1)

6. At the time of the alleged neglect, the Subject was employed by [redacted] as a Direct Support Professional (DSP) for six weeks and was trained on the facility supervision policies. The Subject's duties included advocating for the service recipients in the IRA and assisting them with their activities of daily living. (Hearing testimonies of the Investigator and the Subject; Subject Exhibit A) The Subject was a custodian as that term is defined in Social Services Law § 488(2).

7. The facility maintained a "turn over" policy in the event the Subject needed a break or had to leave an area and was unable to give an account of her assigned service recipients. The turn over policy required the Subject to ask a specific staff to watch a specific service recipient(s). The specific staff was then held accountable for the specific service recipient until the Subject returned. (Hearing testimonies of the Subject and Investigator; Justice Center Exhibit 20)

8. At the time of the alleged neglect, the Service Recipient was a fifty-five-year-old

[1] The Program Director was [redacted].
[2] The Assistant Program Director was [redacted].
[3] The Shift Supervisor of the IRA was [redacted].

male and had diagnoses of a seizure disorder and functioned within the profound range of intellectual disability. The Service Recipient was non-verbal and required staff support to ambulate because he walked with an unsteady gait and was at risk of falling. (Hearing testimonies of the Subject and Investigator; Justice Center Exhibits 6, 13 and 18) The Service Recipient was on general supervision (also referred to as "standard grouping supervision"). General supervision required the staff to know the whereabouts of their assigned service recipients at all times and conduct checks at a maximum interval of ten minutes. (Hearing testimony of the Investigator; Justice Center Exhibits 6, 20, 25 and 26)

9. On [redacted], the Subject worked with four other staff – DSP 1[4], DSP 2[5], DSP 3[6] and DSP 4[7] – during the [redacted] shift. (Justice Center Exhibits 11 and 12) In addition, the shift supervisor, the Program Director and the Assistance Program Director were present in the IRA. (Hearing testimony of the Subject) The Subject was assigned to the Service Recipient and Service Recipient 2. (Justice Center Exhibit 12)

10. At approximately 5:50 p.m., the Subject left the Service Recipient in the first floor living room, went upstairs to the third floor, and spoke to the shift supervisor about whether her daily assignment also included community inclusion. (Hearing testimony of the Subject; Justice Center Exhibit 7) The Subject did not remember where she left Service Recipient 2 but recalled that both DSP 1 and DSP 3 were in the living room when she went to the third floor. (Hearing testimony of the Subject) The Subject did not communicate with either DSP 1 or DSP 3 to transfer supervision of the Service Recipient or Service Recipient 2. (Hearing testimonies of the Subject and Investigator; Justice Center Exhibits 6, 27 and 34)

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[4] DSP 1 was [redacted].
[5] DSP 2 was [redacted].
[6] DSP 3 was [redacted].
[7] DSP 4 was [redacted].

11. The Shift Supervisor went downstairs to the first floor with the Subject to look at the bulletin board for community inclusion and informed the Subject that she was not assigned to community inclusion. While the Shift Supervisor was on the first floor, she conducted a head count and noticed that the Service Recipient was missing. The Shift Supervisor yelled out asking where the Service Recipient was as she ran to the second floor and observed DSP 4 sitting next to one of DSP 4's assigned service recipients. (Justice Center Exhibits 7, 8, 22 and 26)

12. Approximately six minutes after first going downstairs with the Subject, the Shift Supervisor went downstairs again to the first floor yelling out for another headcount. The Shift Supervisor found the Subject mopping the dining room floor. The Shift Supervisor instructed the Subject to help her look for the Service Recipient. As the Shift Supervisor and the Subject exited the front steps of the IRA, a neighbor came up the front steps and told them that the Service Recipient was outside a few doors down. The Shift Supervisor directed the Subject to find the Service Recipient as she went to the third floor and reported to the Program Director and Assistant Program Director that the Service Recipient eloped. (Justice Center Exhibits 8, 22, 24, 26 and 36)

13. DSP 1 and the Subject found the Service Recipient sitting in front of [redacted] on the ground, two doors north of the IRA. (Justice Center Exhibit 8) As a preventive measure and pursuant to facility policy, the Service Recipient was taken to [redacted] Hospital Medical Center Emergency Room for evaluation and was found to have no injuries. (Hearing testimony of the Investigator; Justice Center Exhibits 6 and 9)

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 36) The investigation underlying the substantiated report was conducted by the Investigator, who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and presented one document. (Subject Exhibit A)

The Administrative Law Judge presiding over the hearing admitted one document. (ALJ Exhibit 1)

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 credible evidence demonstrates that the Subject had a duty to transfer supervision of the Service Recipient to another staff member by communicating with the specific staff member when she needed to take a break. While a copy of the written policy was not provided, the Subject in her testimony admitted that she was trained on the various supervision policies during her orientation. She further testified that she understood that she had to ask the other staff member to watch her assigned service recipients while she took a break. (Hearing testimonies of the Investigator and the Subject)

Following the incident, the Subject was re-trained on the facility's supervision policy. The retraining confirmed that if the Subject had to leave an area, the Subject had to do an "appropriate turn over" which required the Subject to ask a specific staff member to watch a specific service recipient. (Hearing testimony of the Investigator; Justice Center Exhibit 20)

The credible evidence demonstrates that the Subject breached her duty when she failed to comply with the facility's supervision policy. By her own admission, the Subject did not make any attempt to transfer supervision of the Service Recipient prior to going upstairs to the third floor. The Subject admitted that she "forgot" to ask the other staff to watch the Service Recipient. (Justice Center Exhibit 27) The Subject's inability at the hearing to recollect whether she spoke to either DSP 1 or DSP 3 and what she told them, if anything, is not credited any weight considering her prior admission to the Investigator, and the lack of any corroborating evidence from either DSP 1 or DSP 3 that they were asked or that they agreed to take over supervision of the Service Recipient. (Hearing testimony of the Subject; Justice Center Exhibits 23, 28, 31 and 32) The

Subject's reliance on the "reasonable expectations" of other staff to watch her assigned Service Recipient is both unreasonable and irrational considering that the Subject failed to take any affirmative action to turn over or attempt to turn over supervision. (Hearing testimony of the Subject; Justice Center Exhibit 2)

The Subject's compliance of duties was not impossible. The Subject did not have an emergency necessitating her immediate in person communication with the Shift Supervisor. The Subject could have used the telephone in the first-floor hallway as she went from the dining room to the living room or from the living room to the third floor without breaching her supervision to the Service Recipient. (Hearing testimony of the Subject; Justice Center Exhibit 7; ALJ Exhibit 1) The fact that the Shift Supervisor did not always answer the telephone is not an excuse for failing to turn over supervision of the Service Recipient.

The credible evidence demonstrates that although the Service Recipient did not sustain any physical injury, the Subject's breach of duty was likely to result in physical injury or a serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. The Subject's breach of duty resulted in the Service Recipient eloping. The Service Recipient was alone in the community without supervision for at least six minutes and such injury and impairment was likely to occur considering the Service Recipient was non-verbal, functioned within the profound range of intellectual disability, had a history of seizures and was at risk of falling. (Justice Center Exhibits 7, 8, 10, 18, 19 and 22)

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 abuse or 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: October 4, 2019
Brooklyn, New York

Susanna Requets, ALJ