STATE OF NEW YORK JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS

In the Matter of the Appeal of

Pursuant to § 494 of the Social Services Law

FINAL
DETERMINATION
AND ORDER
AFTER HEARING
Adjud. Case #:

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: November 18, 2020

Schenectady, New York

Elizabeth M. Devane, Esq. Administrative Hearings Unit

Elyiber M. Devane

cc. Vulnerable Persons' Central Register Amanda Smith, Esq.

, Subject, Pro se

STATE OF NEW YORK JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS

In the Matter of the Appeal of

RECOMMENDED DECISION AFTER HEARING

Pursuant to § 494 of the Social Services Law

Adjud. Case #:

Before: Sharon Golish Blum

Parties:

Administrative Law Judge

Held at: New York State Justice Center for the Protection

of People with Special Needs

125 East Bethpage Road, Suite 104

Plainview, New York 11803

On:

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.

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating (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:

- The VPCR contains a substantiated report dated
 of neglect by the Subject of a Service Recipient.
- 2. The Justice Center's Report of Substantiated Finding concluded that:

Allegation 1

It was alleged that on the overnight shift between and , at the , located at , while a custodian, you committed neglect when you failed to provide proper supervision to a service recipient, resulting in her being assaulted.

This allegation has been SUBSTANTIATED as Category 1 neglect pursuant to Social Services Law § 493(4)(a).

- An Administrative Review was conducted and, as a result, the substantiated report was retained.
- 4. The facility, located at ______, located at ______, located at ______, is an Intermediate Care Facility (ICF) for females, that is operated by ______, which is certified by the New York State Office for

People With Developmental Disabilities (OPWDD) and is, therefore, a provider agency that is

subject to the jurisdiction of the Justice Center. (Hearing testimony of Justice Center Investigator (Investigator))

- 5. At the time of the alleged neglect, the Service Recipient was a verbal, ambulatory forty-three-year-old female whose diagnoses included schizoaffective disorder, borderline personality disorder, mild intellectual disability and pica. The Service Recipient required 1:1 supervision at all times, including during her sleeping hours, due to her behaviors. (Justice Center Exhibit 9) The Service Recipient was assessed and found to be unable to give informed consent to sexual contact. (Justice Center Exhibit 10)
- 6. At the time of the alleged neglect, the Subject was employed at the facility by as a Direct Support Professional (DSP) and was assigned the overnight shift from on the facility on the direct supervision to the Service Recipient from 10:30 a.m. until 2:30 a.m. (Hearing testimony of the Investigator; Justice Center Exhibit 11) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).
- 7. The facility policy regarding 1:1 supervision required staff to remain at arm's length from the Service Recipient when she was awake and that they were to stay in her bedroom while she slept, unless the Service Recipient requested privacy, wherein staff were to stay immediately outside her bedroom door, with the door ajar, maintaining line of sight supervision. (Hearing testimony of DSP 1; Justice Center Exhibit 30: Audio interview of the Residential Manager)
- 8. Upon commencing her 1:1 supervision of the Service Recipient, the Subject stationed herself immediately outside the Service Recipient's bedroom door, but at some point before 1:00 a.m., the Subject moved her chair to a location down the hall from the Service Recipient's bedroom, closer to an electrical outlet for the purpose of recharging her cellphone, a

place from which she was unable to maintain 1:1 supervision of the Service Recipient. (Hearing testimony of the Subject; Justice Center Exhibit 30: audio interrogation of the Subject)

- 9. At some point between 1:00 a.m. and 1:17 a.m., the Subject observed a male individual (man) enter the hallway from an unused office behind where she was sitting. The Subject asked him who he was, and the man responded by providing his first name. The Subject asked him what he was doing there, and he responded by saying that he was there to "check on the girls." The man walked past the Subject, down the hall and entered the Service Recipient's bedroom. After the man moved away from the Subject, she telephoned the Residential Manager, but was initially unable to reach her. The Subject attempted to telephone the Residential Manager again and when the Residential Manager answered, the Subject asked her if a man was supposed to be in the facility to do bed checks, to which the Residential Manager replied "no" and instructed the Subject to get him out of there and call the police. (Hearing testimony of the Subject; Justice Center Exhibits 17, 24 and 30: audio interrogation of the Subject)
- 10. Once inside the Service Recipient's bedroom, the man slapped the Service Recipient on the face twice to awaken her, forced her onto the floor, tore off her clothes, threatened to kill her if she made any noise and raped her. (Justice Center Exhibit 19)
- 11. After her conversation with the Residential Manager, the Subject located DSP 1 in the living room and advised her that there was a man in the Service Recipient's bedroom. Thereafter, the Subject took no further steps and waited in the hallway for other staff to enter the Service Recipient's bedroom to confront the man. (Hearing testimonies of the Subject and DSP 1; Justice Center Exhibits 17, 24, 27 and 30: audio interview of DSP 1 and audio interrogation of the Subject)
- 12. Upon hearing that there was a man in the Service Recipient's bedroom, DSP 1 ran to the kitchen, where she unsuccessfully attempted to secure a knife for self-defense, and then

recruited DSP 2 to assist her in confronting the man. DSPs 1 and 2 observed that the Service Recipient's bedroom door was shut and that the room was dark. They opened the door, turned on the lights and found the Service Recipient on the floor naked. When the DSPs asked her where the man was, the Service Recipient looked at the closet. DSPs 1 and 2 then approached the closet and while DSP 2 face-timed the encounter with the Residential Manager. DSP 1 opened the door and jumped back when she observed the man standing in the closet with his pants down. DSP 1 yelled at him and told him to "get the hell out," which he did immediately by backtracking through a window in the unused office, which was how he had initially gained access to the facility. (Hearing testimony of DSP 1; Justice Center Exhibits 25, 27 and 30: audio interviews of DSP 1 and DSP 2)

- 13. DSP 1 attempted to pursue the man but was prevented from following him when the unused office door locked after him. DSP 1 then telephoned 911 and police arrived shortly thereafter. It was determined that the man was a service recipient who was known to the Service Recipient; that he resided in another facility and that he had gained access to the facility by removing a window screen and opening the window which led into the unused office. (Hearing testimony of DSP 1; Justice Center Exhibits 25, 27 and 30: audio interviews of DSP 1 and DSP 2)
- 14. Thereafter, the Subject did not resume 1:1 supervision of the Service Recipient but, instead, began to supervise another service recipient elsewhere in the facility. When the other staff, the Residential Manager and the police investigators attempted to question the Subject immediately after the incident, the Subject was not cooperative and provided very little information regarding what had transpired. (Hearing testimony of DSP 1; Justice Center Exhibit 30: audio interviews of DSP 1, DSP 2 and the Residential Manager)
 - 15. On

Degree in the New York State Court with respect to the incident. (Justice Center Exhibit 28)

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 allegation constitutes 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 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 abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488. Under SSL § 488(1)(h) neglect is defined as:

"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 1, which is defined as follows:

- (a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, the relevant provision of which includes...
 - (vi) any conduct that is inconsistent with a service recipient's individual treatment plan or applicable federal or state laws, regulations or policies, that encourages, facilitates or permits another to engage in any conduct in violation of article one hundred thirty of the penal law, with a service recipient.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the act of neglect alleged in the substantiated report that is the subject of the proceeding and that such act constitutes 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 Category 1 neglect, as described in Allegation 1 of the substantiated report.

In support of its substantiated findings, the Justice Center presented evidence obtained during the investigation. (Justice Center Exhibits 1-30) The investigation underlying the

substantiated report was conducted by the Investigator, who, together with DSP 1, testified as witnesses for the Justice Center.

The Subject testified at the hearing and provided Subject Exhibit 1 in her own behalf.

A finding of neglect requires that a preponderance of the evidence establishes that the Subject was a custodian who owed a duty to the Service Recipient, that she breached that duty, and that the 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 this case, the facts are largely undisputed. The Subject admitted in her testimony and her interrogation statement (Justice Center Exhibit 30) that she was aware that the Service Recipient required 1:1 supervision at all times; that she moved her chair away from the Service Recipient's bedroom door down the hall to charge her cellphone; that she did not require the man to provide identification when, at some time after 1:00 a.m., he indicated that he was there to "check on the girls"; that she did not immediately, or at any time, telephone 911 for police assistance; that she did not attempt to stop the man or accompany him to the Service Recipient's bedroom; that at no time did she enter the Service Recipient's bedroom to assist with confronting the man and/or providing care to the Service Recipient; and that after the incident, she did not resume supervision of the Service Recipient while the Service Recipient was being attended to and questioned by the police investigators.

The Subject testified that everything happened very quickly; that she was afraid of the man, who was a large, heavy set, strong looking person whom she did not recognize; that the man walked past her as she questioned him; that she immediately telephoned the Residential Manager; that, despite the Residential Manager's instruction to get the man out of there, she decided to notify other staff of his presence first in an attempt to maintain everyone's safety; that she was being

cautious as they all were potential targets; that she did not do anything wrong, such as running away or hiding, but rather was trying to make sure everything was alright; that, although she did not telephone the police, she answered their questions when they responded to DSP 1's 911 call; that she did what she could under the circumstances; and that she felt the allegation against her was unjustified, as the man was the one who impersonated staff and perpetrated the abuse; and that she should not have been penalized because she disclosed the man's presence to the Residential Manager.

The Subject argued that she did not abuse the Service Recipient; that she did her job by questioning the man and stopping him; that she did her best to take steps to ensure everybody's safety; that the man should not have entered the facility and impersonated staff; that, as all of the overnight staff and service recipients were females, they were all potential targets; and that carrying out the Residential Manager's instruction to get the man out of there would have been unsafe, as it might have posed a danger to her to "chase down this big heavy set guy."

The evidence established that the Subject had a duty to provide 1:1 supervision to the Service Recipient, which she breached by moving her chair away from the Service Recipient's bedroom door to charge her cellphone and, more consequently, by failing to ensure the Service Recipient's safety by maintaining the prescribed supervision after the Subject's interaction with the unknown man. As a result of the Subject's breach of duty, the man found the Service Recipient alone and unsupervised and exploited the opportunity to repeatedly slap the Service Recipient on the face, force her onto the floor, tear off her clothes, threaten to kill her and rape her, all of which certainly meets the criteria of not only physical injury, but also, undoubtedly, a serious impairment of the Service Recipient's physical, mental and emotional condition. Accordingly, the Justice Center has established that the Subject did commit an act of neglect under SSL § 488(1)(h).

The Justice Center argued that the Subject's conduct constituted Category 1 neglect under

SSL § 493(4)(a)(vi) which, in this case, would be defined as any conduct that was inconsistent with the Service Recipient's individual treatment plan...or policies, that...permitted another to engage in any conduct in violation of article one hundred thirty of the penal law, with the Service Recipient. Here, the Service Recipient's Annual Report dated (Justice Center Exhibit 8) and Psychological Review (Justice Center Exhibit 9) both indicate that the Service Recipient's protocol called for 1:1 supervision at all times. The Subject's conduct of moving her chair away from the Service Recipient's bedroom door to charge her cellphone and of failing to maintain the prescribed supervision of Service Recipient knowing that the unknown man had entered the Service Recipient's bedroom was inconsistent with the Service Recipient's well documented supervision level. Furthermore, the Subject's conduct permitted the man to rape the Service Recipient, which was a violation of New York State Penal Law §130.25.1, which states that a person is guilty of rape in the third degree when "he or she engages in sexual intercourse with another person who is incapable of consent by reason of some factor other than being less than seventeen years old..." Here, the Service Recipient was determined to have been unable to give consent to sexual conduct. (Justice Center Exhibit 10)

Given the finding that the Subject's breach of duty to the Service Recipient met the test of serious conduct under SSL § 493(4)(a)(vi), it is determined that the category of the affirmed substantiated serious neglect was properly substantiated as a Category 1 act.

A substantiated Category 1 finding of abuse and/or neglect will result in the Subject being placed on the VPCR Staff Exclusion List and the fact that the Subject has a substantiated Category 1 report will be disclosed to entities authorized to make inquiry to the VPCR. Substantiation of a Category 1 offense permanently places the Subject on the Staff Exclusion List.

DECISION:

The request of

, that the substantiated report dated

of neglect by the Subject of the

Service Recipient 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 1 act.

This decision is recommended by Sharon Golish Blum, Administrative Hearings Unit.

DATED:

November 2, 2020 Plainview, New York

> Sharon Golish Blum, Esq. Administrative Law Judge