

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

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In the Matter of the Appeal of

████████████████████

Pursuant to § 494 of the Social Services Law

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**FINAL  
DETERMINATION  
AFTER HEARING**

**ADJUDICATION CASE**

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Vulnerable Persons' Central Register  
Justice Center for the Protection of People with  
Special Needs  
161 Delaware Avenue  
Delmar, New York 12054-1310  
Appearance Waived

Justice Center for the Protection of People with  
Special Needs  
161 Delaware Avenue  
Delmar, New York 12054-1310  
By: Juliane O'Brien, Esq.

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By: Nicole Murphy, Esq.  
Fine, Olin and Anderman, LLP  
39 Broadway, Suite 1910  
New York, New York 10006

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The Findings of Fact and Conclusions of law are incorporated from the Recommendations of the presiding Administrative Law Judge's Recommended Decision.

**ORDERED:** The request of [REDACTED] [REDACTED] that the substantiated report [REDACTED] 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 properly determined that the Subject's neglect of the service recipient constituted a Category three finding.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(c).

[Type text]

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:** Schenectady, New York  
January 23, 2015

A handwritten signature in black ink, appearing to read "David Molik", written over a horizontal line.

David Molik  
Administrative Hearings Unit

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

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In the Matter of the Appeal of

████████████████████

Pursuant to § 494 of the Social Services Law

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**RECOMMENDED  
DECISION  
AFTER  
HEARING**

**ADJUDICATION CASE**

████████████████████

Before: Sharon Golish Blum  
Administrative Law Judge

Held at: Adam Clayton Powell Jr. State Office Building  
163 W 125th Street  
New York, New York 10027  
On: ████████████████████

Parties: Vulnerable Persons' Central Register  
Justice Center for the Protection of People with  
Special Needs  
161 Delaware Avenue  
Delmar, New York 12054-1310  
Appearance Waived

Justice Center for the Protection of People with  
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By: Julianne O'Brien, Esq.

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By: Nicole Murphy, Esq.  
Fine, Olin and Anderman, LLP  
39 Broadway, Suite 1910  
New York, New York 10006

## JURISDICTION

The New York State Vulnerable Persons' Central Register (hereinafter "the VPCR") maintains a report substantiating [REDACTED] (hereinafter "the Subject") for neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a Subject of a 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.

## 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 [REDACTED], dated [REDACTED] of abuse and/or neglect of Service Recipient A, by the Subject.
2. The initial report alleges, in pertinent part, that on [REDACTED], the Subject, [REDACTED], committed an act of neglect at the [REDACTED], located at [REDACTED] (hereinafter "the facility") when she was responsible to supervise Service Recipient A, and other patients, at the on-campus dental clinic. During that time, the Subject fell asleep, allowing Service Recipient A to escape. (Justice Center Exhibit 4)
3. The initial report was investigated by the facility Risk Manager, [REDACTED] and subsequently referred to the Justice Center for the Protection of People with Special Needs (hereinafter "the Justice Center").
4. On or about [REDACTED], the Justice Center substantiated the report against the Subject for *neglect*. The Justice Center concluded that:

**Offense 1**

On [REDACTED], at the [REDACTED], located at [REDACTED], while acting as custodian (MHTA), you committed an act of neglect by failing to provide adequate supervision to a service recipient when you fell asleep while on duty.

This offense has been SUBSTANTIATED as Category 3 offense pursuant to Social Services Law § 493.

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

6. At the time of the alleged neglect, the Subject had been employed since 1995 as a Mental Health Therapy Aid (hereinafter "MHTA") by the facility. The facility is operated by the New York State Office of Mental Health, which is a facility or provider agency that is subject to the jurisdiction of the Justice Center.

7. At the time of the alleged neglect, Service Recipient A, had a primary diagnosis of schizophrenia, and had been a patient at the facility for four months. Service Recipient A had previously attempted to escape the facility. (Justice Center Exhibit 17)

8. At 8:00 A.M. on the morning of [REDACTED], MHTA [REDACTED] started a second consecutive overtime shift, having worked at the facility from 11:30 P.M. until 8:00 A.M. the preceding night.

9. That morning, the Subject and another aid, MHTA [REDACTED], were assigned to escort approximately eleven patients from their units to the on-campus dental clinic, located in an adjacent building that is accessed through an underground tunnel that connects the two buildings. (Testimony of MHTA [REDACTED]; Subject)

10. When MHTA [REDACTED] picked up Service Recipient A from his unit, Ward [REDACTED], to escort to him to the dental clinic, on duty RN [REDACTED] gave instructions to MHTA

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██████████ that included the direction to watch Service Recipient A carefully. (Testimony of MHTA ██████████; Subject)

11. When they arrived at the dental clinic, MHTA ██████████ was to stay in the waiting area, supervising the patients who were waiting for their appointments. MHTA ██████████ was to take the patients who were finished back to their respective units and pick up more patients who were scheduled to see the dentist. (Testimony of MHTA ██████████; Subject)

12. There are three doors in the dental clinic waiting room area: a locked door that leads to the basement corridor of the building, a locked door that leads to the dentist's office area and a fire door that leads to the gated building parking lot. The fire door is several feet higher than the waiting room floor at the top of a small stairwell with some stairs on one side and a wheelchair lift on the other. Across the front of the fire door is a railing that leads to the stairs and just below the front, is one of the many chairs for the people waiting. The fire exit is an unmarked plain door that has a horizontal push bar mechanism to open it. No alarm is sounded when it is opened. Neither MHTA ██████████ nor facility Risk Manager ██████████ were aware that the fire exit door was unlocked from the inside. (Testimony of ██████████ and MHTA ██████████; Subject)

13. At approximately 10:25 A.M., MHTA ██████████ was supervising between six to eight patients in the dental clinic waiting room. She was seated on the chair located immediately in front of and below the fire exit stairwell, with her back to the door. All of the patients were seated directly across from MHTA ██████████ except Service Recipient A, who did not sit down and, instead, was pacing back and forth. (Justice Center Exhibit 4)

14. At some point, MHTA ██████████ fell asleep. While MHTA ██████████ was asleep, Service Recipient A went up the stairs to the fire exit and, after determining that it was unlocked,

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escaped through the unlocked door by pushing on the horizontal bar. (Justice Center Exhibit 4)

15. Immediately after Service Recipient A fled, MHTA ██████████ woke up and took steps to alert facility Security personnel of his escape. Security personnel had observed Service Recipient A running through the gate and were already in pursuit. (Testimony of MHTA ██████████; Subject)

16. Thereafter, Service Recipient A was located by facility Safety personnel and returned to the facility at approximately 11:30 A.M., approximately one hour after he had fled. (Justice Center Exhibit 4)

### **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 or neglect.
- Pursuant to Social Services Law § 493(4), the category level of abuse that such act or acts constitute.

### **APPLICABLE LAW**

The Justice Center is responsible for investigating allegations of abuse 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 or 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 evidence that the alleged act or acts of abuse or neglect occurred,...” (Title 14 NYCRR 700.3(f))

Pursuant to SSL §§ 494(1)(a)(b) and (2), and Title 14 NYCRR § 700.6(b), this hearing decision will determine: whether the Subject has been shown by a preponderance of the

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evidence to have committed the act or acts giving rise to the substantiated report, and if there is a finding of a preponderance of the evidence; whether the substantiated allegations constitute abuse or neglect; and pursuant to Social Services Law § 493(4), the Category of abuse or neglect that such act or acts constitute.

The abuse and neglect of a person in a facility or provider agency is defined by SSL § 488:

1. "Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:
  - (a) "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.
  - (b) "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.
  - (c) "Psychological abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by verbal or non-verbal conduct, a substantial diminution of a service recipient's emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor, or causing the likelihood of such diminution. Such conduct may include but shall not be limited to intimidation, threats, the display of a weapon or other object that could reasonably be perceived by a service

recipient as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments or ridicule.

- (d) "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.
- (e) "Use of aversive conditioning," which shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the absence of a person-specific authorization by the operating, licensing or certifying state agency pursuant to governing state agency regulations. Aversive conditioning may include but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.
- (f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.
- (g) "Unlawful use or administration of a controlled substance," which shall mean any administration by a custodian to a service recipient of: a controlled substance as defined by article thirty-three of the public health law, without a prescription; or other medication not approved for any use

by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article thirty-three of the public health law, at the workplace or while on duty.

- (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.

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 abuse or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the Category of abuse and neglect set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

Substantiated reports of abuse or neglect shall be categorized into categories pursuant to SSL § 493:

4. Substantiated reports of abuse or neglect shall be categorized into one or more of the following four categories, as applicable:
  - (a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:

(i) intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur;

(ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;

(iii) threats, taunts or ridicule that is likely to result in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

(iv) engaging in or encouraging others to engage in cruel or degrading treatment, which may include a pattern of cruel and degrading physical contact, of a service recipient, that results in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

(v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;

(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;

(vii) any conduct encouraging or permitting another to promote a sexual performance, as defined in subdivision one of section 263.00 of the penal law, by a service recipient, or permitting or using a service recipient in any prostitution-related offense;

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- (viii) using or distributing a schedule I controlled substance, as defined by article thirty-three of the public health law, at the work place or while on duty;
- (ix) unlawfully administering a controlled substance, as defined by article thirty-three of the public health law to a service recipient;
- (x) intentionally falsifying records related to the safety, treatment or supervision of a service recipient, including but not limited to medical records, fire safety inspections and drills and supervision checks when the false statement contained therein is made with the intent to mislead a person investigating a reportable incident and it is reasonably foreseeable that such false statement may endanger the health, safety or welfare of a service recipient;
- (xi) knowingly and willfully failing to report, as required by paragraph (a) of subdivision one of section four hundred ninety-one of this article, any of the conduct in subparagraphs (i) through (ix) of this paragraph upon discovery;
- (xii) for supervisors, failing to act upon a report of conduct in subparagraphs (i) through (x) of this paragraph as directed by regulation, procedure or policy;
- (xiii) intentionally making a materially false statement during an investigation into a report of conduct described in subparagraphs (i) through (x) of this paragraph with the intent to obstruct such investigation; and
- (xiv) intimidating a mandated reporter with the intention of preventing him or her from reporting conduct described in subparagraphs (i) through (x) of this paragraph or retaliating against any custodian making such a report in good faith.
- (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.
- (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.

- ██████████
- (d) Category four shall be conditions at a facility or provider agency that expose service recipients to harm or risk of harm where staff culpability is mitigated by systemic problems such as inadequate management, staffing, training or supervision. Category four also shall include instances in which it has been substantiated that a service recipient has been abused or neglected, but the perpetrator of such abuse or neglect cannot be identified.

If the Justice Center proves the alleged abuse, 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 abuse cited in the substantiated report constitutes the Category of abuse set forth in the substantiated report.

If the Justice Center did not prove the abuse and/or neglect by a preponderance of evidence, the substantiated report must be amended and sealed.

### **DISCUSSION**

The issue in this case is whether MHTA ██████████ conduct constituted abuse and/or neglect under SSL § 488(1)(h) when she failed to provide adequate supervision to Service Recipient A by falling asleep while on duty. The Justice Center has succeeded in establishing by a preponderance of evidence that the Subject, MHTA ██████████, did commit the abuse and/or neglect as alleged in the substantiated report.

In support of its indicated findings, the Justice Center presented a number of documents obtained during the course of investigation. (Justice Center Exhibits 1-18) The investigation underlying the substantiated report was conducted by facility Risk Manager, ██████████ who, along with RN ██████████, were the two witnesses who testified for the Justice Center at the hearing. Signed statements were obtained from Service Recipient A, and another patient, Service Recipient B. MHTA ██████████ testified on her own behalf at the hearing.

The Justice Center's witness, RN ██████████ hearing testimony was that, on ██████████

██████████, when MHTA ██████████ had attended Ward ████ to pick up the patients scheduled for dental appointments that morning, RN ██████████ had warned MHTA ██████████ that Service Recipient A was an escape risk, as he had escaped before, and that she should watch him carefully. (Testimony of ██████████)

An email that RN ██████████ had sent to Risk Manager ██████████ dated ██████████, is consistent with her testimony and states that:

On ██████████, patient Service Recipient A went to the dental clinic with staff ██████████ and ██████████. Patient escaped from the dental clinic. Staff ██████████ was told that he was an escape risk. (Justice Center Exhibit 14)

MHTA ██████████ admitted in hearing testimony that RN ██████████ had warned her to watch Service Recipient A closely, but she could not remember the reason for the special instruction. (Testimony of MHTA ██████████; Subject)

It was clear that RN ██████████ testimony was a truthful and accurate account of her ██████████, conversation with MHTA ██████████. She had no reason to fabricate and no interest in the outcome of this matter. Accordingly, RN ██████████ hearing testimony is credited evidence.

The evidence that MHTA ██████████ had fallen asleep on duty at the time that Service Recipient A escaped from the facility through the fire exit door is based primarily on the signed statements of patients Service Recipient A and Service Recipient B, and on Risk Manager ██████████ evidence regarding his interviews with them. There were no other staff present as the dental staff members were with a patient in the dental office and MHTA ██████████ had left the area to escort other patients.

Risk Manager ██████████ interviewed and took the statement from Service Recipient B. Other than Service Recipient A, Service Recipient B was the only person in the dental clinic waiting area who was able to provide an account of what he saw. The other patients who had

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been present at the time were either asleep or could not coherently answer questions. (Testimony of ██████████)

Both Service Recipients' written and verbal statements are hearsay evidence. Hearsay is admissible in administrative proceedings and an administrative determination may be based solely upon hearsay evidence under appropriate circumstances. *Gray v. Adduci*, 73 N.Y.2d 741 (1988), 300 *Gramatan Avenue Associates v. State Division of Human Rights*, 45 N.Y.2d 176 (1978), *Eagle v. Patterson*, 57 N.Y.2d 831 (1982), *People ex rel Vega v. Smith*, 66 N.Y.2d 130 (1985). A crucial concern with respect to hearsay evidence is the inability to cross-examine the person who originally made the statement in order to evaluate his or her credibility. Such evidence, then, must be carefully scrutinized and weight attributed to it would depend upon its degree of apparent reliability. Factors to be considered in evaluating the reliability of hearsay include: the circumstances under which the statements were initially made, information bearing upon the credibility of the person who made the statement and his or her motive to fabricate, and the consistency and degree of inherent believability of the statements.

According to Risk Manager ██████████, Service Recipient B's answers in the interview were consistent with his handwritten signed statement dated ██████████, which indicates that:

About fifteen minutes after arriving, I saw patient ██████ begin to pace in the waiting area. The staff at some point fell asleep and Service recipient A hopped over the railing to the stairs and began to play with the push bar on the door. He did this for about 1.5 minutes. He would push the door lock to see if it would open and peek at the lookout glass. At that point, I go (sic) to the bathroom and I hear staff yell out... when I came out of the bathroom and the patient ██████ was gone. (Justice Center Exhibit 6).

Counsel for MHTA ██████████ argued that Service Recipients B's credibility was diminished, firstly, because he was a patient in the facility and secondly, because a question was raised regarding the matter of how he had gotten into the locked bathroom during the incident, a

fact that is referred to in his statement. These concerns do not adversely affect his credibility. Service Recipient B was a disinterested witness who had no reason to fabricate his version of events and his statement is credited as such.

Initially, Service Recipient A refused to answer questions regarding the incident. However, on [REDACTED], Service Recipient A provided a signed statement that:

On [REDACTED], I was escorted to the dental clinic by staff. When we arrived to the dental clinic. (sic) Shortly after the staff went to sleep and I left. I don't know her name. (Justice Center Exhibit 7).

Service Recipients A's statement is a short simple explanation of what happened when he escaped. There was no benefit to him to invent the detail that MHTA [REDACTED] had fallen asleep if she had not and he had no interest in the outcome of the investigation.

MHTA [REDACTED] insisted, both in her hearing testimony and her earlier recorded interview, that she had not fallen asleep. MHTA [REDACTED] consistently stated that Service Recipient A had been pacing back and forth in front of her and that he suddenly jumped up to the top of the stairs leading to the fire exit door opened it and ran right through it. MHTA [REDACTED] repeated avowal that she had not fallen asleep was not convincing testimony.

The fact that the escape occurred under MHTA [REDACTED] watch on a second consecutive second shift in the mid-morning, after she had already worked through the night, must also be taken into account. MHTA [REDACTED] was tired and had been sitting in what, by all accounts, was a quiet dental office waiting room, for approximately 45 minutes when Service Recipient A escaped.

In this case, we have the sworn testimony of MHTA [REDACTED], the Subject of this hearing. Unlike Service Recipients A and B, who have no motive to fabricate and no interest in the outcome of this hearing, MHTA [REDACTED] has a good reason to be less than candid with her

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evidence, namely the preservation of her employment. Her insistence that she did not fall asleep qualifies as testimony that is “inherently incredible.” The statements of Service Recipients A and B are accepted and, as such, they prove that MHTA ██████████ did fall asleep while on duty, thereby allowing Service Recipient A to escape.

While there was some evidence regarding staffing ratios and the fact that the door which Service Recipient A escaped through was unlocked, these concerns are not particularly relevant to the issue of the alleged neglect in this case.

In the final analysis the evidence shows that ██████████ had been warned that Service Recipient A was an escape risk and that she had fallen asleep while on duty. Her conduct did constitute neglect under SSL§488(1)(h) as it was “...inaction or lack of attention that breaches a custodian's duty ... 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...” Included under that definition is subsection (ii) which further defines neglect as “...failure to provide proper supervision...”

██████████ failed to provide adequate supervision to Service Recipient A when she fell asleep while on duty. The language of SSL§488(1)(h) is very specific and clearly contemplates the type of situation as has arisen in this case.

The Justice Center has met its burden of showing by a preponderance of the evidence that ██████████ committed the neglect alleged in the substantiated report. The substantiated report will not be amended.

The conduct as alleged and the substantiation of the report having both been determined, pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the act cited in the substantiated report constitutes the category of abuse or neglect set forth in

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the substantiated report. Pursuant to SSL § 493(4), the act cited does fit within the meaning of Category three abuse or neglect, that is, "...abuse or neglect by custodians that is not otherwise described in categories one and two."

A substantiated Category three finding of abuse or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that she has a substantiated Category three report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to NY SSL § 496 (2). This report will be sealed after five years.

**DECISION:** The request of ██████████ ██████████ that the substantiated report ██████████ dated ██████████ be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report properly determined that the Subject's neglect of the service recipient constituted a Category three finding.

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

**DATED:** January 8, 2015  
Spring Valley, New York

  
Sharon Golish Blum, Esq.  
Administrative Law Judge