

**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
AFTER HEARING**

Adjud Case #:

[REDACTED]

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

New York State Justice Center for the Protection
of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Christopher Mirabella, Esq.

[REDACTED]

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

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

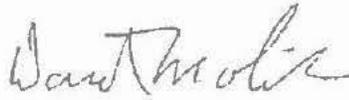
ORDERED: The request of [REDACTED] that the report "substantiated" on [REDACTED] [REDACTED] dated and received on [REDACTED] [REDACTED] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

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

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).

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
July 24, 2015



David Molik
Administrative Hearings Unit

**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**

[REDACTED]

Before:

Sharon Golish Blum
Administrative Law Judge

Held at:

Adam Clayton Powell State Office Building
163 West 125th Street
New York, New York 10027
On: **[REDACTED]**

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 Special
Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Christopher Mirabella, Esq.

[REDACTED]

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 (the VPCR) maintains a report substantiating [REDACTED] (the Subject) for abuse and/or 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 report "substantiated" on [REDACTED], [REDACTED] [REDACTED] dated and received on [REDACTED] of abuse and/or neglect by the Subject of a Service Recipient.

2. The Justice Center substantiated the report against the Subject. The Justice Center concluded that:

Offense 1

It was alleged that on [REDACTED], in Building [REDACTED] at the [REDACTED] [REDACTED], located at [REDACTED], while acting as a custodian, you committed neglect when you failed to follow procedure when you discovered that a service recipient was not in his room during bed checks.

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

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

4. The facility, the [REDACTED], located at [REDACTED] [REDACTED], is a secure [REDACTED]

██████████
Recipient had been visiting with family members on the first floor of Building █. (Justice Center Exhibit 4)

8. A security camera video reveals that the Service Recipient's family left the facility at approximately 8:30 p.m. that evening. (Justice Center Exhibit 19)

9. After the visit, the Service Recipient returned to the █ Wing, changed his shirt and went to the nurse's station, which is located on the same floor, but not on the █ Wing, where he requested and received insulin. (Justice Center Exhibit 4)

10. The Subject did not see the Service Recipient between the time that the Service Recipient returned to the █ Wing, at approximately 8:30 p.m. and the time that the Subject took his assigned break from 9:00 p.m. until 9:45 p.m. (Hearing testimony of ██████████; Subject)

11. A security camera video reveals that at approximately 9:05 p.m., the Service Recipient eloped from the facility by following immediately behind a pharmacy delivery person who had security door keys, as she was leaving the building. (Justice Center Exhibit 19)

12. Shortly after his return from his break at 9:45 p.m., the Subject conducted the 10:00 p.m. bed checks of the █ Wing residents and the Subject discovered that the Service Recipient was not in his room. The Subject indicated on the Bed Check Sheet (Justice Center Exhibit 7) that the Service Recipient was "O" for out of bed. The Subject looked around the █ Wing, but he did not locate the Service Recipient. (Hearing testimony of ██████████, Subject)

13. During the Subject's shift, the telephone in the █ Wing office was not in working order. Consequently, any staff that did not have use of a cell phone had to physically go out of the █ Wing to communicate with either the nurse's station or with Midlevel Supervisor (MS) ██████████ office; both of which are located on the same floor, but not in

the [REDACTED] Wing. (Hearing testimony of [REDACTED], Subject)

14. In the meantime, once outside, the Service Recipient had taken a bus to his family's neighborhood and, after seeing that his parent's houselights were dark, he went to a nearby drugstore to purchase a snack for himself. There, the Service Recipient spent some time speaking with the store security guard, whom he knew. (Justice Center Exhibit 4)

15. Once he finished at the drugstore, the Service Recipient took a taxi back to the facility. At approximately 11:00 p.m., the taxi driver telephoned facility MS [REDACTED] [REDACTED], to advise her that he had brought the Service Recipient back to the facility and that he was waiting outside to be paid. (Justice Center Exhibit 4)

16. A security camera video reveals that at approximately 11:20 p.m., the Service Recipient was escorted back into the facility by staff members. (Justice Center Exhibit 19)

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 abuse and/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 the 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 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 and/or neglect; and pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

The abuse and/or 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(s) committed the act or acts of abuse and/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/or neglect as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

Substantiated reports of abuse and/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;

(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 and/or 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 abuse and/or neglect cited in the substantiated report constitutes the category of abuse and/or neglect as 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 Justice Center has established by a preponderance of the evidence that the Subject committed a prohibited act, described as Offense 1 in the substantiated report. Specifically, the evidence establishes that the Subject committed an act of neglect by failing to follow procedure when he discovered that the Service Recipient was not in his room during routine bed checks conducted at 10:00 p.m. and 10:30 p.m. on █.

Neglect, under SSL § 488(1)(h), was established in that the Subject's "inaction or lack of attention" was a breach of his duty to the Service Recipient that was "likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition" of the Service Recipient.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-19) The investigation underlying the substantiated report was conducted by then OPWDD Internal Investigator █, who was the only witness who testified at the hearing on behalf of the Justice Center.

██████████

The Subject testified at the hearing on his own behalf and provided no other evidence.

Since the allegation of neglect is based on the Subject's failure to follow procedure, it is important to identify the procedure that the Subject should have followed upon discovering that the Service Recipient was missing.

The form that documents bed checks for each shift, the Bed Check Sheet (Justice Center Exhibit 7) provides codes and instructions in bold letters on its face immediately under the resident bed check chart. The codes correspond to the letter that should be entered on the bed check chart, depending on where each resident is at the time of the bed check. The options are: client sleeping (S), client awake (A), client out of bed (O) or client in bathroom (B). For the 10:00 p.m. and 10:30 p.m. bed checks, the Subject had written an "O" indicating that the Service Recipient was not in his bed. Under the code directions, the instruction is typed in bold, "If awake or out of bed comment on back behavior /activity (for each time check)." (Justice Center Exhibit 7)

The Bed Check Sheet requires staff to provide a written explanation of a resident's behavior or activity if the resident is not in bed during the bed checks. The Bed Check Sheet reflects the duty of the DSA to monitor the residents and to be able to account for each resident's whereabouts throughout the night.

The "██████████ Policy and Procedure Manual on the Topic of Reportable Incidents," issued in February, 2013, categorizes a "Missing Person" as a "Serious Reportable Incident." Under the subheading entitled "Missing Person," a missing person is defined as "(t)he unexpected or unauthorized absence of a person after formal search procedures have been initiated by the agency." The question of when formal search procedures must be initiated is determined on a case by case basis, but in all cases, cannot be more than four hours after the discovery of a person's absence. The facility Policy Manual then states that:

It is mandated that formal search procedures be initiated immediately upon discovery of the absence of a person whose absence constitutes a recognized and possible danger to the wellbeing of that person or others. This classification is always considered serious reportable. (Justice Center Exhibit 16)

Additionally, the facility Policy Manual requires that "(a)ny (s)taff" who "(o)bserves or discovers any situation categorized as a reportable or serious reportable incident" must notify his or her "... supervisor as quickly as possible after administering whatever emergency intervention the individual may need ..." (Justice Center Exhibit 16)

The undated OPWDD training aid entitled: "Promoting Positive Relationships and Safe Environments for People with Developmental Disabilities Participant Manual" (PRAISE) also includes, under the heading "Serious Reportable Incidents," the category entitled "Missing Person." Similar to the facility Policy and Procedure Manual, the PRAISE Manual page states that a Missing Person is:

the unexpected or unauthorized absence of a person after formal search procedures have been initiated. Formal search must begin if the person's whereabouts are unknown for four (4) hours. Formal search is initiated immediately upon discovery of absence of a person whose absence constitutes a possible danger to the wellbeing of that person or others. (Justice Center Exhibit 17)

There was ample evidence adduced by the Justice Center that the Service Recipient is a person whose absence constitutes a recognized and possible danger to his own wellbeing and the wellbeing of others. The Service Recipient has well documented issues of sexual inappropriateness, aggression and noncompliance. The Service Recipient is an insulin dependent diabetic. Moreover, the Service Recipient is required to have twenty four hour general supervision and is not allowed out of the █ Wing unsupervised. (Justice Center Exhibit 9)

The Service Recipient's "Behavioral Observation Sheets" (Justice Center Exhibit 8) explicitly focus on his sexually inappropriate, aggressive and noncompliant behaviors and are to be completed daily. The Service Recipient's "Functional Analysis of Behavior Assessment"

[REDACTED] dated [REDACTED] (Justice Center Exhibit 9) is a thirty-page detailed analysis and plan related to the aforementioned three behaviors. Furthermore, there are three Behavioral Intervention Plans (Justice Center Exhibits 11, 12 and 13) for each one of the Service Recipient's problematic targeted behaviors.

The Subject admitted on cross examination that he was aware of the Service Recipient's behavioral issues and previous criminal history at the time that he conducted the bed checks and found the Service Recipient to be missing.

The facility Policy and Procedure Manual and the PRAISE Manual both establish that the Service Recipient's absence qualified as a serious reportable incident and that a formal search should have been initiated immediately upon the discovery of his absence. Furthermore, the facility Policy and Procedure Manual requires the Subject to notify his supervisor as quickly as possible after the discovery.

The Subject's testimony as to what actions he took upon first discovering the absence of the Service Recipient at the 10:00 p.m. bed check (and again at the 10:30 p.m. bed check) diverged significantly from statements that he provided when he was interviewed by Investigator [REDACTED].

On [REDACTED], Investigator [REDACTED] conducted a recorded interview of the Subject, who stated that on [REDACTED], he had not seen the Service Recipient prior to the 10:00 p.m. bed check. Upon discovering that the Service Recipient was not in his bed at 10:00 p.m. that night, the Subject stated that he had assumed that the Service Recipient was at the nurse's station, as the Service Recipient "usually hangs around the nurse's station until 11:00 p.m." and that it was the Service Recipient's "daily routine" to be at the nurse's station until 11:00 p.m. or later.

The Subject told Investigator [REDACTED] that he did look around the [REDACTED] wing but

██████████

when he was unable to locate the Service Recipient there, he “did not worry much that he was not in bed” because the Service Recipient was “normally not in bed” until after 11:00 p.m. and that he did not think that the Service Recipient was missing. The Subject testified that he assumed that the Service Recipient was at the nurse’s station reading the newspaper or watching TV. The Subject also stated repeatedly that he was the only staff on the █ Wing for some time and that the two other staff members who were on the █ Wing were occupied by their 1:1 assignments. (Justice Center Exhibit 19)

The Subject also indicated to Investigator ██████████ that he did not really consider the possibility that the Service Recipient could have eloped. Regarding the Service Recipient, the Subject stated that he “never thought he’d get out,” that he “did not know who opened the door for him” because he did not “expect anyone to open the door for consumers like that” and that “three doors were locked to get out.” (Justice Center Exhibit 19)

The Subject further told Investigator ██████████ that he did check the nurse’s station after 10:45 p.m., but that the door was locked, and that at around 11:00 p.m. he was informed by MS ██████████ that the Service Recipient had eloped and was in the process of returning to the facility. (Justice Center Exhibit 19)

The substance of the Subject’s hearing testimony differed materially from his recorded interview. At the Hearing, the Subject’s testimony was that he did follow procedure to the best of his abilities, given the constraints of understaffing and a broken telephone.

The Subject testified that on ██████████, after he returned from his break at 9:45 p.m., he cleaned up the medication cart and brought it to the nurse’s station. He then conducted the 10:00 p.m. bed check and observed that the Service Recipient was the only █ wing resident who was not in his bed. The Subject repeatedly testified that he assumed that the Service Recipient was at the nurse’s station, as the Service Recipient regularly spent time at the nurse’s

██████████ station from anywhere around 10:00 p.m. until 11:00 p.m. or later. (Hearing testimony of ██████████, Subject)

The Subject testified that at 10:00 p.m., he was the only staff member on the wing. He was able to conduct a quick comprehensive search of the wing; checking the other bedrooms, the bathroom, the shower room, the dining room, the common room and the porch. He determined that the Service Recipient was not there. (Hearing testimony of ██████████, Subject)

The Subject testified that he then went into the █ Wing office and tried to call MS ██████████ but something was wrong with the phone, as had been the case all week. (Hearing testimony of ██████████, Subject)

The Subject testified that at approximately 10:20 p.m., he left the sleeping residents unsupervised and the Subject went to check for the Service Recipient at the nurse's station but that it was locked and no one was there. (Hearing testimony of ██████████, Subject)

The Subject testified that he asked DSA ██████████; whose shift was ending at 10:30 p.m., to tell MS ██████████, on his way out, that the Service Recipient was missing. (Hearing testimony of ██████████, Subject) Interestingly, Investigator ██████████ report of DSA ██████████ statement does not corroborate the Subject's testimony that the Subject had told DSA ██████████ that the Service Recipient was missing and had asked him to report the incident to MS ██████████. There is no mention in the investigative report of any such communication. (Justice Center Exhibit 4)

The Subject testified that after he conducted the 10:30 p.m. bed checks, and the Service Recipient was still missing, he went to the visiting room on the first floor and no one was there. The Subject testified that at approximately 11:00 p.m., he went to MS ██████████ office, assuming that she already knew that the Service Recipient was missing and that while he was there, MS ██████████ received a telephone call from the

██████████
cab driver who had brought the Service Recipient back to the facility. (Hearing testimony of ██████████, Subject)

Even according to this alternate account, the Subject's search for the Service Recipient falls short of having been initiated immediately upon discovering the Service Recipient's absence at the 10:00 p.m. bed check. Furthermore, although the Subject testified about the broken telephone and understaffing, neither of these factors prevented him from initiating a formal search immediately upon discovering the Service Recipient's absence at the 10:00 p.m. bed check; or from notifying MS ██████████ as quickly as possible after the discovery. The Subject admitted that he was familiar with the correct procedure to be followed upon the discovery of a missing person but that he did not follow procedure because he assumed that the Service Recipient was at the nurse's station and it never occurred to him that the Service Recipient had eloped.

While the statements taken from other facility staff members provided partially differing accounts of events, there were no material conflicts in evidence which need to be resolved. In any case, the entirety of the evidence establishes that the Subject's failure to follow the appropriate procedures constitutes an act of neglect.

The Subject breached his duty to properly monitor the Service Recipient. He did not follow the Bed Check Sheet protocol of writing a comment as to where the Service Recipient was when he was not in bed at either 10:00 p.m. or 10:30 p.m. Because the Subject failed to monitor the Service Recipient, as required, the discovery of the Service Recipient's elopement was delayed.

The Subject knew from his familiarity with the Service Recipient, that the Service Recipient's absence was a danger to his own wellbeing and, possibly to the wellbeing of others. He also knew that the procedure was to initiate a formal search immediately upon discovering

██████████
the Service Recipient's absence at the 10:00 p.m. bed check.

Furthermore, the facility Policy and Procedure Manual required the Subject to notify his supervisor as quickly as possible after the discovery.

By all accounts, none of the applicable procedures were followed and, under SSL § 488(1)(h), the Subject's "inaction or lack of attention" was a breach of his duty to the Service Recipient that was "likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition" of the Service Recipient.

Accordingly, in the final analysis, based on all of the evidence, it is concluded that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect as alleged in Offense 1 of the substantiated report.

Moreover, based upon the totality of the circumstances, the evidence and testimony presented, it is determined that the category of the affirmed substantiated neglect that such act constitutes was properly substantiated as a Category 3 act.

A substantiated Category 3 finding of abuse and/or 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 NY SSL § 496 (2). This report will be sealed after five years.

DECISION: The request of ██████████ that the report "substantiated" on ██████████
██████████ dated and received on ██████████
██████████ 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 Sharon Golish Blum, Administrative Hearings Unit.

DATED: July 1, 2015
Plainview, New York


Sharon Golish Blum, Esq.
Administrative Law Judge