

**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]

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: Theresa Wells, Esq.

[REDACTED]
[REDACTED]
[REDACTED]

By: Sara Frankel, Esq.
Legal Services of the Hudson Valley
7A Perlman Drive
Spring Valley, New York 10977

██████████

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 ██████████ 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 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: May 20, 2016
Schenectady, New York



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

██████████

Pursuant to § 494 of the Social Services Law

**RECOMMENDED
DECISION
AFTER
HEARING**

Adjud. Case #:

██████████

Before:

Elizabeth M. Devane
Administrative Law Judge

Held at:

Office of Children and Family Services
Spring Valley Regional Office
11 Perlman Drive
Spring Valley, New York 10977
On: ██████████

Parties:

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
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New York State Justice Center for the Protection
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By: Theresa Wells, Esq.

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Legal Services of the Hudson Valley
7A Perlman Drive
Spring Valley, New York 10977

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 findings of the report to reflect that the Subject has not committed the act of neglect giving rise to the substantiated report. The VPCR did not do so, and a hearing was 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], [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 [REDACTED], at the [REDACTED], located at [REDACTED], while acting as a custodian, you committed neglect when you failed to provide required supervision to a service recipient, during which time he left the [REDACTED] undetected.

This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

3. An Administrative Review was conducted at the request of the Subject and following that review, the substantiated report was retained.

4. The facility, located at [REDACTED], [REDACTED] is a certified [REDACTED] operated by [REDACTED]

██████████. The ██████████ in turn is an agency certified by The Office for People With Developmental Disabilities (OPWDD) which is a provider agency that is subject to the jurisdiction of the Justice Center. At the time of the alleged neglect there were five male residents at ██████████. (Hearing testimony of ██████████ Director of Investigations ██████████, Hearing testimony of Subject, Justice Center Exhibit 6)

5. At the time of the alleged neglect, the Subject had been employed by ██████████ for 18 years and had worked at ██████████ for 5 years. The Subject was employed as a Direct Support Professional (DSP). The Subject was a custodian as that term is defined in Social Services Law §488(2). The Subject was required to complete bed checks of service recipients, do light cleaning and complete required paperwork. (Hearing testimony of ██████████ Director of Investigations ██████████, Hearing testimony of Subject)

6. At the time of the alleged neglect, the Service Recipient was 18 years old, attended a local high school and had been a resident of ██████████ since ██████████ 2012. (Justice Center Exhibits 7, 11, 18, 19 and 24)

7. The Service Recipient had a history of stealing, breaking into houses and injuring himself climbing into or out of windows. The Service Recipient's Semi-Annual Individualized Service Plan (ISP) dated ██████████, dictated that, because of the Service Recipient's history of theft and elopement, staff must remain vigilant and the Service Recipient must be supervised at all times when in the residence. (Justice Center Exhibits 7 and 11).

8. The Service Recipient eloped from the facility on ██████████. As a result, ██████████ Behavior Specialist put further Program Safeguards (Safeguards) into place on ██████████ in regard to the Service Recipient. The Safeguards required staff to complete bed checks during the overnight hours every fifteen minutes during the first two hours after the

Service Recipient fell asleep, and then to complete bed checks every thirty minutes for the remainder of the shift. Staff was required to document if the Service Recipient awoke and, if that occurred, resume fifteen minute bed checks. Staff was also required to position themselves so they could see the Service Recipient if he left his room. The Overnight Shift Responsibilities sheet directed that, while staff is completing assigned chores, one staff shall complete the tasks while the other staff shall supervise the Service Recipient. (Hearing testimony of [REDACTED] Director of Investigations [REDACTED]; Hearing testimony of Subject; Hearing testimony of DSP [REDACTED]; Justice Center Exhibit 7, 8, 14)

9. The Subject signed a statement on [REDACTED] acknowledging that she read the Safeguards and that if she had any questions she would ask the Residence Manager or the Behavior Specialist. (Hearing testimony of [REDACTED] Director of Investigations [REDACTED], Hearing testimony of Subject, Justice Center Exhibits 7 and 9)

10. The Subject was on duty from 11:00 p.m. [REDACTED] until 7:00 a.m. [REDACTED]. During her shift, she was responsible for supervising the two service recipients on the first floor, specifically the Service Recipient and another service recipient. The Subject completed the Night Log for the shift indicating that she completed bed checks every 30 minutes from 11:00 p.m. to 6:00 a.m. She also did laundry and cleaned the kitchen. When not engaged in other tasks during her shift, the Subject sat on a couch in the dining room. DSP [REDACTED] was on duty on the second floor of [REDACTED] during that same shift and was responsible for the residents on that floor. (Hearing testimony of [REDACTED] Director of Investigations [REDACTED]; Hearing testimony of Subject; Hearing testimony of DSP [REDACTED]; Justice Center Exhibits 12, 13 and 28)

11. On [REDACTED], the Service Recipient disclosed that he had eloped from

██████████ around 1:00 a.m. on ██████████. The Service Recipient verified that the Subject was asleep during her shift on this evening and that he climbed out of his bedroom window. Once outside, the Service Recipient opened a gate and ran over to the ██████████, which was near ██████████. The Service Recipient walked around the ██████████ building and looked through the windows. He saw laptops in an office. The Service Recipient moved a small cement mixer that was nearby, put it under the office window, climbed on top of the mixer, pushed out the screen and climbed into Hospice through the window. Once inside, he stole two laptops and a cell phone. The Service Recipient then climbed out the window, put the screen back in place and returned the cement mixer to the location where he found it. The Service Recipient returned to his room by climbing through his bedroom window. Once inside he hid the stolen items in his room. The items were later found in his room and turned over to the authorities. (Hearing testimony of ██████████ Director of Investigations ██████████; Justice Center Exhibits 6, 7, 16, 17, and 23)

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, in relevant part, is defined by SSL § 488 (1)(h):

- (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...”

Substantiated reports of abuse and/or 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.

In this matter, the Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the act(s) of neglect alleged in the substantiated report that is the subject of the proceeding and that such act(s) 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 does 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 the act of neglect described as “Allegation 1” in the substantiated report. Specifically, the preponderance of the evidence established that the Subject, while acting as a custodian for the Service Recipient, breached the duty of care she owed to the Service Recipient by failing to properly supervise him. As a result, the Service Recipient was able to elope from the facility undetected. The Subject’s breach of duty to the Service Recipient was likely to result in physical injury or serious or protracted impairment to 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- 28) [REDACTED] Director of Investigations [REDACTED] testified regarding the investigation underlying the substantiated report. She was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject presented two Exhibits (Subject’s Exhibits A and B). DSP [REDACTED] testified on behalf of the Subject and the Subject testified in her own behalf.

There is no dispute that the Subject was acting as a custodian for the Service Recipient as defined in Social Service Law § 488 (2) and that she owed a duty of care to him. The Subject worked for [REDACTED] for 18 years and had worked at the [REDACTED] site for five years. The Subject was aware of the Service Recipient’s elopement history and the Safeguards put in place for his welfare. The Subject worked from 11:00 p.m. on [REDACTED] until 7:00 a.m. [REDACTED]. During that shift, the Subject was specifically assigned to supervise the Service Recipient and complete the bed checks for him. (Hearing testimony of [REDACTED] Director of Investigations [REDACTED]; Hearing testimony of Subject; Hearing testimony of DSP [REDACTED]; Justice

Center Exhibits 7, 12, 13, 14 and 28)

The need for vigilant supervision was further reinforced after the Service Recipient eloped on [REDACTED]. The next day, [REDACTED], additional Safeguards were effectuated. Staff was required to provide bed checks every fifteen minutes during the first two hours after the Service Recipient fell asleep, then every thirty minutes thereafter for the remainder of the overnight shift. Should the Service Recipient awake, staff must resume fifteen minute checks. The Subject was aware of these Safeguards and knew that she should seek clarification if needed. (Hearing testimony of [REDACTED] Director of Investigations [REDACTED]; Hearing testimony of Subject; Hearing testimony of DSP [REDACTED]; Justice Center Exhibits 8, 9 and 11)

The Subject testified that the Service Recipient started to fall asleep during the shift around midnight. Therefore, she was required to complete fifteen minute checks starting at midnight until 2:00 a.m. on [REDACTED], and then to do checks every thirty minutes commencing at 2:30 a.m. The Subject also testified that the Service Recipient awoke at 3:00 a.m. to use the rest room. According to the Safeguards, the Subject was then required to check the Service Recipient every 15 minutes until 5:00 a.m. and then every thirty minutes after that. There is no evidence that the Subject did not understand the Safeguards or that she asked any questions of the Residence Manager or Behavior Specialist regarding the Safeguards. (Hearing testimony of Subject, Justice Center Exhibits 8, 9 and 11)

According to the Night Log, the Subject completed bed checks for the Service Recipient every half hour from 11:00 p.m. [REDACTED] until 7:00 a.m. [REDACTED]. During the investigation, the Subject and DSP [REDACTED] admitted that, while they signed off on the Night Log indicating checks occurred every half hour, they both conducted hourly bed checks. They

provided no explanation for this significant discrepancy. At the hearing, the Subject initially testified that she checked the Service Recipient every 15 minutes from 11:00 p.m. until 12:30 a.m.; every half hour from 1:00 a.m. 2:30 a.m.; and then every hour until the last check at 6:30 a.m. The Subject later testified that she checked the Service recipient every hour from 1:00 a.m. on. The Subject subsequently testified that she checked the Service Recipient every 15 minutes until 1:00 a.m.; checked him at 1:30 a.m.; and then hourly for the remainder of the shift. There was no testimony indicating that bed checks were conducted every 15 minutes as required after the Service Recipient awoke at 3:00 a.m.

While there are some discrepancies in the record as to the frequency of the bed checks, all of the evidence in the record establishes that the Subject failed to follow the bed check protocol. The Subject breached her duty as she failed to properly supervise the Service Recipient. (Hearing testimony of Subject; Hearing testimony of DSP [REDACTED]; Justice Center Exhibits 7, 12, 25 and 28)

The Subject also did not keep the required line of sight so that she could see the Service Recipient if he exited his room. The Subject was aware of this requirement. The Subject testified that during the shift she was situated on the couch in the dining room. The investigation established that, when sitting on that couch, it is not possible to see the Service Recipient leave his room. The Subject testified that she was doing laundry and cleaning in the kitchen. The Service Recipient's room was not visible from the laundry room, which was in the basement, nor was his room visible from the kitchen. There was no evidence that DSP [REDACTED] kept watch on the Service Recipient while the Subject completed her tasks, despite the directive on the Overnight Shift Responsibilities sheet. While he did not elope through his bedroom door, the Subject again failed to follow a Safeguard for the Service Recipient. (Hearing testimony of

Subject; Justice Center Exhibits 7, 8, 9, 14, 28; Subject's Exhibit B)

In her defense, the Subject testified that she was not sleeping during the shift. She also testified that the Service Recipient was sleeping at 1:00 a.m. so he could not have eloped from Stokum at that time. Subject's witness DSP [REDACTED] testified that she saw the Subject awake at approximately 1:00 a.m. when DSP [REDACTED] went to the kitchen to make coffee. DSP [REDACTED] testified that she saw the Subject check on the Service Recipient at 1:00 a.m. However, testimony, as well as a drawing made by the Subject, established that the Service Recipient's room was not visible from the kitchen. Neither witnesses' statements are credible in this regard. (Hearing testimony of Subject; Hearing testimony of DSP [REDACTED]; Justice Center Exhibits 7, 25; Subjects Exhibit B)

The Subject argued that the Service Recipient's statements should not be credited evidence and that his statement that she was sleeping during her shift, as well as his statement that he eloped during that shift, are not reliable. A "Credibility Evaluation" conducted by the Behavior Analyst concluded that the Service Recipient's statements in regard to the incident were credible. The Service Recipient had nothing to gain by making the statement and, in fact, was admitting to wrongdoing. The items were later found in the Service Recipient's room and turned over to the local police department. After considering all of the evidence, the Service Recipient's statements in regard to the incident are credited evidence. Further, whether or not the Subject was sleeping is not material to the analysis of neglect under the theory forwarded by the Justice Center. Additionally, the time of the Service Recipient's elopement is an approximation. (Hearing testimony of Subject, Justice Center Exhibits 17 and 24)

The Subject argued that as the Service Recipient was a fast runner and [REDACTED] was close by, he could have completed his actions in fifteen minutes. The Subject did not complete the bed

checks every fifteen minutes as required, therefore, that argument is not persuasive. Irrespective, the Service Recipient eloped from [REDACTED] out of his bedroom window, ran to the nearby [REDACTED], walked around the [REDACTED], looked through the windows, observed items he wanted, moved a small cement mixer, climbed on the mixer, removed the window screen, gained access to the Hospice, stole two laptops and a cellphone, climbed back out of the [REDACTED] window, put the window screen back, moved the cement mixer back into place, and returned to [REDACTED], where he climbed into his bedroom window and hid the objects. It is improbable that this could be accomplished in less than fifteen minutes. (Hearing testimony of Subject; Justice Center Exhibits 6, 7, 17 and 23)

The Subject argued that [REDACTED] should have employed stricter supervision of the Service Recipient, and that the Night Log sheets were inadequate. As proof, the Subject pointed out that changes were made to the Service Recipient's supervision after this incident. When the Service Recipient eloped in August, [REDACTED] immediately implemented additional Safeguards. The Service Recipient had a stricter level of supervision than any of the other service recipients. The Subject was responsible for two service recipients overnight on the date of the incident. Her argument that [REDACTED] restrictions were not strict enough is disingenuous when she did not follow the already heightened Safeguards that were in place. While the Night Log did not have specified spaces to check off fifteen minute intervals, those intervals could have easily been written in. The Subject's arguments are not persuasive. (Hearing testimony of Subject; Justice Center Exhibits 7, 8, 11, 12, 20)

The Subject breached her duty of proper supervision to the Service Recipient and, as a result, there was a likelihood of serious or protracted impairment of the Service Recipient's physical, mental or emotional welfare. The Service Recipient could have easily been injured any

one of the four times he climbed through a window during the incident, as well as at any point when he moved the cement mixer back and forth. Additionally, the Service Recipient had a well-documented history of engaging in theft and entering buildings that he was not authorized to be in. This in and of itself placed the Service Recipient at a likelihood of serious or protracted impairment of his physical, mental or emotional welfare. (Hearing testimony of [REDACTED] Director of Investigations [REDACTED], Justice Center Exhibit 8)

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 or sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of neglect set forth in the substantiated report. Based upon the totality of the circumstances, the evidence presented, and the witnesses' testimony, it is determined that the substantiated report is properly categorized as a Category 3 act.


DECISION:

The request of [REDACTED] that the substantiated report dated [REDACTED], [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.

This decision is recommended by Elizabeth M. Devane, Administrative Hearings Unit.

DATED: May 10, 2016
Schenectady, New York



Elizabeth M. Devane
Administrative Law Judge