

**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: Thomas Parisi, Esq.

[REDACTED]
[REDACTED]
[REDACTED]

██████████

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 ██████████ ██████████ of neglect by the Subject of a Service Recipient be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 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: June 7, 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**

Adjudication Case #:

██████████

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: ██████████

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
Appearance Waived

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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [REDACTED] (the Subject) for neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a substantiated report dated [REDACTED] of neglect by the Subject of a Service Recipient.

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

Allegation 1

It was alleged that on [REDACTED], at the [REDACTED], located at [REDACTED], while acting as a custodian, you committed neglect when you failed to provide the required level of supervision to a service recipient, and failed to ensure that the front door was closed and the alarm was activated, which resulted in the service recipient eloping from the residence.

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

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

4. The facility, [REDACTED], located at [REDACTED] is a ten bed residential facility that is operated by the [REDACTED]. [REDACTED] is certified by the New York State Office for

People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center.

5. The facility is a two story residence with the office, the pantry, the medicine cabinet and a bathroom located in the basement. Three bedrooms, the dining room and the kitchen are on the facility's first floor. Seven bedrooms and the living room are on the facility's second floor. The facility has a security alarm system that must be deactivated when anyone enters or leaves through the front door and reactivated when the front door is shut thereafter. A facility policy is that staff members are to supervise service recipients at all times, including supervising the service recipients by checking on them periodically and by being present on the first and second floors when they are sleeping at night. (Hearing testimony of [REDACTED] Investigator [REDACTED] and Subject Exhibit A)

6. At the time of the alleged neglect, the Service Recipient was an ambulatory and marginally verbal person with diagnoses of severe cognitive deficits and autism, as well as medical conditions. The Service Recipient was forty-five years of age and had resided at the facility for approximately one year. At the time, the Service Recipient had recently attempted to elope from the facility and elopement was considered a danger to him. (Justice Center Exhibit 15)

7. At the time of the alleged neglect, the Subject had been employed at the [REDACTED] as a Direct Care Worker (DCW) for approximately one and one-half years. On [REDACTED], the Subject was assigned as the shift leader and the Approved Medication Administration Personnel (AMAP) for the 2:30 p.m. to 11:00 p.m. shift (the afternoon shift). (Hearing testimony of the Subject)

8. On [REDACTED], the other staff members who worked the afternoon shift were

(Hearing testimony of [REDACTED] Investigator [REDACTED])

10. At approximately 10:30 p.m., DCW [REDACTED] arrived at the facility early to count the medication. The Subject deactivated the security alarm to allow her to enter the facility through the front door and reset the alarm once she was inside. When DCW [REDACTED] arrived at the facility just before 11:00 p.m., the Subject similarly let her in through the front door by deactivating the security alarm and resetting the alarm after she had entered. (Hearing testimony of the Subject)

12. At the front door, the Subject and DCW [REDACTED] encountered temporary DCW [REDACTED], who was also preparing to leave. One of them said “let’s go” and deactivated the security alarm.

Center Exhibit 10)

deactivated and the service recipients unsupervised. (Hearing testimony of the Subject)

testimony of [REDACTED] Investigator [REDACTED])

that the security alarm be activated at all times. (Hearing testimony of the Subject)

ISSUES

- committed the act or acts giving rise to the substantiated report.

- Whether the substantiated allegation constitutes 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 neglect presently under review was substantiated. A “substantiated report” means a report “wherein a determination has been made as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred...” (Title 14 NYCRR 700.3(f))

The neglect of a person in a facility or provider agency is defined by SSL § 488(1)(h):

"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.

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).

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

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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 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 described as Allegation 1 in the substantiated report. Specifically, the evidence establishes that the Subject breached her duty to the Service Recipient, by failing to provide proper supervision to him and by failing to ensure that the facility's security alarm was activated when she left the facility after her shift, which resulted in the Service Recipient eloping from the facility. Even if the Subject had not been assigned as the shift leader, her conduct would have constituted a breach of duty. However, because the Subject was the assigned shift leader, her responsibility was elevated and consequently, the seriousness of her breach of duty was even more concerning.

In support of its substantiated findings, the Justice Center presented evidence obtained during the investigation. (Justice Center Exhibits 1-15) The investigation underlying the substantiated report was conducted by ██████████ Investigator ██████████ ██████████, who together with Quality Assurance Coordinator ██████████, testified on behalf of the Justice Center.

The Subject testified at the hearing on her own behalf and provided one document that was admitted into evidence. (Subject Exhibit A)

The substantiation of the finding of neglect against the Subject was based on the Subject's breach of her to duty to the Service Recipient, namely her failure to provide proper

██████████ supervision to him and her failure to ensure that the front door was locked and the security alarm was set when she exited the facility at the end of her shift.

With respect to the Subject's failure to provide proper supervision, the evidence showed that on ██████████, the Subject exited the facility at the end of her shift, leaving the service recipients on the first and second floors, knowing that there were no staff members on either of the two floors.

The Subject testified that at the time that she left the facility, DCW ██████ and DCW ██████ were still in the basement. The Subject testified that before exiting the building, she yelled "good night" to DCW ██████ who responded by indicating that she would be coming upstairs shortly. The Subject testified that she did not wait for either of the overnight shift staff members to be present on the first floor to assume supervision of the service recipients before she exited the facility. (Hearing testimony of the Subject)

The ██████████ Addendum to the Service Recipient's Behavior Plan (Justice Center Exhibit 15) states that the Service Recipient had recently attempted to elope from the facility, and because his lack of familiarity with his environment and his lack of awareness of traffic were concerns, elopement constituted a danger to him. The Addendum further states that staff must be vigilant of the Service Recipient's whereabouts at all times and keep him within sight at all times.

Although the Subject denied in her testimony that she had knowledge of the Service Recipient's elopement risk or familiarity with his Behavior Plan, the Subject did testify that she understood that another facility service recipient, who was also present and asleep in the facility on ██████████, was an elopement risk, a fact which should have heightened the Subject's awareness of the importance of providing proper supervision to all of the service recipients at all

times. The Subject's failure to provide that supervision constituted a breach of her duty to all of the service recipients, and specifically, to the Service Recipient.

With respect to the Subject's failure to ensure that the front door was locked and the security alarm set when she exited the facility after her shift, the evidence showed that when the Subject exited the facility, neither of the overnight shift staff members were present to reactivate the alarm after she exited through the front door.

The Subject testified that at the time that she left the facility, DCW [REDACTED] was still in the basement bathroom and DCW [REDACTED] had responded to her called down "good night" by indicating that she would be coming upstairs shortly. The Subject testified that she did not wait for either of the overnight shift staff members to come upstairs to the first floor to reactivate the alarm after she exited the facility. (Hearing testimony of the Subject)

The [REDACTED] Addendum to the Service Recipient's Behavior Plan (Justice Center Exhibit 15) states that the facility security alarm must be activated at all times so that staff members are aware of any service recipients exiting the facility and to allow them to take emergency measures in that case, if necessary.

Although the Subject denied in her testimony that she was aware of the [REDACTED] Addendum to the Service Recipient's Behavior Plan (Justice Center Exhibit 15), the Subject did testify that she knew of the facility requirement that the security alarm be activated at all times. The Subject testified that on the two occasions that she let in each of the overnight staff during that shift, she immediately reactivated the security alarm after they entered. The Subject admitted in her testimony that she knew that the alarm was always supposed to be activated and that she was supposed to wait for another staff member to come to the door to reactivate the alarm before she exited the facility. (Hearing testimony of the Subject)

As a result of the Service Recipient's elopement, the Subject was required to sign an acknowledgment (Subject Exhibit A) that emphasizes the extreme importance of providing diligent supervision to the service recipients and of ensuring that the facility security alarm is activated at all times. At the time of the incident, the Subject was already familiar with both of these important safety measures, which she admitted in her testimony and demonstrated by her other conduct during that shift.

During the hearing, the Subject provided arguments and explanations in her submissions and testimony regarding the incident. She testified that she had called down to DCW [REDACTED] two times before she exited the facility and that she assumed that DCW [REDACTED] would be right behind her, that when she performed her rounds for the last time that shift, the Service Recipient had been asleep in his bed, that temporary DCW [REDACTED] had not asked if the afternoon DCWs should wait for an overnight shift member before leaving the facility, that when she left, the facility door had locked behind her, that she did not know that the Service Recipient was an elopement risk, and that she had not read the [REDACTED] Addendum to the Service Recipient's Behavior Plan (Justice Center Exhibit 15). None of these contentions excuse the fact that the Subject knew that she had a duty to ensure that the facility security alarm be activated by another staff member at the time that she exited the facility after her shift ended. The Subject's failure to ensure that the facility security alarm was activated constituted a breach of her duty to the service recipients and specifically, to the Service Recipient.

As a result of the Subject's breach of duty, the Service Recipient was able to go to the first floor and elope from the facility undetected sometime after the Subject exited the facility and before the overnight staff members went upstairs from the basement.

Despite the fact that there was no evidence that the Subject's breach of duty actually

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resulted in physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient, such evidence is not necessary for a finding of neglect.

While it is true and fortunate that the Service Recipient was eventually located unharmed, given his severe cognitive deficits and autism and the concerns raised in the ██████████ Addendum to the Service Recipient's Behavior Plan (Justice Center Exhibit 15), the Service Recipient's elopement posed a serious danger to him. Consequently, the Subject's breach of duty constituted neglect because it was likely to have resulted in his physical injury or serious or protracted impairment of the physical, mental or emotional condition as set out in SSL § 488(1)(h).

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 under SSL § 488(1)(h), as specified in Allegation 1 of the substantiated report.

The report will remain substantiated. The next issue to be determined 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 statements, it is determined that the substantiated report is properly categorized 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 [REDACTED] that the substantiated report dated [REDACTED] of neglect by the Subject of a Service Recipient be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

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

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

DATED: May 26, 2016
Plainview, New York



Sharon Golish Blum, Esq.
Administrative Law Judge