

**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: Jennifer Oppong, Esq.

[REDACTED]
[REDACTED]
[REDACTED]

By: Linda Clark, Esq.
Barclay Damon
80 State Street
Albany, New York 12207

██████████

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: August 30, 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

[REDACTED]

Pursuant to § 494 of the Social Services Law

**RECOMMENDED
DECISION
AFTER
HEARING**

Adjud. Case #:

[REDACTED]

Before:

Louis P. Renzi
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
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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By: Jennifer Oppong, Esq.

[REDACTED]

[REDACTED]

[REDACTED]

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Barclay Damon
80 State Street
Albany, New York 12207

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], [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], New York, while acting as a custodian, you committed neglect when the [REDACTED] was left without staff after you directed a custodian to report to another location at the start of her shift, during which time service recipients arrived at the [REDACTED] and were unsupervised for over an hour.

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, located at [REDACTED], is a group home where three service recipients reside on the second floor in a supportive [REDACTED] and three service recipients reside on the first floor in a supervised [REDACTED]. It is operated by [REDACTED] which is certified

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

5. At the time of the alleged neglect, the Subject was employed by [REDACTED] for approximately thirty four years and worked as a Senior Coordinator.

6. At the time of the alleged neglect, the Service Recipients were young adults, and had been residents of the facility since it opened in [REDACTED]. The Service Recipients are all diagnosed with Down syndrome and all lived on the first floor in a 24 hour supervised [REDACTED]. (Justice Center Exhibits 4, 11, 12, 13)

7. On the day of the alleged neglect, the three Service Recipients were out of the [REDACTED] at work and day programs. Service Recipient [REDACTED] arrived home first and found no staff present. Service Recipient [REDACTED] arrived at the [REDACTED] next, followed by Service Recipient [REDACTED] who was let into the [REDACTED] by Service Recipient [REDACTED]. Service Recipient [REDACTED] telephoned DSP [REDACTED] who was not able to answer the telephone as he was driving. DSP [REDACTED] had taken another service recipient to a medical appointment. This appointment was shown on the staff schedule for the [REDACTED] (Hearing Testimony of Residential Coordinator [REDACTED], Justice Center Exhibits 4, 14)

8. Service Recipient [REDACTED] next telephoned his mother who in turn telephoned his father who happened to be in the neighborhood. Service Recipient [REDACTED] father arrived at the [REDACTED] at 3:55 p.m. and found the three Service Recipients alone with no staff present. (Hearing Testimony of Residential Coordinator [REDACTED] Hearing Testimony of Service Recipient [REDACTED] father, Justice Center Exhibits 4, 14)

9. On the day of the alleged neglect, the Subject had received a telephone call from RN [REDACTED] advising the Subject that she could not enter the [REDACTED] to administer an exam for DSP [REDACTED]. The Subject texted morning shift DSP [REDACTED] and Resident Supervisor [REDACTED] and was

informed that they were both out of the [REDACTED] at a course. The Subject subsequently instructed DSP [REDACTED] to go to another facility in order to take the exam. The Subject did not communicate this change in DSP [REDACTED] schedule to the residence supervisor. (Hearing Testimony of Subject, Hearing Testimony of RN [REDACTED], Justice Center Exhibits 4, 5)

10. On the day of the alleged neglect, DSP [REDACTED] was scheduled to work at the [REDACTED] from 2:00 p.m. through 10:00 p.m. (Justice Center Exhibit 10).

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

The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1)(h), to include:

(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.

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

If the Justice Center proves the alleged neglect, the report will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the act of neglect cited in the substantiated report constitutes the category of neglect as set forth in the substantiated report.

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

DISCUSSION

The Justice Center has established by a preponderance of the evidence that the Subject

committed an act, described as “Allegation 1” in the substantiated report. Specifically, the evidence establishes that the Subject committed neglect when the [REDACTED] was left without staff after the Subject directed a custodian to report to another location at the start of her shift, during which time service recipients arrived at the [REDACTED] and were unsupervised for over an hour.

In order to sustain an allegation of neglect, the Justice Center must prove that the Subject was a custodian who owed a duty to the Service Recipients, that she breached that duty, and that her breach either resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipients. (SSL § 488(1)(h))

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-21) The investigation underlying the substantiated report was conducted by [REDACTED] who at the time was a Residential Coordinator for [REDACTED], and was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and presented [REDACTED], RN, [REDACTED], [REDACTED] and Service Recipient [REDACTED] father as witnesses. The Subject also presented three documents, the [REDACTED] Standing Committee Post-Incident Report, OPWDD Form 148 and a Home Alone Assessment Tool for the three Service Recipients. (Subject Exhibits A-C)

On the day of the alleged neglect, the Subject was employed by [REDACTED] as a Senior Coordinator and was a custodian as that term is defined in Social Services Law § 488(2). Part of the Subject’s job responsibilities was to supervise the supervisors of each program, including the [REDACTED] (Hearing Testimony of [REDACTED] VP of Residential Services) The

Subject owed a duty of care to the Service Recipients to ensure that 24-hour supervision was provided at all times. The Subject breached this duty by instructing DSP [REDACTED] to report to another location, during which time the Service Recipients arrived at the [REDACTED] and were unsupervised.

At the time of the alleged neglect, the Subject knew that the [REDACTED] had the lowest minimum staffing of only one staff per shift. (Hearing Testimony of Subject) The Subject also became aware that both the supervisor of the [REDACTED] and the morning shift DSP were not at the [REDACTED]. (Justice Center Exhibit 5) There is conflicting evidence as to the conversation that took place between the Subject and DSP [REDACTED] prior to the Subject sending DSP [REDACTED] to another location. The Subject testified that she asked DSP [REDACTED] whether she was covering the shift. The Nurse who was to administer DSP [REDACTED] exam testified that she overheard the Subject ask DSP [REDACTED] whether DSP [REDACTED] was working. However, DSP [REDACTED] written statement and the Investigation Report refutes this. (Hearing Testimony of Subject, Hearing Testimony of [REDACTED], RN, Justice Center Exhibits 4, 8) As the Subject telephoned DSP [REDACTED] prior to the beginning of her shift, DSP [REDACTED] had no way of knowing who was at the [REDACTED]. The Subject did not ask DSP [REDACTED] whether she was aware of DSP [REDACTED] appointment until after DSP [REDACTED] had already returned to the [REDACTED]. (Justice Center Exhibit 8) Accordingly, the Subject's reliance upon DSP [REDACTED] assessment (whatever that was) was not reasonable.

The Subject did not take steps to ensure that there would be 24-hour supervision at the [REDACTED] prior to sending DSP [REDACTED] to another location. The Subject did not communicate the shift change to the Supervisor of the [REDACTED] and, if she had, would have learned that DSP [REDACTED] had been instructed to take another service recipient to an appointment. (Justice Center Exhibit 4) The Subject also failed to check the [REDACTED] Staff Schedule and, if she had, would have seen

the notation of the appointment. (Justice Center Exhibit 10) There is no evidence that the Subject telephoned the [REDACTED] to ensure that DSP [REDACTED] or any other staff was there. (Justice Center Exhibit 4) Accordingly, the Subject breached her duty of care to the Service Recipients.

Service Recipient [REDACTED] father testified that he arrived at the [REDACTED] after receiving a telephone call from his wife, and found that there was no staff present and that all three Service Recipients appeared to be unharmed. He further stated that his son was able to stay alone for an hour or two when he was at home. (Hearing Testimony of Service Recipient [REDACTED] father) Although no physical injury occurred, the Subject's breach was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipients. At the time of the alleged neglect, the Service Recipients had been residing at the [REDACTED] for approximately two years with 24-hour supervision. Service Recipient [REDACTED] parents were concerned that Service Recipient [REDACTED] had never been left alone and that she risked hurting herself if she decided to cook for herself. Service Recipient [REDACTED] parents stated that Service Recipient [REDACTED] was used to having someone open the front door for him and were concerned at what could have happened had Service Recipient [REDACTED] not done so. (Justice Center Exhibit 4)

Service Recipient [REDACTED] telephoned DSP [REDACTED] and then his mother, who telephoned his father. Service Recipient [REDACTED] father happened to be in the neighborhood and arrived at the [REDACTED] shortly after the call, but this does not excuse the neglect by the Subject. The duty of care owed to the Service Recipients by the Subject included 24-hour supervision. A staff person must be present 24 hours a day whenever the Service Recipients are at the [REDACTED] (Hearing Testimony of [REDACTED], VP of Residential Services) There is no certainty about what might have happened to these Service Recipients if the parent had not arrived, but the likelihood of harm was significant.

DSP staff did not arrive at the [REDACTED] until approximately 4:00 p.m. – 4:15 p.m., whereas the

first Service Recipient arrived at the [REDACTED] between 3:00 p.m. – 3:15 p.m.

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 abuse or 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.

DECISION:

The request of [REDACTED] that the substantiated report dated [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 Louis P. Renzi, Administrative Hearings
Unit.

DATED: August 22, 2016
Schenectady, New York



Louis P. Renzi, ALJ