

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

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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**FINAL  
DETERMINATION  
AND ORDER  
AFTER HEARING**

**Adjud. Case #:**

[REDACTED]

The attached Recommended Decision After Hearing (Recommended Decision) is incorporated in its entirety including but not limited to the Findings of Fact, Conclusions of Law and Decision section.

ORDERED: The attached and incorporated Recommended Decision is hereby adopted in its entirety.

ORDERED: The Vulnerable Persons' Central Register shall take action in conformity with the attached Recommended Decision, specifically the Decision section.

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:** February 9, 2018  
Schenectady, New York



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David Molik  
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register  
Administrative Appeals Unit  
[REDACTED], Subject  
Nathaniel K. Charny, Esq.

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

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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**RECOMMENDED  
DECISION  
AFTER  
HEARING**

**Adjud. Case #:**

[REDACTED]

Before:

Jean T. Carney  
Administrative Law Judge

Held at:

Eleanor Roosevelt State Office Building  
4 Burnett Blvd., 2nd Floor  
Poughkeepsie, NY 12601  
On: [REDACTED]

Parties:

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

[REDACTED]

By: Nathaniel K. Charny, Esq.  
Charny & Associates  
Attorneys at Law  
9 West Market Street  
Rhinebeck, NY 12572

### **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 multiple dates preceding [REDACTED], as reportedly observed on [REDACTED], at the [REDACTED], located at [REDACTED], while acting as a custodian, you committed neglect when you failed to provide adequately for a service recipient's environmental needs and activities of daily living.

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

3. An Administrative Review was conducted the substantiated report was retained.

4. The facility, located at [REDACTED], is an Individualized Residential Alternative [REDACTED], and is operated by the Office for People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the Subject had been employed by the OPWDD for 38 years and worked at [REDACTED] for 11 years. The Subject worked at [REDACTED] as a Developmental Assistant 2 (DA 2), also known as a “House Director.” (Hearing testimony of the Subject)

6. At the time of the alleged neglect, the Service Recipient was 64 years old, and had been a resident of the facility for approximately 17 months. The Service Recipient is an adult with relevant diagnoses of moderate intellectual disability and generalized gingivitis. (Justice Center Exhibit 30)

7. The Service Recipient can perform most of his activities of daily living (ADL) with minimal supervision, but a staff member must remain with the Service Recipient to ensure that he does not rush through his personal hygiene routine. (Justice Center Exhibit 30)

8. The Service Recipient works at [REDACTED] as a cart pusher. (Justice Center Exhibit 12; Hearing testimony of Subject)

9. At the time of the alleged neglect, the Service Recipient’s fluid intake was restricted to 2000 cc per day. (Justice Center Exhibits 25, 33) On [REDACTED], the dietician emailed the Subject an updated fluid allowance chart from 1500 cc to 2000 cc per day for the staff and directed the Subject to place the chart in the Service Recipient’s communication book. (Justice Center Exhibit 25) While the fluid restriction change was placed on the refrigerator, the Subject did not write the change in the Service Recipient’s communication book. (Hearing testimony of OPWDD Office of Investigation and Internal Affairs Internal Investigator [REDACTED] [Investigator [REDACTED]])

10. The Service Recipient lived in the basement bedroom of [REDACTED]. The Service Recipient complained of being cold in his room to the Subject, his mother and sister, and two staff



workers. (Justice Center Exhibits 7, 15, 16) The weather for [REDACTED] showed seven (7) days of freezing or below freezing temperatures in [REDACTED]. (Justice Center Exhibit 24)

11. The Service Recipient's mother and sister visited the Service Recipient on [REDACTED] at [REDACTED]. (Justice Center Exhibit 6) Both the Service Recipient's mother and sister observed a cold room, a razor that fell apart when the Service Recipient's sister touched it, an ADL Box (also referred to at the hearing as a "shower caddy") containing a Poland Spring water bottle filled with black possibly moldy water and a dirty old toothbrush, ants in the bathroom, a broken headboard, disorganized clothes in the closet, a ripped jacket unsuitable for winter, and no tops to the Service Recipient's pajamas. (Justice Center Exhibits 6 and 7; Hearing testimony of Subject)

12. On [REDACTED], the Service Recipient's mother and sister reported their observations to the Service Recipient's Medicaid Service Coordinator (MSC), [REDACTED]. (Justice Center Exhibits 6, 7, 12)

13. On [REDACTED], the Treatment Team Leader (TTL) discovered that the head of the Service Recipient's toothbrush "looked very used with the bristles bent over. ..." (Justice Center Exhibit 18) The TTL directed staff to buy new toothbrushes for all the service recipients at [REDACTED], and to discard the Service Recipient's old toothbrush. (Justice Center Exhibit 18)

14. On [REDACTED], a crew began cleaning the [REDACTED]. (Subject Exhibit B) The crew cleaned on three separate days. (Subject Exhibit B) The cleaning crew discovered dirt and clutter under the furniture and layers of dirt on the windowsills. (Justice Center Exhibit 18) The TTL, along with other staff members, cleaned the office and file cabinets, finding old condiments in one closet and new toothbrushes in another closet. (Justice Center Exhibit 18)

15. On [REDACTED], OPWDD Lead Investigator [REDACTED] (Investigator

██████████) visited ██████████, smelled the odor of cleaning products, and observed staff cleaning the residence and throwing items into garbage bags. Investigator ██████████ observed an unopened tube of toothpaste and an unopened new electric razor on the Service Recipient's bed. (Justice Center Exhibit 10)

16. Following the alleged incident, the Service Recipient's bed was fixed and ██████████ staff planned on getting a new bedroom set for the Service Recipient. The furnace repairs were completed on ██████████, the Service Recipient received a new razor, the ██████████ was cleaned, old toothbrushes were replaced for all service recipients, and the Service Recipient's Plan for Protective Oversight (POPO) was amended to include the fluid restriction. (Justice Center Exhibits 18 and 30)

### 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 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))

Neglect is defined by SSL § 488(1)(h) as:

"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 three, 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.

In support of its substantiated findings, the Justice Center presented a number of documents and audio interviews obtained during the investigation. (Justice Center Exhibits 1-36) The investigation underlying the substantiated report was initially conducted by Investigator [REDACTED]. Investigator [REDACTED] concluded the investigation. Investigator [REDACTED] was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and provided documentary evidence. (Subject [REDACTED] Exhibits A – B) Photographs taken by Investigator [REDACTED] during his investigation were also submitted into evidence. (ALJ Exhibit 1) The Subject’s supervisor, DA 3 [REDACTED], also testified at the hearing.

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 Recipient, 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 Recipient. (SSL § 488[1][h])

There is no issue that the Subject was a custodian as that term is defined in SSL § 488(2). The issues in this case are whether the Subject breached her duty to the Service Recipient by failing to provide for his environmental needs and activities of daily living, and whether that breach was likely to result in physical injury or serious or protracted impairment of the physical, mental or



emotional condition of the Service Recipient.

The Justice Center proved by a preponderance of the evidence that between [REDACTED], the Subject breached her duty by failing to support the emotional, physical and personal well-being of the Service Recipient. (NYS Executive Law § 554) The Subject worked as a DA 2 for 11 years at [REDACTED] prior to the incident. (Hearing testimony of Subject) The Subject's responsibilities included assigning and supervising staff to ensure that the Service Recipient's ADL's were performed correctly, submitting work orders for heat related issues, and reporting to pest control for pests, such as ants in the bathroom. (Hearing testimony of Investigator [REDACTED]; Hearing testimony of Subject; Justice Center Exhibit 18; and Subject [REDACTED] Exhibit A)

The Subject had a duty to the Service Recipient, and breached this duty by failing to provide for his environmental needs and activities of daily living.

Specifically, the evidence establishes that the Service Recipient is a 64 year old man with mild intellectual disability who works at [REDACTED] pushing carts outside. (Justice Center Exhibits 6, 24, 30) The Service Recipient worked with a ripped coat in freezing and subfreezing weather, even though the Subject admitted that the Service Recipient told her about the ripped coat and that the Service Recipient had a new jacket available under the [REDACTED]. (Hearing testimony of Subject)

The Service Recipient was cold in his room at [REDACTED] and complained to the Subject as well as other staff that the Subject supervised. (Justice Center Exhibits 7, 15, 16) The Subject failed to submit any work orders to repair the heat in the Service Recipient's bedroom between [REDACTED]. (Justice Center Exhibit 23) The Subject knew about the lack of heat in the Service Recipient's room from prior years and testified that a determination was

made to keep the Service Recipient's bedroom door open for the heat to circulate from the first floor, even though this would subject Service Recipient to a loss of privacy. (Justice Center Exhibits 36: Interrogation of Subject) Eventually, it was discovered that a valve needed replacement, and approximately three months after the alleged incident, the furnace repairs were completed on [REDACTED]. (Justice Center Exhibit 18) Because the Subject failed to adequately investigate the Service Recipient's complaints, these repairs were needlessly delayed.

The Service Recipient was on a fluid restrictive diet of 1500 cc per day, which was changed on [REDACTED] to 2000 cc per day. The dietician requested that the Subject write the change in the Service Recipient's communication notebook, but the Subject failed to do so. The Subject and staff were aware that if the Service Recipient drank too much water, he could be hospitalized again due to his electrolyte imbalance. (Justice Center Exhibits 14, 16, 30, and 33)

The Service Recipient required supervision and verbal prompting to ensure that he did not rush through his personal hygiene routine. (Justice Center Exhibits 12, and 30) Despite this mandated supervision and the Service Recipient's diagnosis of generalized gingivitis, the Service Recipient was using a "very used" toothbrush. (Justice Center Exhibit 18) The evidence in the record indicates that staff were not adequately supervising the Service Recipient as required by his treatment plan. (Justice Center Exhibits 18, 30, and 36: Interrogation of Subject)

In her defense, the Subject testified that she did not work on [REDACTED], the two days that the Service Recipient's mother and sister visited. The Subject testified that she was not notified of the issues, including the broken bed and the old toothbrush until after [REDACTED]. (Hearing testimony of Subject) The Subject's lack of knowledge does not negate her duty to supervise the staff to ensure that the Service Recipient's ADL's were performed correctly. (Hearing testimony of Investigator [REDACTED])

The Subject's lack of knowledge also does not negate her duty to take corrective action, including submitting work orders to repair the heat if complaints are made to the staff. (Hearing testimony of Investigator [REDACTED]; Hearing testimony of Subject; Justice Center Exhibit 18; and Subject [REDACTED] Exhibit A) Even if the Subject did not receive any complaints about the Service Recipient's room on or about the time of the alleged neglect, the Subject should have known and should have been proactive in expecting that the Service Recipient's room lacked adequate heat based on her experience. The Subject worked 11 years at [REDACTED], the Subject admitted that the Service Recipient was cold the year before the alleged neglect, and the only remedy the year before was to keep the Service Recipient's door open for the warm air to circulate to the Service Recipient's room in the basement. (Hearing testimony of Subject; Justice Center Exhibit 36: Interrogation of Subject). The Subject's professed lack of knowledge is also contradicted by the Subject's own testimony wherein she admitted that the Service Recipient complained about his ripped coat and broken razor, and is also contradicted by the Service Recipient's statements to his family that he complained to the Subject about being cold and the Subject told him to keep warm. (Hearing testimony of Subject; Justice Center Exhibit 7) Therefore, the Administrative Law Judge presiding over the hearing, having observed and evaluated the hearing testimony of the Subject on this material issue, does not find her testimony to be credible.

Although not determinative, it is worthwhile to mention that the Subject's lack of adequate oversight to ensure that the Service Recipient's environmental and daily needs are met also includes: (i) the Service Recipient's family observing staff cooking hot dogs for lunch or dinner on several occasions, even though hot dogs were not on the [REDACTED] menu; and (ii) both the MSC and the TTL expressing concern with the Subject's ability in the past to respond to complaints in a timely fashion. (Justice Center Exhibits 7, 11, 13, 18, and 26)

Based on a totality of the circumstances, the Justice Center also proved by a preponderance of the evidence that the Subject's breach of her duties was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Specifically, the evidence establishes that the Service Recipient is likely to get sick and/or hospitalized if his fluid intake was above 2000 cc per day. (Justice Center Exhibit 33) A broken razor is also likely to cause physical injury to the Service Recipient, especially when the razor "fell apart" when the Service Recipient's sister held the razor. (Hearing testimony of Investigator [REDACTED]; Justice Center Exhibit 7) One of the Service Recipient's behaviors was hiding old items and was more reason for the staff to provide oversight to ensure that used and broken items were not in his possession. (Hearing testimony of Investigator [REDACTED]) The evidence also establishes that considering the Service Recipient's age, a light canvas jacket with a rip on the underarm side area was not appropriate for the work performed by the Service Recipient in freezing and subfreezing weather. (Hearing testimony of Investigator [REDACTED])

Furthermore, the Subject had the authority to address the ongoing condition of the lack of heat in the Service Recipient's room, but failed to take any action from at least [REDACTED] [REDACTED]. (Hearing testimony of Investigator [REDACTED], Justice Center Exhibit 23) The lack of heat and the Subject being cold is likely to cause physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. The evidence establishes that the Service Recipient was 64 years old at the time of the alleged neglect, had no pajama tops and complained to the Subject and at least two staff members about being cold. (Justice Center Exhibits 6, 7, 15, and 16)

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 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.

Substantiated Category 3 findings of 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 SSL § 496(2). The report will be sealed after 5 years.

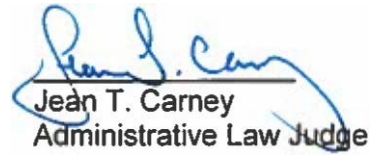
**DECISION:**

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 Jean T. Carney, Administrative Hearings  
Unit.

**DATED:** January 17, 2018  
Schenectady, New York



Jean T. Carney  
Administrative Law Judge