

**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]

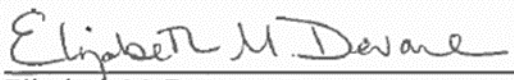
The attached Recommended Decision After Hearing (Recommended Decision) is incorporated in its entirety including but not limited to the Findings of Fact, Conclusions of Law and Decision section.

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 Elizabeth M. Devane, ALJ Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

Dated: September 06, 2018
Schenectady, New York


Elizabeth M. Devane
Administrative Law Judge

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[REDACTED], Subject
Joseph J. Ranni, Esq.

**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: Elizabeth M. Devane
Administrative Law Judge

Held at: New York State Justice Center for the Protection of
People with Special Needs
Eleanor Roosevelt State Office Building
4 Burnett Boulevard
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: Alliah S. Rozan, Esq.

[REDACTED]
[REDACTED]
By: Joseph J. Ranni, Esq.
148 N Main Street
Florida, New York 10921-1101

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 [REDACTED], located at [REDACTED], while a custodian, you committed neglect when you failed to provide proper supervision to a service recipient, during which time she eloped from the building.

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 day habilitation program that provides services and support to individuals with intellectual and developmental disabilities and is operated by the New York State Office for

People With Developmental Disabilities (OPWDD) which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of Justice Center Investigator [REDACTED]; Justice Center Exhibit 6)

5. At the time of the alleged neglect, the Subject had been employed by OPWDD for twenty-nine years and worked as a Direct Support Assistant (DSA). The Subject's duties included supervision of service recipients and assistance of service recipients with their activities of daily living. The Subject was a custodian as that term is defined in Social Services Law § 488(2). (Hearing testimony of Justice Center Investigator [REDACTED]; Justice Center Exhibits 6, 7, 11, 22 and 23)

6. At the time of the alleged neglect, the non-verbal female Service Recipient was 70 years old and had been attending day habilitation at the facility for approximately 23 years, since [REDACTED]. The Service Recipient had diagnoses including profound intellectual disability, impulse control disorder, behavioral disorder and a number of other health concerns. (Hearing testimony of Justice Center Investigator [REDACTED]; Justice Center Exhibits 6, 11, 16, 17, 18, 19, 22 and 23)

7. The Service Recipient had a history of wandering about and walking out of her residence and day program and required constant supervision. The Service Recipient's supervision level at the facility was general whereabouts, meaning staff must know of her whereabouts at the site at all times. When outdoors and in the community, the Service Recipient required field-of-vision supervision. (Hearing testimony of Justice Center Investigator [REDACTED]; Justice Center Exhibits 6, 18, 19, 22 and 23)

8. The Service Recipient did not recognize dangerous or potentially hazardous situations and did not have the ability to protect herself. The facility was located on a main road in the town and there was ongoing construction in the facility parking lot. (Hearing testimony of Justice Center Investigator [REDACTED]; Justice Center Exhibits 6, 18, 19, 22 and 23)

9. The doors of the facility were equipped with alarms to notify staff when a door was opened. Staff was responsible for reactivating the alarm by resetting it when they or another staff member left the facility. (Hearing testimony of Justice Center Investigator [REDACTED]; Justice Center Exhibits 6, 22 and 23)

10. Each staff is assigned to supervise two to three service recipients during a shift and each staff is assigned another staff partner. If a staff needs a break or to leave the area, that staff is required to tell their partner so that the partner will supervise that staff's assigned service recipients during that time. (Hearing testimony of Justice Center Investigator [REDACTED]; Justice Center Exhibits 6, 22 and 23)

11. On the day of the alleged incident, the Subject worked at the facility and was assigned to supervise the Service Recipient, who was there from 9:10 a.m. to 3:05 p.m. Another DSA (DSA 2) was assigned as the Subject's partner that day. (Hearing testimony of Justice Center Investigator [REDACTED]; Justice Center Exhibits 6, 7, 20, 22 and 23)

12. At around 1:50 p.m., local police responded to a call from a community member that a service recipient was outside unsupervised. A police officer found the Service Recipient walking in a parking lot near an alley outside of the facility. The officer returned the Service Recipient to the facility. (Hearing testimony of Justice Center Investigator [REDACTED]; Justice Center Exhibits 6, 7, 10, 11, 12, 13, 14, 22 and 23)

13. A body check of the Service Recipient done by the Subject and another staff found no injuries on the Service Recipient and no known incidents occurred as a result of the Service Recipient eloping. (Hearing testimony of Justice Center Investigator [REDACTED]; Justice Center Exhibits 6, 7, 8, 10, 11, 22 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 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 neglect of a person in a facility or provider agency is defined by SSL § 488(1) (h) as:

- (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 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

[REDACTED]

evidence that the Subject committed the act of neglect alleged in the substantiated report that is the subject of the proceeding and that such act 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 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 obtained during the investigation (Justice Center Exhibits 1- 21) as well as a CD with audio recordings of witness interviews (Justice Center Exhibit 22) and transcripts of the recorded interviews. (Justice Center Exhibit 23) The investigation underlying the substantiated report was conducted by Justice Center Investigator [REDACTED], who was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject did not testify and provided no additional evidence.

In order to prove neglect, the Justice Center must establish by a preponderance of the evidence that the Subject's action, inaction or lack of attention breached a duty that 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))

The relevant facts are generally not in dispute. The Subject was responsible for the supervision of the Service Recipient and required to know her whereabouts at the facility.

[REDACTED] (Hearing testimony of Justice Center Investigator [REDACTED]; Justice Center Exhibits 22 and 23) During this time, the Service Recipient was able to leave the facility unnoticed and without permission and was found wandering outside of the facility unattended. (Hearing testimony of Justice Center Investigator [REDACTED]; Justice Center Exhibits 6, 7, 10, 11, 12, 13, 14, 22 and 23)

The Subject told the Investigator that she was cleaning up after lunch in the kitchen with a service recipient that required eyes-on supervision when she looked out the kitchen door and saw another staff speaking with a police officer in the facility. She then discovered that the Service Recipient had gone outside. The Subject completed a body check of the Service Recipient with another staff member and proceeded to notify the appropriate parties of the situation. The Subject said she may have yelled out that she was in the kitchen with a service recipient so that other staff could assist. The Subject acknowledged that she should have asked her partner for assistance but did not and that she did not yell out to anyone specifically. (Justice Center Exhibits 6, 7, 8, 22 and 23)

However, the Subject argued that she did not commit neglect as alleged because the fault lies with the facility, not the Subject. The facility alarm apparently did not alert when the Service Recipient opened the door and the facility protocol regarding the alarm was defective. Therefore, it was a failure on the part of the facility that allowed the Service Recipient to elope.

Evidence established that each of the two doors at the facility were locked and equipped with an alarm that alerts staff when either door was opened. The alarm had to be reactivated from inside of the facility after each time the door was opened. Facility protocol required exiting staff to inform another staff of their departure so that the other staff can reactivate the alarm. Likewise, when staff entered the facility they were required to reactivate the alarm after doing so. Additionally, all staff are responsible for reactivating an alarm that is in alert status. Evidence established that no staff reported hearing the alarm sound at around the time the Service Recipient

left the building. (Hearing testimony of Justice Center Investigator [REDACTED]; Justice Center Exhibits 6, 22 and 23)

However, the alarm system was supplementary and not a replacement of staff supervision of service recipients and did not relieve the Subject of her duty and responsibility to be aware of the Service Recipient's whereabouts. In this instance, the Subject breached her duty before the Service Recipient left the building. The Service Recipient had a history of wandering about and walking out of the facility and her residence, and her diagnoses included impulse control disorder. (Hearing testimony of Justice Center Investigator [REDACTED]; Justice Center Exhibits 6, 18, 19, 22 and 23) The Subject was responsible for the supervision of the Service Recipient and for being aware of the Service Recipient's general whereabouts at all times in the facility. General whereabouts meant that staff must know of her whereabouts at the site at all times. (Hearing testimony of Justice Center Investigator [REDACTED]; Justice Center Exhibits 6, 18, 19, 22 and 23) Outside of the facility, the Service Recipient's supervision level was field-of-vision supervision. The Subject was not aware of the Service Recipient's whereabouts in the facility at the time the Service Recipient left the building. The Service Recipient was out of the building for an unknown period of time, but long enough that a call was placed to the authorities, the authorities responded and the Service Recipient was found wandering in the parking lot near an alley.

The Subject's lack of attention resulted in the likelihood of physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. The Service Recipient had no concept of danger and no ability to protect herself. The facility was located on a main road with significant traffic and there was ongoing construction in the parking lot where the Service Recipient was found.

The Justice Center proved by a preponderance of the evidence that the Subject breached her duty to properly supervise the Service Recipient, that the Subject's breach of duty resulted in the Service Recipient being able to elope from the facility, and that the Service Recipient's

elopement was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

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' statements, it is determined that the substantiated report is properly categorized as a Category 3 act.

Substantiated Category 3 findings of physical abuse 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 five 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 Elizabeth Devane, Administrative Hearings Unit.

DATED: August 21, 2018
Schenectady, New York

Elizabeth Devane
Administrative Law Judge