

**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]

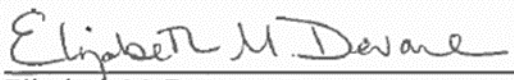
The attached Recommended Decision After Hearing (Recommended Decision) is incorporated in its entirety including but not limited to the Findings of Fact, Conclusions of Law and Decision section.

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: October 15, 2018**  
Schenectady, New York

  
Elizabeth M. Devane  
Administrative Law Judge

CC. Vulnerable Persons' Central Register  
Administrative Appeals Unit  
[REDACTED], Subject

**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:

Mary B. Rocco  
Administrative Law Judge

Held at:

New York State Justice Center for the Protection  
of People with Special Needs  
125 E. Bethpage Road, Suite 104  
Plainview, New York 11803  
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: Amanda Smith, Esq.

[REDACTED]

### **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 a custodian, you committed neglect when you failed to provide proper supervision to a service recipient, during which time he eloped.

The 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 an Individualized Residential Alternative (IRA) for adults with developmental disabilities, and was

operated by [REDACTED]<sup>1</sup> and 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.

5. At the time of the alleged neglect, the Subject had been employed at the facility for approximately nine months as a Direct Support Professional (DSP) with a regular [REDACTED] shift three days a week. On [REDACTED], the day of the alleged incident, the Subject was working an earlier shift of 6:00 p.m. to 8:00 a.m. As a DSP, the Subject's duties included supervision of the residential service recipients, as well as assisting with their activities of daily living. (Justice Center Exhibits 19 and 28; Hearing testimony of the Subject)

6. At the time of the alleged neglect, there were three service recipients and three staff members present in the facility. DSP 1 and DSP 2 were assigned 2:1 supervision of Service Recipient [REDACTED] and were attending to him on the second floor. The Subject was assigned general supervision of Service Recipient [REDACTED], which meant Service Recipient [REDACTED] was able navigate independently throughout the facility, but was required to be checked on every 30 minutes. Service Recipient [REDACTED] was a 23-year-old non-verbal male with relevant diagnoses of autism, intermittent explosive disorder and moderate intellectual disability. (Justice Center Exhibits 3, 7, 11, 13, 22, 26, 27 and 28; Hearing testimonies of the Subject and facility Assistant Residence Manager [REDACTED] (ARM [REDACTED]))

7. At approximately 9:00 p.m., the Subject assumed supervision of Service Recipient [REDACTED], who was asleep, from DSP 3 who had ended his shift. The Subject positioned himself inside Service Recipient [REDACTED] bedroom seated on a bean bag chair a few feet from Service Recipient [REDACTED] bed. Service Recipient [REDACTED] required line of sight supervision during waking hours only.

---

<sup>1</sup> Subsequently renamed [REDACTED].

Service Recipient [REDACTED] was a 23-year-old verbally limited male with relevant diagnoses of moderate intellectual disorder, autism, anxiety disorder and a history of self-injurious behavior including rectal digging. (Justice Center Exhibits 3, 7, 12, 14, 22, 26, 27 and 28; Hearing testimonies of the Subject and ARM [REDACTED])

8. At approximately 9:30 p.m., the Subject, still seated inside Service Recipient [REDACTED] bedroom, heard one of the facility door alarms sound. The Subject immediately responded by checking the facility doors and looking for Service Recipient [REDACTED]. Unable to locate Service Recipient [REDACTED], the Subject yelled upstairs to DSP 1 and DSP 2 inquiring if they had seen him. Responding that they had not, DSP 2 joined the Subject in searching the facility and surrounding outside areas for Service Recipient [REDACTED]. The Subject called 911 and Service Recipient [REDACTED] was located by the police and transported to the hospital at approximately 10:15 p.m. (Justice Center Exhibits 7, 8, 26, 27, 28; Hearing testimony of the Subject)

### **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))

The neglect of a person in a facility or provider agency 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 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 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 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 he breached that duty, and that his 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))

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-29) The investigation underlying the substantiated report was conducted by facility Corporate Compliance Officer [REDACTED], and, together with facility Assistant Residence Manager [REDACTED], testified at the hearing on behalf of the Justice Center.

The Subject testified in his own behalf and provided no other evidence.

On the day of the alleged neglect, the Subject was employed as a DSP and was therefore acting as a custodian as that term is defined in Social Services Law § 488(2).

The evidence in the record established that Service Recipient [REDACTED] required general supervision within the facility and that the Subject had a duty to regularly monitor him, with 30-minute interval checks as a safeguard. (Justice Center Exhibits 3, 7, 11, 13, 19, 22, 28; Hearing

testimonies of the Subject and ARM [REDACTED]) Furthermore, the evidence established that the Subject had a duty to provide supervision to a sleeping Service Recipient [REDACTED] who required line of sight supervision during waking hours. The Subject was trained in both Service Recipient [REDACTED] and Service Recipient [REDACTED] required supervision levels. (Justice Center Exhibits 3, 7, 12, 14, 19, 22, 28, 29; Hearing testimonies of the Subject and ARM [REDACTED])

In his defense, the Subject argued that Service Recipient [REDACTED] elopement was a product of the facility's failure to provide Service Recipient [REDACTED] with an appropriate level of supervision, as well as a deficiency in staffing. The Subject testified that it was established practice in the facility that Service Recipient [REDACTED] was to be monitored at all times, not just during waking hours, because Service Recipient [REDACTED] often engaged in rectal digging while in bed. The Subject testified that facility management was unaware of the practical aspect of caring for Service Recipient [REDACTED] and that he executed his duties in the manner in which he was trained and in the best interest of Service Recipient [REDACTED]. The Subject testified that he was compelled to remain within arm's length distance of Service Recipient [REDACTED] and therefore, positioned himself close to Service Recipient [REDACTED] bed, which prevented him from seeing any movements of Service Recipient [REDACTED]. (Hearing testimony of the Subject)

Service Recipient [REDACTED] Behavioral Support Plan, revised only a few weeks before the instant matter, specifically addressed the Service Recipient's history of rectal digging and detailed preventative strategies in response to his challenging behaviors. Along with routine prompting for toileting, staff were instructed to have Service Recipient [REDACTED] wear one-piece pajamas in an effort to thwart the potential for nighttime rectal digging. Moreover, in the development and subsequent modifications of Service Recipient [REDACTED] comprehensive and detailed behavioral plan, the management team and clinicians determined that line of sight supervision during waking hours



was the necessary and appropriate level of supervision. (Justice Center Exhibits 14 and 23)

The Subject testified that he had last observed Service Recipient [REDACTED] sometime between 8:40 p.m. and 8:50 p.m. in his bedroom, which was only a few feet from Service Recipient [REDACTED] room. (Justice Center Exhibit 21) The Subject further asserted that his obligation to remain inside and close to Service Recipient [REDACTED] prevented him from properly monitoring Service Recipient [REDACTED]. The Subject proffered that had a fourth staff member been present that evening, Service Recipient [REDACTED] would not have eloped. (Justice Center Exhibit 3 and 28; Hearing testimony of the Subject)

The Subject's arguments were not convincing. The Subject was unable to provide a sufficient explanation for his failure to perform the required 30-minute interval check after the last 8:40 p.m./8:50 p.m. observation of Service Recipient [REDACTED]. Of further interest to note was the Subject's inconsistent statements as to Service Recipient [REDACTED] location at the 8:40 p.m./8:50 p.m. sighting. In his written request for an amendment dated [REDACTED], the Subject noted numerous times that Service Recipient [REDACTED] was in the living room on the computer before eloping. In his testimony, the Subject insisted that his last sighting of Service Recipient [REDACTED] was in his bedroom. (Justice Center Exhibits 3 and 28; Hearing testimony of the Subject)

Similarly, when questioned on why he did not position himself near Service Recipient [REDACTED] bedroom door which would have provided him a clear view of Service Recipient [REDACTED] bedroom door, the Subject was unable to provide a credible justification, except to offer that he was mandated to be within arm's length distance from Service Recipient [REDACTED] in order to properly supervise him. (Hearing testimony of the Subject)

In his testimony, the facility Assistant Residence Manager stated that when weekly staff assignments are scheduled, consideration is based on the supervision levels of the service recipients and, in accordance, staffing for the evening at issue was appropriate. There were two

DSPs assigned to Service Recipient [REDACTED], who required 2:1 supervision, and the Subject was assigned to Service Recipient [REDACTED] on general supervision and supervision of Service Recipient [REDACTED] upon the exiting of DSP 3 at 9:00 p.m., at which time the Subject admitted Service Recipient [REDACTED] was already asleep. It was standard practice in the facility to assign dual supervision of a general supervision service recipient and a line of sight supervision service recipient. (Justice Center Exhibits 18, 19, 20, 25; Hearing testimony of Assistant Residence Manager [REDACTED]) Furthermore, the facility Residence Manager, the facility Behavioral Intervention Specialist and both DSP 1 and DSP 2 all corroborated that staffing was customary, appropriate and adequate that evening. (Justice Center Exhibits 22, 23, 26 and 27)

Based on the credible evidence, the Justice Center also proved by a preponderance of the evidence that the Subject's breach of duty was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of Service Recipient [REDACTED]. (SSL § 488(1)(h)) The record clearly established that Service Recipient [REDACTED] was non-verbal, unequipped to interact with the community and he was unable to communicate the need for assistance or find his way if he was lost. The Subject's disregard for his duty owed to Service Recipient [REDACTED] was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of Service Recipient [REDACTED].

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.

The report will remain substantiated and therefore 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'

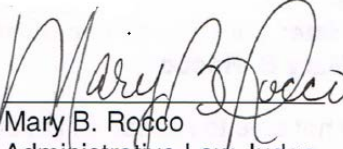
statements, it is determined that the substantiated report is properly categorized as a Category 3 act. A substantiated Category 3 finding of neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to NY SSL § 496(2). This report will be sealed after five years.

**DECISION:** The request of [REDACTED] that the substantiated report dated [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 Mary B. Rocco, Administrative Hearings Unit.

**DATED:** September 28, 2018  
Plainview, New York

  
Mary B. Rocco  
Administrative Law Judge