

**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, of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

Dated: November 13, 2020
Schenectady, New York



Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Gary Kropkowski, Esq.
Russell Wheeler, Esq.
[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:

Sharon Golish Blum
Administrative Law Judge

Held at:

New York State Justice Center for the Protection
of People with Special Needs
By: Video Conference Hearing
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: Gary Kropkowski, Esq.

[REDACTED]

By: Russell Wheeler, Esq.
Charny & Wheeler
9 West Market Street
Rhinebeck, New York 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. In accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR, the Subject requested a hearing (Administrative Proceeding).

Prior to the Administrative Proceeding, the Justice Center filed a motion for collateral estoppel (the "Motion"), requesting that the Subject be precluded from litigating issues raised in a prior Disciplinary Proceeding held at the offices of the New York State Office for People With Developmental Disabilities Institutional Services Unit, which was decided against the Subject. The Subject opposed the Motion.

After giving due consideration to the arguments of the parties, the Motion was granted to the extent of adopting the findings of fact from the Disciplinary Proceeding and applying those facts to the substantiated report herein, and thereby precluding the Subject from relitigating the issues of whether he had a duty and breached his duty to provide proper supervision to Service Recipients 1, 2 and 3. As a result, the evidentiary scope of the Administrative Proceeding was limited to the following issues: (1) whether the Subject's breach of duty resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of any of the Service Recipients pursuant to Social Services Law § 488 (1)(h); and (2) if the allegations were substantiated, whether the category levels were appropriately charged pursuant to Social Services Law § 493(4). (Justice Center Exhibit 1)

PROCEDURAL HISTORY

The New York State Office for People With Developmental Disabilities (OPWDD) served the Subject with a Notice of Discipline (NOD) dated [REDACTED], and made the following Charges against the Subject:

Charge 1: On [REDACTED], between [REDACTED] and [REDACTED], while on duty at [REDACTED], you failed to maintain range of scanning supervision of Individuals [REDACTED], [REDACTED], and [REDACTED].

Charge 2: On [REDACTED], between [REDACTED] and [REDACTED], while on duty at [REDACTED], you left Individuals [REDACTED], [REDACTED], and [REDACTED] unattended in OPWDD van, [REDACTED], with the windows closed and the doors locked.

Charge 3: On [REDACTED], between [REDACTED] and [REDACTED], while on duty at [REDACTED], you directed a non-OPWDD employee to watch Individuals [REDACTED], [REDACTED], and [REDACTED].

Charge 4: On [REDACTED], between [REDACTED] and [REDACTED], while on duty at [REDACTED], you took Individuals [REDACTED], [REDACTED], and [REDACTED] to a non-authorized location.

Charge 5: On [REDACTED], while on duty at [REDACTED], you falsified the Van Log when you indicated you left [REDACTED] at [REDACTED], when you left at approximately [REDACTED].

Charge 6: On [REDACTED], during an interrogation regarding the incident of [REDACTED], you were less than truthful when you told the investigator that you were only in the home on [REDACTED] for approximately 15 minutes, when you were in the location for at least 51 minutes.

The penalty to be assessed against you will be TERMINATION.

(Justice Center Motion Exhibit 2)

A disciplinary hearing was conducted on [REDACTED] and [REDACTED], before an Arbitrator, at which time [REDACTED], Senior Attorney for the New York State Justice Center represented the State, and [REDACTED] represented the Civil Service Employees Association (the Union). The Subject was present and testified at the hearing. The purpose of the disciplinary hearing was to arbitrate the disciplinary grievances against the Subject. (Justice Center Exhibit 4: Arbitration Opinion and Award)

By Opinion and Award dated [REDACTED], the Arbitrator, [REDACTED],

(Arbitrator) found by a preponderance of the evidence that the Subject was guilty of the misconduct set forth in the NOD. (Justice Center Exhibit 4: Arbitration Opinion and Award)

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's Report of Investigation Determination concluded that:

Allegation 1

It was alleged that on or about [REDACTED], while away from [REDACTED], located at [REDACTED], you committed Neglect against/to a Service Recipient.

This allegation has been SUBSTANTIATED as Category 1 Neglect pursuant to Social Services Law § 493(4)(a).

The investigation revealed the Subject failed to provide proper supervision to the Service Recipient during which time he was left unattended in the vehicle.

Allegation 2

It was alleged that on or about [REDACTED], while away from [REDACTED], located at [REDACTED], you committed Neglect against/to a Service Recipient.

This allegation has been SUBSTANTIATED as Category 1 Neglect pursuant to Social Services Law § 493(4)(a).

The investigation revealed the Subject failed to provide proper supervision to the Service Recipient during which time he was left unattended in the vehicle.

Allegation 3

It was alleged that on or about [REDACTED], while away from [REDACTED], located at [REDACTED], you committed

Neglect against/to a Service Recipient.

This allegation has been SUBSTANTIATED as Category 1 Neglect pursuant to Social Services Law § 493(4)(a).

The investigation revealed the Subject failed to provide proper supervision to the Service Recipient during which time he was left unattended in the vehicle.

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

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

5. At the time of the alleged neglect, the Subject had been employed by the OPWDD as a Direct Support Assistant (DSA) for approximately ten years and was assigned to use a facility van (van) to transport and supervise Service Recipients 1, 2 and 3 on a community outing to [REDACTED] Park, a short distance from the facility. (Justice Center Exhibit 4: Arbitration Opinion and Award) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

6. At the time of the alleged neglect, Service Recipient 1, a facility resident, was a partially verbal ambulatory forty-seven year old male whose diagnoses included a profound range of intellectual disability, autism, multiple sclerosis, impulse control disorder, mood disorder, seizure disorder and pica, and whose behaviors included restlessness, hyperactivity, elopement attempts, pushing others and agitation. Service Recipient 1 was unable to identify himself or provide any pertinent information. Service Recipient 1 had experienced significant medical concerns over the past few years which had an adverse impact on his overall presentation. Service

Recipients 1 was unable to recognize a dangerous or threatening situation or health or safety hazard and did not have the ability to defend himself or report any type of encounter to staff. Service Recipient 1 was dependent on staff to assist him with his activities of daily living (ADLs), to administer his medication and to drain urine from his bladder through a suprapubic catheter. Whenever he was in a vehicle or during any activity or outing, Service Recipient 1 was required to be accompanied by staff at all times. Service Recipient 1's regular psychotropic medication was Klonopin and Seroquel which were prescribed to reduce his hyperactivity and agitation. (Justice Center Exhibits 20, 21 and 22)

7. At the time of the alleged neglect, Service Recipient 2, a facility resident, was a nonverbal visually impaired ambulatory [REDACTED] male whose diagnoses included a profound range of intellectual disability, autistic disorder with obsessive compulsive features and psychotic disorder, and whose behaviors included throwing things, self-injury, impulsivity and agitation. Service Recipient 2 became agitated when he sensed another person was sitting or standing too close to him and could become aggressive as a result. Due to his blindness, profound intellectual disability and autism, Service Recipient 2 likely had much difficulty understanding and/or adapting to changes in his routine, which may have led to his frustration and resulting impulsive actions (hitting/biting others, destruction of property and/or self-abuse). Service Recipient 2 was completely dependent on staff to assist him with his ADLs and with ambulating and required twenty-four-hour supervision, the baseline for which was range of hearing. Service Recipient 2 required total staff support to ensure his safety when in the community. Service Recipient 2's regular psychotropic medication was Depakote ER, Inderal, Lithium Carbonate, Thorazine and Seroquel to stabilize his mood and reduce his agitation, aggression and impulsivity. (Justice Center Exhibits 25 and 26)

8. At the time of the alleged neglect, Service Recipient 3, a facility resident, was a

partially verbal primarily non-ambulatory adult male with left side paralysis, whose diagnoses included moderate intellectual disability, cerebral palsy, mood disorder, impulse control disorder and seizure disorder, and whose behaviors included agitation and verbal abuse. In the past, Service Recipient 3's ambulation deteriorated due to his shakiness and an increase in seizure activity and, as a result, Service Recipient 3 generally relied on a wheelchair and wore a soft helmet. Service Recipient 3 was completely dependent on staff to assist him with his ADLs and medication administration, he required two staff to assist in showering, and he required twenty-four-hour supervision, the baseline for which was range of hearing. Service Recipient 3's regular psychotropic medication was Risperdal, Celexa and Thorazine to stabilize his mood and reduce his agitation, aggression and anxiety. (Justice Center Exhibits 30 and 32)

9. On [REDACTED], the Subject drove the van from the facility directly to a trailer park, where he parked and exited the van at approximately 10:00 a.m., locked the doors and went inside one of the trailers, leaving the three Service Recipients unsupervised in the locked van. A neighbor, who heard yelling and banging coming from the van, unsuccessfully attempted to open the doors and contacted the police, who arrived at approximately 11:05 a.m. It is not clear from the evidence where the Subject was situated when the police arrived. (Justice Center Exhibit 4: Arbitration Opinion and Award)

10. The Arbitrator noted the undisputed fact, to which the Subject admitted in his testimony, that he did not have the three Service Recipients within range of scanning supervision when he left them unattended in the locked van. The Arbitrator found that the Subject was inside the trailer home for at least 65 minutes and, based on all the evidence, she found the Subject guilty of all charges. (Justice Center Exhibit 4: Arbitration Opinion and Award)

11. The Service Recipients were examined subsequent to the incident and no evidence was offered that any of them suffered injury or discernable harm as a result of the Subject's

conduct. (Justice Center Exhibits 12 and 19)

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 allegation constitutes neglect.
- Pursuant to Social Services Law § 493(4), the category of neglect that such act or acts constitute.

APPLICABLE LAW

Collateral Estoppel

It is settled law that the determination of disciplinary arbitrators can form the basis for collateral estoppel in subsequent administrative proceedings. *See In re Claim of Harewood*, 253 A.D.2d 934 (3d Dept. 1998); *In re Claim of Guimaraes*, 68 N.Y.2d 989 (1986). The Third Department Appellate Division precluded a party from relitigating the questions of fact determined in a disciplinary proceeding to a subsequent Justice Center administrative proceeding. *Anonymous v. New York State Justice Ctr. for the Protection of People with Special Needs et al.*, 167 A.D.3d 113, 121 (3d Dept. Nov. 21, 2018).

In order for the doctrine of collateral estoppel to apply, there must be: “(1) an identity of issue that was necessarily decided in the prior action and is decisive of the present action, and (2) a full and fair opportunity to contest the issue in the prior action now said to be controlling.” *Collins v. Indart-Etienne*, 59 Misc.3d 1026, 1037 (Kings Cty. Sup. Ct., Feb. 5, 2018 (*citing Buechel v. Bain*, 97 N.Y.2d 295, 303-04 (2001))) The issue need not have been “actually litigated”, but it must have been raised and actually determined in the prior proceeding. *Collins*, 59 Misc. 3d at 1037 (*citing Evans v. Ottimo*, 469 F.3d 278, 283 (2d Cir. 2006), *citing D’Arata v. NY Cent. Mut. Fire Ins. Co.*, 76 N.Y.2d 659, 666-667 (1990))

“While the party seeking to invoke collateral estoppel has the burden of demonstrating the identity of issues, the party attempting to defeat its application has the burden of establishing the absence of a full and fair opportunity to litigate the issue.” *Collins*, 59 Misc. 3d at 1037 (citing *Evans v. Ottimo*, 469 F.3d 278, 281 (2d Cir. 2006), citing *Kaufman v. Eli Lilly & Co.*, 65 N.Y.2d 449, 456 (1985))

The Administrative Proceeding

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...” (14 NYCRR § 700.3(f))

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

"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 1 serious conduct pursuant to SSL § 493(4)(a), the relevant part of which is defined as follows:

(ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either.

The two remaining relevant categories of substantiated reports of neglect pursuant to SSL § 493(4) are Categories 2 and 3, which are defined as follows:

- (b) Category two is substantiated conduct by custodians that is not otherwise described in category one, but conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Category two conduct under this paragraph shall be elevated to category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged in category two conduct. Reports that result in a category two finding not elevated to a category one finding shall be sealed after five years.
- (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 acts of neglect alleged in the substantiated report that is the subject of the proceeding and that such acts constitute the category of neglect as set forth in the substantiated report. (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 acts of neglect cited in the substantiated report constitute 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.

The Disciplinary Proceeding

In a Disciplinary Proceeding, the State must establish by a preponderance of the evidence that the Subject is guilty of the charges set forth in the NOD which, in this case, was to prove that the Subject failed to maintain range of scanning supervision of the three Service Recipients; that he left the three Service Recipients unattended in the OPWDD van with the windows closed and the doors locked; that he directed a non-OPWDD employee to watch the three Service Recipients; that he took the three Service Recipients to a non-authorized location; that he falsified the Van Log; and that he was less than truthful when he told the investigator that he was only in the home for approximately 15 minutes. (Justice Center Exhibit 4: Arbitration Opinion and award)

DISCUSSION

Motion for Collateral Estoppel

The Justice Center has met its burden of demonstrating that there was an identity of issues in the two proceedings and that the Subject had a full and fair opportunity during the prior Disciplinary Proceeding to contest the issues of the Subject's duty and breach of duty to provide proper supervision. See *Anonymous*, 167 A.D.3d at 116-117.

The Justice Center argued that the issues of fact and credibility that are decisive in the Administrative Proceeding are identical to those that were resolved in the Justice Center's favor in the Disciplinary Proceeding and that the application of the facts to the instant Administrative Proceeding supports a finding of neglect. These include the Arbitrator's explicit recognition of the undisputed facts that the Subject did not have the three Service Recipients within range of

scanning supervision and that he left the three Service Recipients unattended in the locked van, as well as the Arbitrator's finding that the Subject was inside the trailer home for at least 65 minutes and that the Subject was guilty of all charges. (Justice Center Exhibit 4: Arbitration Opinion and Award).

In opposition to the Motion, it was argued on behalf of the Subject that the Justice Center did not establish identity of issue or identity of standard of proof and that, as the Justice Center failed to establish entitlement to the relief sought, the instant Motion should be denied in all respects and that the Motion should be dismissed. (Respondent's Memorandum of Law in Opposition to the Motion by the Justice Center)

Applying the facts established by the Arbitrator that are subject to the same burden of proof as in the Administrative Proceeding warrants preclusion of the issues that were already materially litigated and decided. The issue of whether the Subject had a duty to have the three Service Recipients within range of scanning supervision and whether the Subject breached his duty when he left the three Service Recipients unattended in the locked van for approximately 65 minutes were raised, addressed and resolved by the Arbitrator. (Justice Center Exhibit 4: Arbitration Opinion and Award)

As the requirements of identity of issue were satisfied, the burden shifted to the Subject to demonstrate that he did not have a full and fair opportunity to contest the Arbitrator's determination concerning his duty and breach of duty. The Subject, who opposed the Motion, has not met his burden of establishing the absence of a full and fair opportunity to litigate those issues. At the Disciplinary Proceeding, the Subject was represented by counsel, testified in his own behalf, cross-examined the employer's witnesses and had the opportunity to present and examine relevant evidence. The Subject is therefore not entitled to relitigate the factual issues of his conduct, which were already determined by the Arbitrator.

The Administrative Proceeding

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-10, 12-13, 15-34) The Justice Center also presented audio recordings of the Justice Center's interview of witnesses and interrogation of the Subject. (Justice Center Exhibit 35) The investigation underlying the substantiated report was conducted by the Investigator, who was the only witness that testified at the Administrative Proceeding on behalf of the Justice Center.

The Subject did not testify in his own behalf. The document identified as Subject Exhibit 1 was admitted as evidence on the Subject's behalf. (Subject Exhibit 1)

The Investigator testified regarding the three Service Recipients' individual diagnoses, behaviors, vulnerabilities, unique medical challenges and their supervision levels, as is found in their respective Plans of Protective Oversight (Justice Center Exhibits 20, 25 and 30), Behavior Support Plans (Justice Center Exhibits 21, 26 and 31) and Individual Support Plans (Justice Center Exhibits 22, 27 and 32).

The Justice Center met its burden, by collateral estoppel, that the Subject had a duty and breached his duty to provide range of scanning supervision to the three Service Recipients, as reflected in Allegations 1, 2 and 3 of the Report of Investigation Determination. Despite the fact that there was no evidence that the Subject's breach of duty actually resulted in physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the three Service Recipients, such evidence is not necessary for a finding of neglect.

Regarding Allegation 1 of the Report of Investigation Determination, given Service Recipient 1's vulnerability due to his numerous and varying diagnoses and behaviors, it is clear that the Subject's breach of duty was likely to result in Service Recipient 1's physical injury or serious or protracted impairment of his physical, mental or emotional condition pursuant to Social

Services Law § 488(1)(h).

Regarding Allegation 2 of the Report of Investigation Determination, given Service Recipient 2's vulnerability due to his numerous and varying diagnoses and behaviors, it is clear that the Subject's breach of duty was likely to result in Service Recipient 2's physical injury or serious or protracted impairment of his physical, mental or emotional condition pursuant to Social Services Law § 488(1)(h).

Regarding Allegation 3 of the Report of Investigation Determination, given Service Recipient 3's vulnerability due to his numerous and varying diagnoses and behaviors, it is clear that the Subject's breach of duty was likely to result in Service Recipient 3's physical injury or serious or protracted impairment of his physical, mental or emotional condition pursuant to Social Services Law § 488(1)(h).

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 described as Allegations 1, 2 and 3 in the Report of Investigation Determination. The substantiated report will not be amended and sealed.

Since 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. Pursuant to SSL § 493(4)(a)(ii), Category 1 conduct is defined as a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either.

The Justice Center argued that the Subject's breach of duty was reckless. Pursuant to SSL § 488(16), "recklessly" has the same meaning as provided in New York Penal Law § 15.05. Under New York Penal Law § 15.05(3), a person acts "recklessly with respect to a result or to a circumstance described by a statute defining an offense" when the person is "aware of and consciously disregards a substantial and unjustifiable risk that such result will occur or that such circumstance exists. The risk must be of such a nature and degree that disregard thereof constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation."

Each of the three Service Recipients had complicated and challenging physical, intellectual and psychological conditions and, as a result, were members of the most vulnerable population. The Subject had been employed at the facility for approximately ten years and was familiar with the Service Recipients' conditions and supervision requirements. All three Service Recipients required range of scanning supervision in the community and none of them possessed the ability to independently manage being left unsupervised for any length of time.

Service Recipient 1's significant vulnerability, the details of which have been discussed above, included the behaviors of restlessness, hyperactivity, elopement attempts, pushing others and agitation. Accordingly, by leaving him unsupervised in the van, the Subject took the substantial and unjustifiable risk that Service Recipient 1 would have attempted to elope and/or become agitated and pushed another Service Recipient.

Service Recipient 2's significant vulnerability, the details of which have been discussed above, included legal blindness and the behaviors of throwing things, self-injury, impulsivity, aggressiveness and agitation when he sensed another person was sitting or standing too close to him. Accordingly, by leaving him unsupervised in the van, the Subject took the substantial and

unjustifiable risk that Service Recipient 2 would have become agitated and/or aggressive toward another Service Recipient who was sitting near him.

Service Recipient 3's significant vulnerability, the details of which have been discussed above, included an increase in seizure activity regarding his seizure disorder, for which he wore a soft helmet. Accordingly, by leaving him unsupervised in the van, the Subject took the substantial and unjustifiable risk that Service Recipient 3 would have a seizure without anyone present to assist him.

SSL § 493(4)(a)(ii) is applicable under the circumstances presented herein. While it was very fortunate that the Service Recipients sustained no actual physical injury that created a substantial risk of death; caused death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of any of their psychological or intellectual functioning, it is clear from the facts that the Subject's reckless failure to provide proper supervision to the Service Recipients was likely to result in the serious impairment of the Service Recipients' health. Furthermore, in all three cases, given the facility's strict supervision guidelines and the severe diagnoses of the Service Recipients, the substantial and unjustified risk taken by the Subject was of such a nature and degree that the Subject's disregard of the risk constitutes a gross deviation from the standard of conduct that a reasonable person would have observed in this situation.

A substantiated Category 1 finding of neglect will result in the Subject being placed on the VPCR Staff Exclusion List and the fact that the Subject has a substantiated Category 1 report will be disclosed to entities authorized to make inquiry to the VPCR. Substantiation of a Category 1 offense permanently places the Subject on the Staff Exclusion List.


DECISION:

The request of [REDACTED], that the substantiated report dated [REDACTED] of neglect by the Subject of the Service Recipients 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 1 act.

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

DATED: November 4, 2020
Plainview, New York



Sharon Golish Blum, Esq.
Administrative Law Judge