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 AFTER HEARING

Adjud. Case #: [redacted]

Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived

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

[redacted]

By: Jason P. Jaros, Esq.
Law Offices of Jaros and Jaros
8027 Main Street, Suite 13
Williamsville, New York 14221

[redacted]

The Findings of Fact and Conclusions of law are incorporated from the Recommendations of the presiding Administrative Law Judge's Recommended Decision.

ORDERED: The request of [redacted] that the substantiated report dated [redacted], [redacted] received and 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.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(c).

This decision is ordered by David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

DATED: Schenectady, New York
November 25, 2015

David Molik
Administrative Hearings Unit

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

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

Adjud. Case #: [redacted]

Before: John T. Nasci
Administrative Law Judge

Held at: [redacted]
On: [redacted]

Parties: Vulnerable Persons' Central Register
New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived

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

[redacted]
By: Jason P. Jaros, Esq.
Law Offices of Jaros and Jaros
8027 Main Street, Suite 13
Williamsville, New York 14221

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for abuse and/or 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], received and 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 acting as a custodian, you committed neglect when you failed to ensure that staffing minimums were adhered to at the [redacted] by approving schedules with unfilled vacancies, during which time a service recipient touched another service recipient inappropriately.

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

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

4. The facility, located at [redacted], is an [redacted], and is operated by the New York State Office for People With

Developmental Disabilities (OPWDD), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center. (See Hearing testimony of OPWDD Investigator [redacted])

5. At the time of the alleged neglect, the Subject was employed by [redacted] and had been employed by [redacted] for approximately twenty-three years. At the time of the report, the Subject worked as a Developmental Assistant 3 (DA3). (See Hearing testimony of the Subject)

6. At the time of the alleged neglect, the Service Recipients affected by the Subject's actions were nine high functioning adult residents of the facility with varying intellectual disabilities. (See Justice Center Exhibit 6 page 5; and Hearing testimony of OPWDD Investigator [redacted])

7. The following are [redacted] staffing policies and practices that were in effect at the time of the alleged neglect: 1) staff vacation schedules are bid by staff, based on seniority and submitted for approval in March for the summer months (May to October) and in September for the winter months (November to April); 2) twenty-eight day work schedules are developed and submitted for approval two to three weeks in advance of the beginning of the work period and posted ten days in advance of the work period; 3) work schedules are reviewed and approved by a Developmental Assistant 3 (DA3) level staff; 4) vacancies caused by vacations are to be filled by a DA1 or a DA2 level staff, with a DA3 level staff approval, through the use of overtime (a full time employee working more than normal work hours) or extra-time (a part time employee working more than the maximum part time hours); and 5) a vacancy approved for overtime is filled by a DA1 or a DA2 level staff by first seeking volunteers, next submitting a request to the Overtime Call Center (OTCC), and lastly by mandating an employee who is

working the shift immediately preceding the shift with the vacancy. (See Justice Center Exhibit 17 – audio recording of Interrogation of the Subject; Justice Center Exhibit 9 page 2; Hearing testimony of [redacted] and Hearing testimony of the Subject)

8. The [redacted] Site Specific Plan For Provision of Protective Oversight (POPO) for the [redacted], that was in effect at the time of the alleged neglect, contains a staffing plan that requires, in pertinent part, that: "There will be 2 Direct Support Assistant(s) present during daytime hours M-F …", and that: "This schedule may be modified as necessary to accommodate operating needs." (See Justice Center Exhibit 9 page 2)

9. At the time of the report, the Subject was the supervisor of four [redacted] including the [redacted]. Among the Subject's responsibilities was reviewing and approving vacation and work schedules submitted to him by his subordinates. (See Hearing testimony of the Subject)

10. Routinely, during weekdays at the [redacted] when the day shift staff arrives at 7:00 a.m., seven of the nine Service Recipients who reside at the [redacted] are in the living room of the [redacted] waiting on a couch for their bus, which will take them to their program work location. The seven Service Recipients leave the [redacted] on the bus between 7:30 a.m. and 7:45 a.m. The remaining two Service Recipients leave the [redacted] for program activities via a second bus that arrives between 8:45 a.m. and 9:20 a.m. After the last two Service Recipients leave the [redacted], there are no Service Recipients in the [redacted] until approximately 3:15 p.m. to 3:30 p.m. when the Service Recipients return from program work and activities. (See Justice Center Exhibit 17, audio recording of Interrogation of the Subject; and Hearing testimony of [redacted])

11. For at least ten years preceding the date of the report, it was a common and regular practice at the [redacted] to not fill a day shift vacancy and to schedule only one

staff to work the shift, unless one of the Service Recipients had an appointment or was sick and stayed at the [redacted] during the day. (See Justice Center Exhibits 17, 18 and 19 - audio recordings of Interrogations of the Subject, [redacted] and [redacted] respectively; Hearing testimony of [redacted]; and Hearing testimony of the Subject)

12. On [redacted], only one staff was scheduled to work the 7:00 a.m. to 3:00 p.m. shift at the [redacted]. The second staff, DA2 [redacted], who would normally work this shift, was on vacation. (See Justice Center Exhibits 7 and 8) Prior to [redacted], DA1 [redacted] prepared and submitted, to the Subject for approval, a work schedule for the work period which included [redacted], and which left unfilled the [redacted] day shift vacancy caused by DA2 [redacted] absence. The Subject approved this work schedule without change. Neither DA1 [redacted] nor the Subject made any attempt to fill the [redacted] vacancy. (See testimony of OPWDD Investigator [redacted]; Hearing testimony of [redacted]; and Hearing testimony of the Subject)

13. On [redacted] at approximately 7:35 a.m., a Service Recipient who resided at the [redacted] told Staff [redacted] (who was the only staff scheduled to work the day shift on [redacted]) that another Service Recipient had grabbed her crotch outside her pants. At the time when the touching was alleged to have occurred, Staff [redacted] was in the basement helping another Service Recipient with laundry, and the other eight Service Recipients were in the living room waiting for their respective buses. (See Justice Center Exhibit 16; and Justice Center Exhibit 18 – audio recording of Interrogation of [redacted])

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 neglect occurred…" (Title 14 NYCRR 700.3(f))

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

> "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(s) 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 does not prove the neglect by a preponderance of evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has established by a preponderance of evidence that the Subject committed a prohibited 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 1-16 and 20) The Justice Center also presented audio recordings of three interrogations conducted by the OPWDD

Investigator during the investigation of the report. (Justice Center 17, 18 and 19) The investigation underlying the substantiated report was conducted by OPWDD Investigator [redacted], who testified at the hearing in behalf of the Justice Center. [redacted], [redacted] Staffing Coordinator also testified in behalf of the Justice Center.

The Subject testified in his own behalf, presented [redacted] as a witness and presented one exhibit. (Subject Exhibit 1)

The Justice Center proved by a preponderance of the evidence that the Subject committed neglect by approving a work schedule which left a day shift vacancy at the [redacted] thereby leaving the [redacted] understaffed and resulting in several Service Recipients being left unsupervised which gave rise to an allegation that one Service Recipient had inappropriately touched another Service Recipient.

The evidence presented by the Justice Center was not disputed by the Subject. The Justice Center contends that the POPO for the [redacted] required two staff on the day shift, that the Subject was responsible for approving the scheduling of staff to work at the [redacted], and that the Subject approved the work schedule for the date in question (September 6, 2013) which contained a vacancy caused by Staff [redacted] being away from work on vacation. The Justice Center further contends that the Subject's approval of the work schedule, with the vacancy unfilled, left the [redacted] understaffed and gave rise to an alleged inappropriate touching of a Service Recipient by another Service Recipient.

The Subject contends that leaving the dayshift staffed with only one person, when one of the dayshift staff was on vacation or called in sick, was a regular and longtime practice at the [redacted] and that this practice was accepted, if not sanctioned by higher levels of management. The Subject further contends that, if a staff from the preceding shift was mandated

to stay and work the daytime shift, the mandated staff would have nothing to do after the last Service Recipient left the [redacted] by 9:20 a.m. at the latest.

It is clear that the [redacted] POPO requires two staff to be assigned and work the day shift. The POPO also provides for changes to this requirement "as necessary to accommodate operating needs." (See Justice Center Exhibit 9 page 2) However, the evidence does not clearly establish that this provision allows the understaffing of a shift due to a vacancy caused by staff vacation or illness. Furthermore, the Subject's evidence establishes that the reason for not attempting to fill the vacancy was not that there was an operational need, but instead that it was the regular practice of the [redacted].

To prove neglect, the Justice Center must establish that the Subject's action, inaction or lack of attention breached his custodial duty to a Service Recipient. The Subject's approval of the work schedule containing the vacancy on [redacted] was clearly in contradiction of facility policy and therefore a breach of duty to the Service Recipients of the [redacted].

The Justice Center must also establish that 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 a service recipient. The Subject contends that injury or impairment to the Service Recipients of the [redacted] was not likely to occur because all nine of the Service Recipients at the [redacted] were high functioning, required minimal supervision and had no history of behavioral issues. (See Hearing testimony of OPWDD Investigator [redacted]; Hearing testimony of [redacted]; and Hearing testimony of the Subject).

The record establishes that while some of the Service Recipients were relatively independent, other Service Recipients required a certain level of protective oversight. Some of the protective safeguards included periodic observations every 30 minutes, periodic observations

every 60 minutes, range of scan supervision, arm's length supervision in the kitchen, arm's length supervision if agitated, supervision or monitoring while eating, and size limitations on food to prevent choking. (See Justice Center Exhibit 6 pages 5 and 6)

Given the requirements of the individual Service Recipients' Plans of Protective Oversight, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a Service Recipient are likely consequences of having less than the required number of staff on duty. Although the allegation of inappropriate touching was not proved at the hearing[1], it is clear that something happened to cause a Service Recipient to make the allegation and that there was no staff present when the alleged act occurred. It is likely that harm could have come to any of the eight Service Recipients who remained on the first floor while the lone facility staff on duty was in the basement helping the ninth Service Recipient with laundry.

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 level 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.

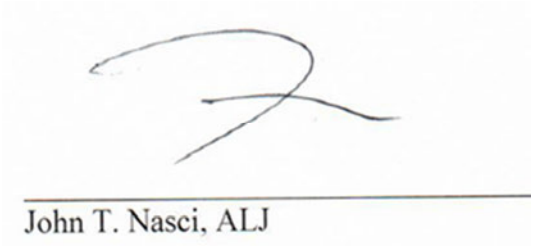
[1] The Justice Center did not attempt to prove this issue in the hearing but instead relied upon the theory that the Subject's breach of his duty resulted in a likelihood of harm to the Service Recipients.

DECISION: The request of [redacted] that the substantiated report dated [redacted], [redacted] received and 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 John T. Nasci, Administrative Hearings Unit.

DATED: November 23, 2015
Schenectady, New York



John T. Nasci, ALJ