

**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]

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: Todd Sardella, Esq.

[REDACTED]
[REDACTED]
[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 ██████████ that the substantiated report dated ██████████, ██████████ 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 2 act.

NOW, THEREFORE, IT IS DETERMINED that reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years. The record of these reports shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(b).

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: June 7, 2016
Schenectady, New York



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:

Elizabeth M. Devane
Administrative Law Judge

Held at:

Office of Children and Family Services
Spring Valley Regional Office
11 Perlman Drive
Spring Valley, New York 10977
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
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161 Delaware Avenue
Delmar, New York 12054-1310
By: Todd Sardella, Esq.

[REDACTED]
[REDACTED]
[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 findings of the report to reflect that the Subject has not committed the act of neglect giving rise to the substantiated report. The VPCR did not do so, and a hearing was 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 [REDACTED] at the [REDACTED], located at [REDACTED], while acting as a custodian, you committed neglect by failing to provide required supervision when you left a service recipient unattended in an agency van for several hours.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(b).

3. An Administrative Review was conducted at the request of the Subject and following that review, the substantiated report was retained.

4. [REDACTED] facility, located at [REDACTED] is a certified [REDACTED] operated by [REDACTED], which in turn

is an agency 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. [REDACTED] is a group home for disabled individuals and provides twenty-four hour care. At the time of the alleged neglect there were five residents at [REDACTED]. (Hearing testimony of Corporate Compliance Officer [REDACTED])

5. At the time of the incident, the Subject was employed as a Direct Support Professional (DSP) and had been employed as such at [REDACTED] for twelve years. The Subject was a custodian as that term is defined in Social Services Law § 488(2). As a DSP, the Subject's duties included day to day caretaking of the service recipient's basic hygienic, nutritional and physical needs and the transportation of service recipients. (Hearing testimony of Corporate Compliance Officer [REDACTED], Justice Center Exhibit 2)

6. At the time of the incident, the Service Recipient was ninety years old and had resided at [REDACTED] for twenty-one years. She had multiple diagnoses including Severe Mental Retardation, Autism, Obsessive Compulsive Disorder and Trichotillomania. The Service Recipient had limited communication abilities and was under 24 hour protective oversight. She easily became withdrawn, anxious or agitated if she felt bothered by staff. During the weekdays, the Service Recipient attended a day program for senior citizens. (Hearing testimony of Corporate Compliance Officer [REDACTED], Justice Center Exhibits 6, 7, 12 and 15)

7. On [REDACTED], the Subject worked at [REDACTED] from 7 a.m. until 12 p.m. She was assigned to assist two service recipients with activities of daily life in the early morning and was also assigned as a driver to shuttle the service recipients in the facility van. (Hearing testimony of Corporate Compliance Officer [REDACTED], Hearing testimony of Subject, Justice Center Exhibits 9 and 10)

8. At 8:56 a.m. on [REDACTED], the Subject departed [REDACTED] with four service recipients in the facility van. The Subject drove the service recipients to their various day programs and completed work related errands. The other staff person on duty remained at [REDACTED] to supervise an ill service recipient. The Subject dropped off three service recipients at their respective day programs.

9. The Service Recipient remained in the van and the Subject made stops at [REDACTED] main campus where she picked up mail and fueled the van. The Subject assisted the Service Recipient into and out of the van during those stops and did not leave the Service Recipient unsupervised in the van.

10. The Subject returned to [REDACTED] at 10:18 a.m., completed the travel log and then, after she shut off the van, she exited the van. The Subject did not check the van interior prior to or upon exiting the van. The Service Recipient was seated in the row and seat directly behind the driver's seat and was left behind when the Subject exited the van. The Subject went into [REDACTED] and worked until 12:00 p.m. when her shift ended. The Subject left [REDACTED] at 12:00 p.m. (Hearing testimony of Corporate Compliance Officer [REDACTED], Hearing testimony of Subject, Justice Center Exhibits 7, 11 and 14)

11. Pursuant to [REDACTED] Policy, all drivers are required to visually inspect vehicle seats from the back to the front, at the end of each trip. This is done to ensure that no individuals remain in the vehicle. [REDACTED] Policy also dictates that service recipients should not be left unattended in a vehicle. (Justice Center Exhibit 13)

12. At 1:48 p.m. staff [REDACTED] arrived to work and entered the van. Upon entering the van, [REDACTED] heard moaning and turned around to see the Service Recipient seated in the seat directly behind the driver. Her arm was out of the correct seatbelt position. Her lunchbox was empty

and on the floor. She had soiled herself. The Service Recipient's pants, as well as the van seat, were saturated with urine. ■■■ reported the incident to a supervisor and an investigation commenced. Upon assessment by the supervising RN, the Service Recipient's vitals were healthy and she had no injuries. (Justice Center Exhibits 7, 9 and 14)

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 neglect.
- Pursuant to Social Services Law § 493(4), the category of 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 abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1). Neglect under SSL § 488 (1) (h) is defined 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 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.

In this matter, the Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the act(s) of neglect alleged in the substantiated report that is the subject of the proceeding and that such act(s) 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 will not be 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 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 the act of neglect described as “Allegation 1” in the substantiated report. The preponderance of the evidence established that the Subject, while acting as a custodian for the Service Recipient, breached the duty of care she owed to the Service Recipient by her inattention and failure to provide proper supervision and leaving the Service Recipient unattended in a van for a number of hours. The Subject’s breach of duty to the Service Recipient was likely to result in physical injury or serious or protracted impairment to the physical, mental or emotional condition of the Service Recipient and seriously endangered the health, safety and welfare to the Service Recipient.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-15) [REDACTED] Corporate Compliance Officer [REDACTED] testified regarding the investigation underlying the substantiated report and was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf. The Subject did not present any exhibits other than her request for amendment, which was in evidence as Justice Center Exhibit 2.

There is no dispute that the Subject was acting as a custodian for the Service Recipient. There is no dispute that the Subject left the Service Recipient, an elderly woman who required twenty-four hour care, unattended in a vehicle for approximately three and one-half hours. The uncontroverted evidence establishes that the Service Recipient was seated in the van behind the

Subject and the Subject failed to drop off the Service Recipient at her day program. (Hearing testimony of Corporate Compliance Officer [REDACTED], Hearing testimony of Subject, Justice Center Exhibits 2 and 14) Further, upon returning to [REDACTED], the Subject left the Service Recipient in the car at 10:18 a.m. The Subject failed to inspect and clear the vehicle and went into the residence. The Subject then left work at 12:00 p.m. while the Service Recipient remained in the vehicle. The Service Recipient was not found until 1:48 p.m., three and one-half hours after returning to [REDACTED], by staff [REDACTED]. The Subject's inattention to the Service Recipient and the Subject's violation of [REDACTED] policy constitute neglect. (Hearing testimony of Corporate Compliance Officer [REDACTED], Hearing testimony of Subject, Justice Center Exhibits 2, 6, 7, 9, 10 and 14)

In her defense, the Subject indicated she was distracted by thinking about a personal matter. The Subject also said there was heavy traffic that day and it was the holiday season which impacted her thoughts. She said she did not realize she failed to drop off the Service Recipient. The Subject testified that she made a "big mistake," but was not negligent. The Subject did say she was very sorry that the incident occurred. While each of these factors may have contributed to her actions, none of them is a valid defense for the neglect and, in fact, amount to an admission.

The Subject also stated that two staff were supposed to be in the vehicle, yet she was assigned to drive the service recipients to their day programs by herself. The Subject wrote that she was therefore the "victim" of the facility's violation of rules. This argument fails. No evidence was presented that there was a two staff member requirement for this staff run. Even if such evidence were provided and two staff were required by rule to be present, that would not lessen the Subject's obligation to ensure that service recipients are not left unattended in

vehicles.

The Subject's breach of her duty to the Service Recipient was likely to result in physical injury or serious or protracted impairment of the Service Recipient's physical, mental or emotional condition. The elderly, disabled Service Recipient was left unattended in a vehicle for three and one-half hours.

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. To reach the level of a Category 2 act, the conduct of the Subject would have had to seriously endanger the health, safety or welfare of the Service Recipient. The Service Recipient was 90 years old, disabled, had limited communication skills and needed assistance with all activities of daily life. The incident occurred in [REDACTED]. One of the doors to the vehicle was frozen shut that morning when the Subject went to put the service recipients in the van and the service recipients all had to enter through the unfrozen door. The Service Recipient was found with her arm through the seatbelt, an apparent effort to get out of the vehicle. Her packed lunchbox was found empty on the floor of the vehicle. She was left sitting for hours soiled and soaked in urine. This incident seriously endangered the health, safety and welfare of this Service Recipient.

Based upon the totality of the circumstances, the testimony presented, and the witnesses' testimony, it is determined that the substantiated report is properly categorized as a Category 2 act.

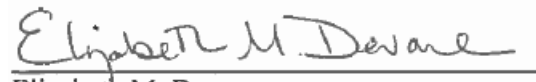
DECISION:

The request of [REDACTED] that the substantiated report dated [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 2 act.

This decision is recommended by Elizabeth M. Devane, Administrative Hearings Unit.

DATED: May 26, 2016
Schenectady, New York


Elizabeth M. Devane
Administrative Law Judge