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: Jennifer Oppong, Esq.

[redacted]
By: [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 [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.

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).

[redacted]

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: August 3, 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: Jean T. Carney
Administrative Law Judge

Held at: New York State Justice Center for the Protection Of People With Special Needs
401 State Street
Schenectady, NY 12305
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: Jennifer DeStefano, Esq.

[redacted]
By: [redacted]

[redacted]

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] 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 someone was assigned to supervise a service recipient and/or she failed to transfer supervision of a service recipient over to another staff member before you left the Program, during which time he was able to elope from the Program, enter a nearby apartment, and engage in a physical altercation with the tenant that led to him suffering severe injuries.
>
> This allegation has been SUBSTANTIATED as Category 2 neglect, pursuant to Social Services Law § 493(4)(b).

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

4. The facility, located at [redacted], is a day program for disabled adults and is operated by [redacted], which is certified by the NYS

[redacted]

Office for People With Developmental Disabilities (OPWDD), and is a facility or provider agency that is subject to the jurisdiction of the Justice Center. (Justice Center Exhibit 7 and hearing testimony of Investigator [redacted]).

5. The Subject had been employed by [redacted] since [redacted] 1997, and at the time of the incident was a Program Specialist II (PS II), which is similar to a Shift Supervisor. As a PS II, the Subject was responsible for creating and posting the schedule, assigning specific duties to staff, ensuring those assignments were carried out, and implementing activities. There were two PSII employees at the facility on the day of the incident. (Hearing testimony of Subject, Justice Center Exhibit 4).

6. At the time of the alleged neglect, the Service Recipient was a 48 year old non-verbal, ambulatory male, and had been attending this program for approximately one year, having previously attended a different day program operated by the same agency. He was diagnosed with autism, severe developmental disability, and required line of sight (LOS) supervision due to his history of elopement. (Justice Center Exhibits 7, 13, 14, 15, and 16).

7. On [redacted], the Service Recipient arrived at the day program at approximately 8:55 a.m. accompanied by a staff person from the [redacted] where he resided. He then eloped from the program by exiting a back door during the morning meeting. The Service Recipient made his way across the parking lot to a rooming house, where he entered a tenant's apartment. The tenant, having never seen the Service Recipient, and fearing for his safety, physically ejected the Service Recipient from his home and called 911. The Service Recipient fell down a flight of steps and hit a portion of the building's stone foundation, a distance of six feet, five inches. (Hearing testimony of Investigator [redacted]).

8. As a result of the scuffle with the tenant, the Service Recipient was significantly injured and brought to a local hospital, then transferred to [redacted] where he was treated for multiple facial fractures, including nasal bone and mandibular fractures; a fractured wrist; dental fractures, including missing teeth; lacerations to his forehead and lip that required sutures; and multiple abrasions. (Justice Center Exhibits 7 and 9).

9. At approximately 9:30 a.m., the staff realized that the Service Recipient was missing, and began searching for him. The authorities notified the program that the Service Recipient had been found, and staff was able to meet the Service Recipient at the hospital. (Hearing testimony of Investigator [redacted], and Justice Center Exhibit 4).

10. The Service Recipient had eloped several months earlier and, as a result, his Behavior Support Plan was changed to require LOS supervision when he was at the program. According to [redacted], LOS means that he must be within visual range of staff at all times, and one staff person is assigned to keep him within visual range. Those assignments are required to be made upon the participant's arrival. The Subject was aware that the Service Recipient had the LOS supervision in his plan, and understood the responsibilities placed on staff pursuant to this policy. (Justice Center Exhibits 7, and 12; hearing testimony of [redacted], and hearing testimony of Subject).

11. On [redacted], the Subject arrived at the program and began to review the previous evening's logs. She assumed that the other PS II was preparing the work schedule. Shortly thereafter, the Subject went out to perform bus duty as the participants arrived. One of the participants arrived without a belt, and his pants were falling down, so the Subject decided to go to another program to borrow a belt for that participant. (Hearing testimony of Subject).

12. As she was leaving, the Service Recipient arrived with his escort and the Subject

[redacted]

met them at the front door. The escort left the Service Recipient with the Subject, who greeted the Service Recipient, opened the doors to the main room and showed the Service Recipient into the main room. (Hearing testimony of [redacted], Justice Center Exhibits 4, and 7).

13. Thereafter, the Subject spoke to her supervisor, Program Manager [redacted], about leaving the building to get the belt for the other participant. [redacted] asked her if everything was covered, and she replied that everything was covered. However, the schedule had not been posted, and the LOS assignments had not been made. (Justice Center Exhibit 4, hearing testimony of [redacted], and hearing testimony of Subject).

14. When the Subject left to run her errand, the program was already short one staff person, and there were at least three participants with LOS supervision requirements. In addition, there were approximately 10 other participants present. As a result, two staff were in the main room covering about 13 participants, including three participants with LOS supervision requirements; while the other PS II was in the office organizing the weekly meeting and putting the schedule together. (Hearing testimony of [redacted], and Justice Center Exhibit 4).

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.

[redacted]

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) to include:

> (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 abuse and/or neglect shall be categorized into categories pursuant to SSL § 493, including Category 2 neglect, which is defined as follows:

> 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

[redacted]

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.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject 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. Category 2 conduct shall be elevated to Category 1 conduct when such conduct occurs within three years of a previous finding that such custodian engaged in Category 2 conduct. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

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 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 1-31). The investigation underlying the substantiated report was conducted by OPWDD Investigator [redacted], who testified on behalf of the Justice Center at the hearing along with PS II [redacted]. The Subject testified on her own behalf and provided one document (Subject Exhibit A).

The Justice Center proved by a preponderance of the evidence that the Subject committed

[redacted]

neglect on [redacted] when she failed to ensure that the Service Recipient's LOS supervision assignment was made prior to her leaving the program to run an errand. As a result of the Subject's lack of attention, the Service Recipient eloped from the program and was seriously injured.

The Subject had been working as a PS II at [redacted] for about two years when this incident occurred. She was responsible for scheduling; ensuring the safety of the participants, staff assignments, and making sure the staff complied with those assignments. (Hearing testimony of Subject, hearing testimony of [redacted], Justice Center Exhibit 6).

The Service Recipient had a history of eloping, so his Behavior Support Plan was amended in [redacted] to require LOS supervision whenever he is at the program. The plan requires that someone must be assigned as his LOS as soon as he arrives at the program. However, the assignments were typically not made until after everyone arrived at the program. Therefore, the Service Recipient may be at the program for over an hour before any staff is assigned to him. This clearly violates the Service Recipient's LOS plan. (Justice Center Exhibits 4, 6, 12, 13, and 14).

The Subject had known the Service Recipient for many years, and was fully aware of his history. The Subject was also trained in the Service Recipient's plan, and understood his LOS requirements. The Subject was aware that on the morning of [redacted] the program was short staffed, and that two employees were in the main room with at least a dozen participants, three of whom had LOS supervision requirements. Nevertheless, the Subject chose to leave the program in order to return a pair of pants, and to borrow a belt for a participant whose pants were falling down. (Hearing testimony of Subject; and Justice Center Exhibits 4 and 6).

In her request to appeal the substantiation, the Subject contends that she was not a custodian because she was not assigned to the Service Recipient, and she was not present when the Service Recipient eloped from the program. As a PS II, the Subject has a duty to ensure the safety of the

[redacted]

participants of the program. This duty is not limited to a particular individual to whom she is assigned. It applies to every person present and participating in the program that day. The Subject also has a duty to ensure that all LOS assignments are made and posted. Therefore, if the assignments have not been made by another employee, then the Subject was responsible for making those assignments. The fact that she chose to leave the premises without making sure those tasks were completed does not relieve her of those duties.

The Subject's actions that morning showed a complete lack of attention to the safety of the individuals in her care. Without communicating to the other PS II, the Subject assumed that the other PS II was making the schedule that day. Without communicating to the other two staff in the main room, the Subject assumed that they would be able to provide LOS supervision to three participants while simultaneously watching the other ten or more individuals in the main room. Moreover, the Subject affirmatively stated to her supervisor before she left that everything was covered; when in fact nothing was covered. Therefore the Subject breached her duty to the Service Recipient that morning. (Hearing testimony of Subject, and Justice Center Exhibit 4).

As a result of this breach of duty, the Service Recipient was able to leave the program and walk to a rooming house where he entered a complete stranger's apartment, causing that person to fear for his safety. The Service Recipient was seriously injured during the reasonably foreseeable struggle, and spent several days in the hospital. He underwent surgery, wound debridement, a CT scan, and several follow up appointments with specialists in order to treat his injuries. Those injuries included multiple facial fractures, including maxillary and nasal bone fractures, a radial fracture to his left wrist, dental fractures, many missing teeth, two lacerations on his face requiring sutures, and multiple abrasions. (Hearing testimony of Investigator [redacted], Justice Center Exhibits 7, 9, and 10).

[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.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category level of abuse or neglect set forth in the substantiated report**.** As a result of the Subject's conduct in leaving the facility despite her obligation under established policy to ensure LOS supervision was assigned to the Service Recipient, his health, safety, and welfare were seriously endangered. He experienced significant trauma, and he suffered serious injuries. Therefore, 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 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.

[redacted]

This decision is recommended by Jean T. Carney, Administrative Hearings Unit.

DATED: June 17, 2016
Schenectady, New York