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]

[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 requests of [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is denied. The Subjects have 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: November 10, 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, New York 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
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New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
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By: Jennifer Oppong, Esq.

[redacted]

[redacted]

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] and [redacted] (the Subjects) for neglect. The Subjects requested that the VPCR amend the report to reflect that the Subjects are not subjects 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 Subjects of a Service Recipient.

2. The Justice Center substantiated the report against the Subjects. The Justice Center concluded that:

Allegation 1

> It was alleged that on [redacted], outside of the [redacted] located at [redacted], while acting as a custodian, you committed neglect when you failed to provide proper supervision to a service recipient by leaving him alone in the agency van, during which time the service recipient exited the van and fell on the ground.
>
> This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Las § 493(4)(b).

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

4. The facility, is an [redacted] and is operated by [redacted], 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.

5. At the time of the alleged neglect, the Subjects were employed by [redacted] as Direct Support Professionals (DSPs).

6. At the time of the alleged neglect, the Service Recipient was 57 years of age, and had been a resident of the facility since [redacted] 2000. The Service Recipient is a non-verbal male with diagnoses of severe intellectual disability, autism, glaucoma (blind in his right eye), hearing impaired (moderate to severe), Parkinson's disease, cerebral palsy, and several other medical issues not relevant to this matter. (Justice Center Exhibit 25)

7. On [redacted], the Subjects returned to the [redacted] between 1:30 p.m. and 1:45 p.m. from an outing with the Service Recipient and two other service recipients. Subject [redacted] had been assigned to supervise the Service Recipient during this shift, and Subject [redacted] had been assigned to supervise the other two service recipients. In addition, Subject [redacted] was the assigned driver for this outing. The Service Recipient had needed significant assistance with getting into the van for the ride back to the [redacted] Upon their arrival, he slid out of his seat onto the van floor, refusing to move any further. (Justice Center Exhibits 5, 6 and 7; Hearing testimonies of Subject [redacted] and Subject [redacted]

8. Subject [redacted] brought the other service recipients into the [redacted] and informed the staff inside the house that Subject [redacted] needed assistance getting the Service Recipient out of the van and into the house. Subject [redacted] then proceeded to complete his paperwork in preparation for ending his shift. He had been called in to work overtime that day and was supposed to end his shift at 1:00 p.m. (Hearing testimony of Subject [redacted]

9. Subject [redacted] waited for someone to assist her with the Service Recipient, but after a few minutes, she went into the [redacted] to use the restroom. Subject [redacted] left the Service Recipient sitting on the van floor, with his legs dangling out the passenger side door. Subject

[redacted] observed several staff members at the dining table, and informed them that the Service Recipient was still in the van, and he needed assistance in getting into the [redacted] After using the restroom, Subject [redacted] asked the other staff if anyone had brought the Service Recipient into the [redacted] but no one answered her. Subject [redacted] then proceeded to tend to the other service recipients in her care. (Hearing testimony of Subject [redacted])

10. Approximately 10-15 minutes after the Service Recipient was left alone outside, the Subjects realized that he was not in the [redacted] and went outside to look for him. The Service Recipient was found on the ground, on the driver's side of the van, facing away from the house. (Justice Center Exhibits 5, 6, and 7) Judicial notice was taken of the weather that day being cold, with temperatures in the 20 degree Fahrenheit range, and with a winter storm advisory for the next day.

11. The Service Recipient had a history of tripping, unsteady gait, and falling. Due to this history, the Service Recipient's Individual Plan of Oversight Protection (IPOP) requires increased supervision when not using a wheelchair, or walking on uneven terrain, or in inclement weather. The Subjects were aware of the provisions in the Service Recipient's IPOP at the time of the incident. (Justice Center Exhibits 5 and 26)

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 abuse and 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)(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 2, 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

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 Subjects 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 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 Subjects committed an 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 1-27B) The investigation underlying the substantiated report was conducted by [redacted] Director of Quality Assurance, [redacted], who has since left that position. The current Director of Quality Assurance at [redacted], [redacted], was the only witness who testified at the hearing on behalf of the Justice Center. The Subjects testified in their own behalf and provided no other evidence.

The Justice Center proved by a preponderance of the evidence that the Subjects committed neglect when they failed to ensure that the Service Recipient was safely brought into the house upon return from the outing.

In order to sustain an allegation of neglect, the Justice Center must show that the Subjects acted, or failed to act, or lacked attention in such a manner that it breached their duty to the Service Recipient. In addition, the Justice Center must show that this breach either resulted in, or was likely to result in either physical injury, or a serious or protracted impairment of the physical, or mental, or emotional condition of the Service Recipient. Here, the Subjects breached their duty to the Service Recipient when they left him alone, sitting on the van floor.

The Subjects were familiar with the Service Recipient's limitations and diagnoses. In addition, they recognized that the Service Recipient was tired and weak by the end of the outing because he needed more help getting into the van than usual. Therefore they should have known that he would also require additional assistance in getting into the house. In fact, they had his wheelchair with them and eventually used it to get the Service Recipient into the house. (Justice Center Exhibits 6 and 7)

In their defense, the Subjects asserted that they told the other staff members that the Service Recipient was still in the van, and they assumed that those other staff would bring the Service Recipient into the house. However, this does not relieve the Subjects of their responsibilities for the Service Recipient. It was incumbent upon the Subjects to ensure that the Service Recipient was safely escorted into the house. Instead, the Subjects failed to follow up with their colleagues, and completed other tasks until they realized that the Service Recipient was still not in the house. Only then did the Subjects go back outside to search for the Service Recipient. (Justice Center Exhibits 6 and 7)

Both Subjects were responsible for the care and well-being of the Service Recipient. As the DSP assigned to supervise the Service Recipient, Subject [redacted] should have escorted him into the [redacted] rather than going into the office to do paperwork and leaving the Service Recipient in the

van with Subject [redacted] As the driver of the van, Subject [redacted] had the additional duty of remaining with the van until all the service recipients were safely in the house. (Hearing testimony of Subject [redacted])

As a result of the Subjects' breach of duty, the Service Recipient was left in the cold weather for approximately 10-15 minutes. The Service Recipient's medical conditions, including Parkinson's disease and cerebral palsy, significantly affected his ability to safely exit the van and walk into the house without assistance. In addition, the Service Recipient was blind in his right eye, and had moderate to severe hearing impairment. All these factors likely contributed to the Service Recipient leaving the van and ending up on the ground on the side of the van facing away from the house. (Justice Center Exhibits 5, 6, 7, and 25) Therefore, the Subjects' conduct rendered it likely that the Service Recipient would suffer a physical injury, or a serious or protracted impairment of his physical, mental, or emotional condition.

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 abuse and/or 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 abuse or neglect set forth in the substantiated report. Category 2 conduct is defined as conduct which "seriously endangers the health, safety or welfare of a service recipient". (SSL § 493(4)(b)) Taking into consideration the weather conditions that day, as well as the Service Recipient's physical and cognitive diagnoses, it is more likely than not that the Service Recipient's health, safety or welfare was seriously endangered. 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.

A substantiated Category 2 finding of abuse or neglect will not result in the Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

DECISION: The requests of [redacted] and [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is denied. The Subjects have 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 Jean T. Carney, Administrative Hearings Unit.

DATED: November 2, 2016
Schenectady, New York