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: Theresa Wells, Esq.

[redacted]
By: Stanley B. Segal, Esq.
Maney McConville Liccardi & Powis, P.C.
77 Troy Road, Suite 4
East Greenbush, New York 12061-1399

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 granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

NOW, THEREFORE, IT IS DETERMINED that the record of this report shall be amended and sealed by the Vulnerable Persons Central Register, pursuant to SSL § 493(3)(d).

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: December 27, 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: 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
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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, 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 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 provide proper supervision to a service recipient, during which time she was displaying signs of suicidal behavior while having scissors in her possession.
>
> 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, [redacted], located at [redacted] is a day habilitation program for approximately 50 adults with developmental disabilities and is operated by the [redacted], a non-

profit agency that is certified by the New York State Office for People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of [redacted] Program Administrator [redacted]

5. At the time of the alleged neglect, the Subject was employed by the [redacted] as a Residential Program Manager for the [redacted]. [redacted] was a nine bed residence for adults with developmental disabilities and operated by the [redacted]. As a Residential Program Manager, the Subject's duties included overseeing program staff and residents of [redacted] on a day-to-day basis. (Hearing testimony of [redacted] Program Administrator [redacted] Hearing testimony of the Subject.)

6. At the time of the alleged neglect, the Service Recipient had been a resident of [redacted] for approximately one and one-half years. The Service Recipient visited [redacted] beginning in [redacted] 2013 and began residing there in [redacted] 2013. From that time until the alleged neglect, the Subject and Service Recipient had almost daily interaction with one another. (Hearing testimony of [redacted] Program Administrator [redacted]; Hearing testimony of [redacted] Behavioral Specialist [redacted] Hearing testimony of the Subject; Justice Center Exhibits 6, 9, 13 and 14)

7. The Service Recipient was a 28 year old female with a diagnosis of borderline personality disorder, attention deficit disorder, mild intellectual disability, mood disorder and anxiety. (Hearing testimony of [redacted] Program Administrator [redacted] Hearing testimony of [redacted] Behavioral Specialist [redacted]; Hearing testimony of the Subject, Justice Center Exhibits 6, 9, 13 and 14)

8. The Service Recipient had a comprehensive Therapeutic Support Plan (TSP) that

directed staff in managing the Service Recipient's behaviors. The TSP was integrated between [redacted] and [redacted], however, some strategies differed depending on whether the Service Recipient was at her day program or residence. (Hearing testimony of [redacted] Program Administrator [redacted] Hearing testimony of Behavioral Specialist [redacted]; Hearing testimony of the Subject, Justice Center Exhibits 6, 9, 14 and 15)

9. The TSP addressed issues of concern with regard to the Service Recipient including: refusing directives; inappropriate social interactions, such as the Service Recipient taking things that did not belong to her and refusing to give them back; requesting to go to the hospital and making medical complaints that were later found to be untrue; suicidal statements and gestures, including her tendency to find any sharp or potentially dangerous objects; attention seeking behaviors and aggression. (Hearing testimony of [redacted] Program Administrator [redacted] Hearing testimony of Behavioral Specialist [redacted]; Hearing testimony of the Subject, Justice Center Exhibits 6, 9 and 21)

10. The TSP specified appropriate levels of supervision for the Service Recipient based on various circumstances. At [redacted], the Service Recipient's supervision level was close proximity. That level increased to shadowing if the Service Recipient made suicidal gestures or was in possession of a potentially dangerous object. (Hearing testimony of [redacted] Program Administrator [redacted] Hearing testimony of Behavioral Specialist [redacted]; Hearing testimony of the Subject, Justice Center Exhibits 6, 9, 14, 15, 21 and 24)

11. The Subject attended and participated in clinical meetings and staff meetings regarding the Service Recipient's behaviors, met with various behaviorists and psychologists regarding the formulation of the Service Recipient's TSP and was trained regarding the TSP and appropriate strategies and interventions to utilize with the Service Recipient. (Hearing testimony

of [redacted] Program Administrator [redacted] Hearing testimony of Behavioral Specialist [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6, 9, 11, 12, 13, 14, 19 and 20)

12. On the morning of the alleged neglect, soon after arriving at [redacted] before 9:00 a.m., the Service Recipient wrote in her journal that she wanted to kill herself. A staff member saw this and contacted the Behaviorist on duty as directed by the TSP. Around 10:30 a.m., the Behaviorist completed a Mental Health Crisis Assessment of the Service Recipient and determined that the Service Recipient was angry because she did not get to go home for Easter. However, the Service Recipient was not deemed to be a threat of harm to herself at that time and the appropriate supervision level was determined to be close proximity. (Hearing testimony of [redacted] Program Administrator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6, 9, 10, 16, 26 and 30)

13. Sometime after 12:00 p.m., the Service Recipient obtained various objects, including scissors. Despite efforts by staff, the Service Recipient would not relinquish control of the items. Later that afternoon, staff at [redacted] called staff at [redacted] to come and transport the Service Recipient back to the [redacted] as she was not allowed on the bus due to her behavior. Staff from the [redacted] picked up the Service Recipient from [redacted] three to four times per week due to a variety of behaviors by the Service Recipient that kept her off the bus. (Hearing testimony of [redacted] Program Administrator [redacted]; Hearing testimony of the Subject; Justice Center Exhibit 6)

14. At 3:30 p.m., the Subject arrived at [redacted] entered the building, and saw the Service Recipient in an office with [redacted] staff who informed the Subject that the Service Recipient was in possession of various objects and would not return them. [redacted] staff did not tell the Subject about the Service Recipient's suicidal statements earlier that day or that an

evaluation was completed by the Behaviorist. The Subject told [redacted] staff to bring the Service Recipient out to the van when the Service Recipient was ready to leave. (Hearing testimony of [redacted] Program Administrator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 2 and 6)

15. A half hour to an hour later, [redacted] staff went to the van and asked the Subject for assistance with the Service Recipient who still had a pair of scissors in her possession and would not leave the bathroom. The scissors were arts and crafts type scissors that are commonly used by children. (Hearing testimony of [redacted] Program Administrator [redacted] Hearing testimony of the Subject; Justice Center Exhibits 2, 6 and 29)

16. The Subject went inside the [redacted] building and saw the Service Recipient in the bathroom by herself. The bathroom consisted of two stalls and a sink, and the main bathroom door was open when the Subject arrived. The Service Recipient was in the first stall, with the door open, holding the scissors. At the same time, [redacted] staff [redacted] was standing outside an office door which was close to but not visible from the bathroom. (Hearing testimony of [redacted] Program Administrator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 2 and 6)

17. When the Subject entered the bathroom, the Service Recipient closed the stall door but did not lock it. The Service Recipient began to play "peek-a-boo" with the Subject through the cracks of the stall door. (Hearing testimony of [redacted] Program Administrator [redacted]; Hearing testimony of the Subject; Justice Center Exhibit 6)

18. The Subject then walked out of the bathroom and had a one minute conversation with staff [redacted] in the hallway outside the bathroom regarding how to handle the situation. At that point, the Subject was approximately 6 feet from the Service Recipient. The Subject could hear the Service Recipient and see her feet and shadow. (Hearing testimony of [redacted] Program

Administrator [redacted]; Hearing testimony of the Subject; Justice Center Exhibit 6)

19. As the Subject turned back into the bathroom, the Service Recipient came out of the stall. The Service Recipient began waving the scissors toward and away from the Subject in a chopping manner that the Subject understood to be the Service Recipient taunting her to try and take the scissors from her. The Subject took the scissors. Thereafter, the Subject and the Service Recipient left [redacted] and returned to [redacted] (Hearing testimony of [redacted] Program Administrator [redacted] Hearing testimony of the Subject; Justice Center Exhibits 2 and 6)

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 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:

> "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 3, which is defined as follows:

> 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 act of neglect alleged in the substantiated report that is the subject of the proceeding and that such act 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 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 not established by a preponderance of the evidence that the Subject committed an act of neglect, 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 - 36) The investigation underlying the substantiated report was conducted by [redacted] Program Administrator [redacted] who was the only witness who testified at the hearing on behalf of the Justice Center. At the time of the incident [redacted] held the position of Director of Quality Improvement at [redacted].

[redacted] Behavioral Specialist [redacted] testified on behalf of the Subject and the Subject testified in her own behalf.

In order to sustain an allegation of neglect, the Justice Center must show that the Subject was a custodian of the Service Recipient and acted, failed to act, or lacked attention in such a manner that it breached her 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.

The Subject argued that she was not a custodian of the Service Recipient at the time of the incident as the incident occurred at [redacted] and she had no responsibility for the Service Recipient inside the walls of [redacted] Additionally, [redacted] and [redacted] are operated by separate departments of [redacted] with different administrators and the Subject had no authority at [redacted]. This argument is not persuasive.

The Subject was a custodian of the Service Recipient by virtue of her employment with [redacted] Additionally, the Subject drove to [redacted] to take responsibility for the Service

Recipient and return her to [redacted]. Further, when the Subject went into the [redacted] building to assist with the Service Recipient, the Subject proactively took responsibility for the Service Recipient. The Subject was a custodian of the Service Recipient as that term is defined in Social Services Law §488(2).

The Justice Center argued that the Subject failed to provide proper supervision as she left the Service Recipient alone in the bathroom with scissors while the Service Recipient was displaying suicidal gestures and thereby breached her duty to the Service Recipient.

Each witness testified that at the time of the incident, close proximity was the appropriate supervision level for the Service Recipient. Staff was not expected to keep constant eyes on the Service Recipient but to be aware of the area for safety while allowing her to "explore" the environment. The Justice Center argued that the appropriate level of supervision heightened to shadowing as the Service Recipient was making suicidal gestures and was in possession of a potentially dangerous object. However, this contention is not supported by the evidence in the record.

Both the Subject and Behavioral Specialist [redacted] were very familiar with the Service Recipient's behaviors and recognized the Service Recipient's actions in taking the scissors and gesturing as attention seeking behavior and inappropriate social interactions and not as suicidal gestures. The Subject utilized the de-escalation technique of "planned ignoring" as dictated in the Service Recipient's TSP. The evidence establishes that the gestures by the Service Recipient with the scissors were made in a playful manner as a game of keep-away with the Subject as opposed to suicidal gestures. Despite her history of suicidal expressions, the record reflects that the Service Recipient never attempted or planned to commit suicide. The credible evidence in the record established that the Service Recipient's expressions of suicide were used by her to seek attention

and to manipulate staff into taking her to the hospital or crisis center where she felt safe and enjoyed the attention and food she received from hospital staff. Furthermore, the scissors were blunt as opposed to sharp and posed no danger to the Service Recipient. Additionally, even if the appropriate supervision level had risen to shadowing, the Subject's actions met that threshold as the Subject was within the required 10 foot shadowing range of the Service Recipient. (Justice Center Exhibits 6 and 24)

In short, at the time of the incident, the Service Recipient was not an actual danger to herself or others, the Subject reacted as she was trained and as required by the Service Recipient's TSP and the Subject provided the appropriate supervision to the Service Recipient. Consequently, the Subject did not breach any duty she owed to the Service Recipient.

Accordingly, it is determined that the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged. The substantiated report will be amended and sealed.

DECISION: The request of [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

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

DATED: December 13, 2016
Schenectady, New York