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** **Adjudication Case #:** [redacted]

:

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

[redacted]
By: Nicole Murphy, Esq.
Fine, Olin & Anderman, LLP
Of Counsel, CSEA
39 Broadway, Suite 1910
New York, NY 10006

ORDERED: The subject, [redacted], has not been shown by a preponderance of the evidence to have committed abuse and/or neglect as contained in the substantiated report [redacted], dated [redacted].

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: Schenectady, New York
September 17, 2014

David Molik
Administrative Hearings Bureau

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** **Adjudication Case #:** [redacted]

Before: Diane Herrmann
Administrative Law Judge

Held at: Adam Clayton Powell State Office Building
163 West 125th Street,
New York, NY 10027
On: [redacted]

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

[redacted]
By: Nicole Murphy, Esq.
Fine, Olin & Anderman, LLP
Of Counsel, CSEA
39 Broadway, Suite 1910
New York, NY 10006

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 Justice Center, Administrative Appeals Unit (AAU) amend the report to reflect that the Subject is not a subject of the substantiated report. The AAU 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, [redacted], of neglect by [redacted] (Subject) against a service recipient**.** The initial report was investigated by the Justice Center for the Protection of People with Special Needs (Justice Center).

2. The initial report alleges, in pertinent part; that on [redacted], while on an outing from the [redacted], while acting as a custodian, the Subject committed an act of neglect when she left a wheelchair bound and profoundly disabled service recipient unaccompanied and unsupervised while she took a restroom break and the service recipient was moved and was missing for some period of time.

3. The Justice Center substantiated the actions as a Category 3 offense pursuant to Social Service Law.

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

5. At the time of the alleged abuse, the Subject was employed as a DSA at [redacted] group home, a facility run by OPWDD, which is an Agency or Provider that is subject to the jurisdiction of the Justice Center.

6. On [redacted] the Subject was working the day shift and left the residence with employee [redacted] and service recipient [redacted] (SR [redacted]). The Subject and SR [redacted] were dropped off at the hospital for a medical appointment and employee [redacted] went to the grocery store.

7. The Subject took SR [redacted] into an eye appointment, answered the physician's questions and provided information on SR [redacted] health.

8. When the appointment ended the Subject called her co-worker to come get them.

9. The Subject needed to use the restroom and the restroom located in the waiting area was locked.

10. The Subject wheeled SR [redacted] into the hallway and located another restroom. The restroom was a single occupancy room and it did not have a separate toilet stall. The Subject left SR [redacted] in the hallway adjacent to the door of the bathroom.

11. While the Subject was in the restroom a medical student wheeled SR [redacted] into another area of the hospital.

12. When the Subject exited the bathroom she immediately began to search for SR [redacted], notified hospital security, and contacted the group home.

13. Approximately 20 minutes later SR [redacted] was located and returned to the Subject.

14. SR [redacted] did not undergo any medical exams, tests or procedures and suffered no injuries.

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 or neglect.
- Pursuant to Social Services Law § 493(4), the category level of abuse or neglect that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse or neglect in residential care facilities. SSL § 492(3) (c) and 493(1) and (3). Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse or neglect presently under review was substantiated. A "substantiated report" means a report made "… if an investigation determines that a preponderance of evidence of the alleged neglect and/or abuse exists."

Pursuant to SSL §§ 494(1)(a)(b) and (2), and Title 14 NYCRR § 700.6(b), this hearing decision will determine: 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, and if there is a finding of a preponderance of the evidence; whether the substantiated allegations constitute abuse or neglect; and pursuant to Social Services Law § 493(4), the category level of abuse or neglect that such act or acts constitute.

The abuse and neglect of a person in residential care is defined by SSL § 488:

> 1 "Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:
>
> (a) "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting,

kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.

(b) "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.

(c) "Psychological abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by verbal or non-verbal conduct, a substantial diminution of a service recipient's emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor, or causing the likelihood of such diminution. Such conduct may include but shall not be limited to intimidation, threats, the display of a weapon or other object that could reasonably be perceived by a service recipient as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments or ridicule.

(d) "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

(e) "Use of aversive conditioning," which shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the

absence of a person-specific authorization by the operating, licensing or certifying state agency pursuant to governing state agency regulations. Aversive conditioning may include but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.

(f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.

(g) "Unlawful use or administration of a controlled substance," which shall mean any administration by a custodian to a service recipient of: a controlled substance as defined by article thirty-three of the public health law, without a prescription; or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article thirty-three of the public health law, at the workplace or while on duty.

(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.

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 abuse or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category level of abuse and neglect set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

Substantiated reports of abuse or neglect shall be categorized into categories pursuant to SSL § 493:

4. Substantiated reports of abuse or neglect shall be categorized into one or more of the following four categories, as applicable:

   (a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:

   > (i) intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur;
   > (ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;
   > (iii) threats, taunts or ridicule that is likely to result in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

(iv) engaging in or encouraging others to engage in cruel or degrading treatment, which may include a pattern of cruel and degrading physical contact, of a service recipient, that results in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;
(v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;
(vi) any conduct that is inconsistent with a service recipient's individual treatment plan or applicable federal or state laws, regulations or policies, that encourages, facilitates or permits another to engage in any conduct in violation of article one hundred thirty of the penal law, with a service recipient;
(vii) any conduct encouraging or permitting another to promote a sexual performance, as defined in subdivision one of section 263.00 of the penal law, by a service recipient, or permitting or using a service recipient in any prostitution-related offense;
(viii) using or distributing a schedule I controlled substance, as defined by article thirty-three of the public health law, at the work place or while on duty;
(ix) unlawfully administering a controlled substance, as defined by article thirty-three of the public health law to a service recipient;
(x) intentionally falsifying records related to the safety, treatment or supervision of a service recipient, including but not limited to medical records, fire safety inspections and drills and supervision checks when the false statement contained therein is made with the intent to mislead a person investigating a reportable incident and it is reasonably foreseeable that such false statement may endanger the health, safety or welfare of a service recipient;
(xi) knowingly and willfully failing to report, as required by paragraph (a) of subdivision one of section four hundred ninety-one of this article, any of the conduct in subparagraphs (i) through (ix) of this paragraph upon discovery;
(xii) for supervisors, failing to act upon a report of conduct in subparagraphs (i) through (x) of this paragraph as directed by regulation, procedure or policy;
(xiii) intentionally making a materially false statement during an investigation into a report of conduct described in subparagraphs (i) through (x) of this paragraph with the intent to obstruct such investigation; and
(xiv) intimidating a mandated reporter with the intention of preventing him or her from reporting conduct described in subparagraphs (i) through (x) of this paragraph or retaliating against any custodian making such a report in good faith.

(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.

(d) Category four shall be conditions at a facility or provider agency that expose service recipients to harm or risk of harm where staff culpability is mitigated by systemic problems such as inadequate management, staffing, training or supervision. Category four also shall include instances in which it has been substantiated that a service recipient has been abused or neglected, but the perpetrator of such abuse or neglect cannot be identified.

If the Justice Center proves the alleged abuse, 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 abuse cited in the substantiated report constitutes the category level of abuse set forth in the substantiated report.

If the Justice Center did not prove the abuse by a preponderance of evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has not established by a fair preponderance of evidence that the Subject neglect SR [redacted]

The Justice Center called one witness, the investigator. The investigator interviewed hospital employees, employees of the group home, visited the hospital and interrogated the Subject.

The investigator testified that the Subject and another employee left the group home with SR [redacted]. The Subject brought SR [redacted] to her eye appointment and employee [redacted] went grocery shopping. The investigator testified that after the appointment the Subject needed to use the restroom. Upon discovering the restroom in the waiting area was locked, the Subject located a restroom in the hallway. The investigator stated that the Subject left SR [redacted] in the hallway while she used the bathroom. When the Subject exited the bathroom SR [redacted] was gone. Security located SR [redacted] a short time later and she was returned unharmed.

The Subject testified that she was left with no choice but to leave SR [redacted] alone because she had to use the bathroom. The Subject testified that she couldn't go to the bathroom before or during the appointment because she had to go into the appointment with SR [redacted] SR [redacted] is nonverbal and the Subject said she had to talk to the physician and answer his questions. When the appointment was over she called her co-worker to come pick them up. She wasn't sure how long she would have to wait and she urgently needed to use the bathroom. The Subject tried the door of the restroom in the waiting area but it was locked.

The Subject said she found an unlocked bathroom in the hallway right outside the waiting room. The bathroom was single occupancy and the Subject testified she tried to fit the wheelchair into the bathroom but the door would not close. The Subject used the restroom and when she opened the door SR [redacted] was gone.

The Justice Center stated that the Subject should not have left SR [redacted] alone and she had three options available to her. The three options were: leave SR [redacted] with patients in the waiting area, ask the receptionist to watch her or ask the doctor to watch SR [redacted] Also, the investigator testified that when he visited the hospital it appeared that a wheelchair would fit inside the bathroom.

The Justice Center investigator testified that a hospital administrator told him there was always a receptionist at the desk. The investigator admitted that he had no firsthand knowledge that an employee was at the desk when the Subject needed to use the bathroom or that the receptionist would have agreed to watch SR [redacted]. The investigator testified that it appeared the wheelchair would fit in the bathroom but he did not try to push a wheelchair in and close the door. The testimony "appearing" to fit in the bathroom is not sufficient to prove the wheelchair could fit in the bathroom with the door closed. The Justice Center did not indicate that there was a sign on the doorway of the bathroom indicating it was handicapped accessible.

The Subject stated that she considered all of these options. The Subject said she could not close the bathroom door with the wheelchair in the room. The Subject was not comfortable leaving SR [redacted] with some random person in the waiting area. The Subject testified that as soon as the appointment was over the doctor called his next patient in.

The Subject was remorseful over what happened but she was faced with the choice of wetting herself in a public place or leaving SR [redacted] alone for a few minutes in a hallway directly outside a bathroom. The Subject was correct, it was not appropriate to ask a patient in the waiting area to watch SR [redacted]. The doctor could not have watched SR [redacted] because he had another patient in his office. The Justice Center failed to prove that asking the receptionist was a viable option because there was no proof that someone was at the desk, or would have agreed to keep an eye on SR [redacted]

The hospital employee who wheeled SR [redacted] away is clearly at fault. The employee transported the first person he saw in a wheelchair to another area of the hospital. It is unclear why the employee thought that a wheelchair bound person in a hallway, not in a waiting area or

office, was the individual he needed to transport. The employee failed to use the hospital protocol, two patient identifier, before moving SR [redacted]

Fault also lies with the [redacted] group home because there were no procedures in place so that employees can have a restroom break when they are off sight. SR [redacted] did not require a one/one aide and the Subject was not required to be within arm's length of SR [redacted] at all times. The Subject made a decision in an emergency situation that had no lasting negative consequences. The Subject's actions do not rise to a level of neglect.

The Justice Center has failed to prove by a preponderance of the evidence that the Subject neglected SR [redacted]

Accordingly, it is determined that the Agency 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 or sealed.

DECISION: The request of [redacted] that the substantiated report [redacted] are amended and sealed is granted.

This decision is recommended by Diane Herrmann, Administrative Hearings Bureau.

DATED: September 15, 2014
Schenectady, New York

_____
Diane Herrmann, ALJ

ENCLOSED IS THE DECISION FOR YOUR ADMINISTRATIVE HEARING

IF YOU DID NOT WIN YOUR HEARING, YOU MAY APPEAL TO THE COURTS PURSUANT TO THE PROVISIONS OF ARTICLE 78 OF THE CIVIL PRACTICE LAW AND RULES. IF YOU WISH TO APPEAL THIS DECISION, YOU MAY WISH TO SEEK ADVICE FROM THE LEGAL RESOURCES AVAILABLE TO YOU (E.G., YOUR ATTORNEY, COUNTY BAR ASSOCIATION, LEGAL AID, OEO GROUPS, ETC.) SUCH AN APPEAL MUST BE COMMENCED IN STATE SUPREME COURT WITHIN FOUR MONTHS AFTER THE DETERMINATION TO BE REVIEWED BECOMES FINAL AND BINDING. AN APPEAL IS **NOT** COMMENCED BY WRITING TO THIS OFFICE OR ANY OFFICE OR OFFICIAL OF THE NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES, INCLUDING THE STATEWIDE CENTRAL REGISTER OF CHILD ABUSE AND MALTREATMENT.