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

Adjud. Case #: [redacted]

Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived

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

[redacted]

By: Constance R. Brown, Esq.
CSEA, Inc.
143 Washington Avenue
Capitol Station Box 7125
Albany, New York 12224-0125

[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 report "substantiated" on [redacted], dated and received on [redacted], be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse and/or neglect.

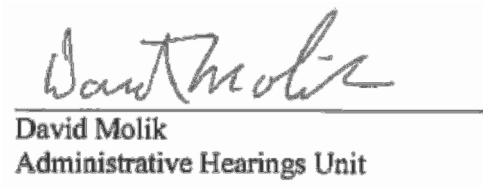
The substantiations are properly categorized, or should be categorized as a Category 3, respectively.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be retained in part by the Vulnerable Person's Central Register, and will be sealed after five years pursuant to SSL § 493(4)(c).

[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: May 26, 2015
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: NYS Justice Center
401 State Street
Schenectady, NY 12305
On: [redacted]

Parties: Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived.

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

[redacted]
By: Constance R. Brown, Esq.
CSEA, Inc.
143 Washington Avenue
Capitol Station Box 7125
Albany, New York 12224-0125

[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 report "substantiated" on [redacted], dated and received on [redacted] of abuse and/or neglect by the Subject of the Service Recipients.

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

Offense 1

> It was alleged that on [redacted], at the [redacted], located at [redacted], you committed neglect when you failed to provide proper supervision of a service recipient, constituting a breach of duty resulting in or creating the likelihood of resulting in physical injury or serious or protracted impairment of the physical, mental or emotional condition of another service recipient.[1]
>
> This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law §493.

Offense 2

> It was alleged that on [redacted], at the [redacted], located at [redacted], you committed neglect when you failed to provide proper supervision

[1] Hereinafter referred to as "Service Recipient A."

[redacted]

> of a service recipient, constituting a breach of duty resulting in or creating the likelihood of resulting in physical injury or serious or protracted impairment of the physical, mental or emotional condition of that service recipient.[2]
>
> This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law §493.

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

4. The facility, [redacted], is a residential facility and is operated by the Office for People With Developmental Disabilities [hereinafter OPWDD], which is a facility or provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged abuse and/or neglect, the Subject was employed by OPWDD [redacted]. The Subject worked as a Direct Service Assistant Trainee.

6. At the time of the alleged abuse and/or neglect, Service Recipient B had been a resident of the facility for approximately [redacted]. Service Recipient A had been a resident of the facility for approximately [redacted]. Both Service Recipients are persons diagnosed with Autism (testimony of [redacted], Justice Center Exhibit 34). In addition, Service Recipient B is diagnosed with Intermittent Explosive Disorder with anti-social traits (Justice Center Exhibit 34).

7. On [redacted], the Subject worked a double shift. During the day shift, from 7:00 a.m. until 3:00 p.m., he was assigned to Service Recipient A. During the evening shift from 3:00 p.m. until 11:00 p.m. he was assigned to Service Recipient B (Hearing testimony of the Subject).

8. At approximately 2:30 p.m., Service Recipient A had a visit from his mother,

[2] Hereinafter referred to as "Service Recipient B."

[redacted], and her fiancé, [redacted]. They had previously been informed that Service Recipient B had been going into Service Recipient A's room, taking his lotion and body wash and squirting it onto the rug. As a result, [redacted] had brought a rug cleaner and vacuum in order to clean up the mess. Upon their arrival, they were informed that additionally, Service Recipient B had ripped the wardrobe door off and damaged some tiles on the floor of Service Recipient A's bedroom (Hearing Testimony of [redacted], Hearing testimony of [redacted], Justice Center Exhibits 4, 28, 33, and 42).

9. [redacted] and [redacted] spent approximately 30-40 minutes cleaning Service Recipient A's room; and then decided to take him for a walk. As they were getting ready to leave, Service Recipient B attempted to enter the room. He prevented [redacted] from closing the door, and [redacted] blocked the entrance with a wheelchair. They attempted to re-direct Service Recipient B, until after several minutes, he left. At no time during this incident did they see Service Recipient B's assigned 1:1 staff (Hearing testimony of [redacted], hearing testimony of [redacted], Justice Center Exhibit 9).

10. During this incident, Service Recipient A appeared scared. He wrapped himself around his mother, trying to climb into her arms (Hearing testimony of [redacted], hearing testimony of [redacted], Justice Center Exhibit 9).

11. On [redacted], Service Recipient B required enhanced supervision, within visual range at all times, while on the residence (Justice Center Exhibit 25).

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.

[redacted]

- 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 evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3(f))

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 and/or neglect; and pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

The abuse and/or neglect of a person in a facility or provider agency 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 report 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.

[redacted]

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject(s) committed the act or acts of abuse and/or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of abuse and/or neglect as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

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

4. Substantiated report 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;

[redacted]

(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. Report 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. Report 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 and/or 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 abuse and/or neglect cited in the substantiated report constitutes the category of abuse and/or neglect as set forth in the substantiated report.

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

DISCUSSION

The Justice Center has established by a preponderance of evidence that the Subject

committed a prohibited act, described as "Offense 1" in the substantiated report. The act committed by the Subject constitutes neglect. The category of the affirmed substantiated neglect that such act constitutes is Category 3. The Justice Center also established by a preponderance of the evidence that the Subject committed a prohibited act, described as "Offense 2" in the substantiated report. The act committed by the Subject constitutes neglect. The category of the affirmed substantiated neglect that such act constitutes is Category 3.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation, as well as audio recordings of witness interviews (Justice Center Exhibits 1-42). The investigation underlying the substantiated report was conducted by , who testified at the hearing on behalf of the Justice Center. and also testified in support of the Justice Center.

The Subject testified on his own behalf and presented no documentary evidence. also testified on his behalf.

The Agency proved by a preponderance of the evidence that the Subject committed neglect by failing to keep Service Recipient B within his sight at all times during his shift. This breach placed the Service Recipient A at risk of harm. Social Services law §488(1)(h) defines neglect as "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."

A Functional Behavior Assessment was performed on Service Recipient B approximately two months prior to this incident. Based on that Assessment, a revised Behavior Support Plan was implemented . The Plan specifically states that Service Recipient B requires 1:1 supervision due to "the dangerousness and unpredictability of his aggression,

[redacted]

property destruction, compulsive behavior, elopement, and self-injurious behavior" (Justice Center Exhibit 34). In addition, the Plan requires staff to record all target behaviors and behavioral observations during every shift. These observations were to be documented on his Behavior Integration Record and in the general notes (Justice Center Exhibit 34). A review of the general notes for the period of [redacted], indicates that the staff did not adhere to this requirement (Justice Center Exhibit 31). The interview of [redacted], Treatment Team Leader, confirms an ongoing issue with that unit's lack of reporting, and lack of documentation.

In support of the Subject's position that Service Recipient B was always within his sight during that shift, the initial investigation conducted by OPWDD investigator [redacted] recommends that the allegations be unsubstantiated (Justice Center Exhibit 4). [redacted] testified that she based that recommendation on the statements of other staff members working that day which did not corroborate [redacted] statement. A careful reading of those statements confirms that [redacted] recitation of the event is not corroborated. However, neither is the Subject's version.

[redacted] was assigned to Service Recipient B during the day shift, from 7:00 a.m. until 3:00 p.m. In his statement he says that when he left, the Subject and the Service Recipient were on the couch together in the common room (Justice Center Exhibit 14). However, the Subject's testimony was that he was sitting in a chair outside the quiet room, across the hall from the Service Recipient's room. In addition, the Subject does not recall seeing [redacted] prior to taking over 1:1 supervision of the Service Recipient. It is notable that [redacted] did not sign in or out on the employee sign in sheet for that day (Justice Center Exhibit 23). It is also notable that [redacted] did not make a report on the Campus Programs Daily Report for that day.

[redacted]

Instead it appears that one person initialed for everyone during that shift (Justice Center Exhibit 30). Therefore it is not clear whether [redacted] was even working that day and therefore his statement is not credited.

[redacted] testified at the hearing in the Subject's behalf. She stated that she was with the Subject during the relevant period of time and that the Subject could see the Service Recipient at all times. She also testified that they were standing outside the laundry room during that time. Her testimony contradicts the Subject's testimony that he was in a chair across from the Service Recipient's room. The laundry room is around a corner and up the hall, past a common room from the Service Recipient's room (Justice Center Exhibit 36). If the Subject was in a chair outside the quiet room, [redacted] would not be able to see him from her position outside the laundry room; and if he was conversing with her by the laundry room, he would not have a direct line of sight into the Service Recipient's room. Therefore her testimony that she saw the Subject and the Service Recipient together during the relevant time is not credited evidence.

The other statements of staff members were vague and non-specific. They did not remember seeing the Service Recipient alone or with the Subject. Therefore those statements really are not helpful in determining what happened.

[redacted] testified that the Service Recipient was attempting to gain entrance into her son's room for a period of time equivalent to the length of a song on her son's CD player. She also testified that after the Service Recipient left, she followed him in order to see if she could find his 1:1 staff. Her testimony was credible. The Service Recipient was left alone for a significant period of time, and given his propensity for violence and self-injurious behavior, it was likely that he would have come to harm.

The Justice Center further proved by a preponderance of the evidence that by failing to

[redacted]

properly supervise Service Recipient B, the Subject placed Service Recipient A at risk of harm, thereby committing neglect against him as well. Specifically, the evidence establishes that by breaching his duty to Service Recipient B, the Subject neglected Service Recipient A as well.

In the days leading up to this incident, there is a well-documented history of Service Recipient B bolting into Service Recipient A's bedroom and destroying personal property (Justice Center Exhibits 12, 4, 31, and hearing testimony of [redacted]). In fact, Service Recipient B ripped the door of Service Recipient A's wardrobe off and attempted to pull the wardrobe down (hearing testimony of [redacted], Justice Center Exhibit 33, and 31). Therefore all staff knew or should have known that it was likely that Service Recipient B would attempt to go into Service Recipient A's bedroom and cause damage.

[redacted] testified that when Service Recipient B tried to get into her son's bedroom, Service Recipient A became scared and sought comfort from her as he had when he was a child. The evidence showed that Service Recipient A was mostly non-verbal. He communicated his fear in the only way he could, by attempting to get his mother to protect him from an unpredictable person who had already damaged his possessions. Notably absent from the investigative record is any information regarding any adverse effect these incidents may have had on Service Recipient A. In fact, the only person who evinced any concern about him was his mother. Given the fact that Service Recipient B had demonstrated violent and unpredictable behavior in the days leading up to this incident, and had vandalized Service Recipient A's room, it may be reasonably inferred that Service Recipient A suffered a serious impairment of an emotional condition because the Subject failed to maintain 1:1 supervision of Service Recipient B.

Accordingly, it is determined that the Justice Center has met its burden of proving by a

[redacted]

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 abuse or neglect set forth in the substantiated report**.** Accordingly, it is determined that the substantiated report is properly categorized (or should be categorized) as a Category 3.

DECISION: The request of [redacted] that the report "substantiated" on [redacted], dated and received on [redacted], be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse and/or neglect.

The substantiations are properly categorized, or should be categorized as a Category 3, respectively.

[redacted]

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

DATED: May 14, 2015
Schenectady, New York