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: Christopher Mirabella, Esq.

[redacted]

By: Larry Rosenfeld, Esq.
Seidner, Rosenfeld & Guttentag, LLP
403 Deer Park Avenue
Babylon, New York 11702

[redacted]

The Findings of Fact and Conclusions of law are incorporated from the Recommendations of the presiding Administrative Law Judge's Recommended Decision.

ORDERED: The request of [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is denied in part and granted in part. The determination that the Subject committed neglect shall remain substantiated. The determination that the Subject committed physical abuse is unsubstantiated.

The substantiated report of neglect is properly categorized as a Category 3 act.

NOW, THEREFORE, IT IS DETERMINED that the record of this report shall be retained in part, by the Vulnerable Persons' 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 20, 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

Adjudication Case #: [redacted]

Before: Sharon Golish Blum
Administrative Law Judge

Held at: Justice Center for the Protection of People with Special Needs
125 East Bethpage Road, Suite 104, Plainview, New York 11803
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 physical abuse and/or neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a substantiated report dated [redacted], [redacted] of physical abuse and 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 physical abuse and/or neglect when you failed to provide adequate supervision to a service recipient by failing to ensure that the shower's water temperature was appropriate, before giving the service recipient a shower, which resulted in her sustaining burns to her back. Subsequent to the shower, you failed to notify medical personnel which delayed the service recipient from receiving treatment for her burns.
>
> This allegation has been SUBSTANTIATED as Category 3 physical abuse and 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, the, [redacted] located at [redacted], is operated by the [redacted]

[redacted]. [redacted] is certified by the New York State Office for People With Developmental Disabilities, which is a provider agency that is subject to the jurisdiction of the Justice Center.

5. The facility provides residential, educational and habilitation services for individuals with developmental delays. (Hearing testimony of facility Investigator [redacted])

6. At the time of the alleged physical abuse and/or neglect, the Service Recipient was a fifty-nine year old female resident of the facility. The Service Recipient was a person with diagnoses that included profound intellectual disability and dementia, and she suffered from numerous other severe physical and developmental issues. The Service Recipient was non-verbal, non-ambulatory, and completely dependent on facility staff, requiring assistance with all of her activities of daily living. (Hearing testimony of facility Investigator [redacted])

7. At the time of the alleged physical abuse and/or neglect, the Subject had been employed by the facility on a part time basis as a Direct Support Professional (DSP) for five years. The Subject was responsible for assisting service recipients with their activities of daily living, which included feeding, hygiene and recreation. (Hearing testimony of the Subject) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

8. On the date of the alleged physical abuse and/or neglect at approximately 3:00 p.m., the Subject and DSP [redacted] bathed the Service Recipient. Bathing the Service Recipient consisted of rolling her into a large shower room on a gurney, rinsing the Service Recipient using a movable shower head, and bathing her while she lay in a supine position. Knowing that the facility shower water temperature fluctuated, the Subject let the water run for a few minutes before starting to bathe the Service Recipient. The Subject touch-tested the shower

[redacted]

water before initially using it on the Service Recipient and found it to be a safe temperature. The Subject then washed the Service Recipient's front without incident. After the Service Recipient was rolled onto her side, the Subject began spraying the shower water onto the Service Recipient's back, which caused the Service Recipient to immediately scream. The Subject stopped using the water on the Service Recipient and checked the water temperature, which she found had become extremely hot. The Subject then adjusted the water to a safe and comfortable temperature and finished bathing the Service Recipient without further incident. (Hearing testimony of the Subject)

9. The Subject thereafter dressed the Service Recipient and did not notice any sign that the Service Recipient had been burned by the shower water. The Subject continued to care for the Service Recipient, including changing her diapers, until the Subject's shift ended at 9:30 p.m., and the Subject did not observe any sign that the Service Recipient was experiencing pain or discomfort. (Hearing testimony of the Subject)

10. The following morning, at approximately 6:35 a.m., another DSP noticed two blisters, one of which was open with loose skin, red streaks and redness on the Service Recipient's back that were all assessed by Registered Nurse (RN) [redacted] as burn marks. (Justice Center Exhibit 13) The Service Recipient was treated with Tylenol for comfort and the topical medication Silvadene was applied to the open area of the burns on her back. (Justice Center Exhibit 18)

11. Upon learning that the Service Recipient had burn marks on her back, the Subject admitted to her inadvertent use of very hot water on the Service Recipient the previous day. (Hearing testimony of the Subject)

[redacted]

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 allegation constitutes 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 physical abuse and/or 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 physical abuse of a person in a facility or provider agency is defined by SSL § 488(1)(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.

Under SSL § 488(1)(h) the relevant part of the definition of neglect is:

> "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...

[redacted]

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 3 which is defined as follows:

> (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.

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).

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 the evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has established by a preponderance of the evidence that the Subject committed an act of neglect under SSL § 488(1)(h), as described in Allegation 1 of the substantiated report. However, the evidence did not establish that the Subject committed an act of physical abuse under SSL § 488(1)(a), also described in Allegation 1 of the substantiated report.

In support of its substantiated findings, the Justice Center presented evidence obtained during the investigation. (Justice Center Exhibits 1-18) The investigation underlying the

[redacted]

substantiated report was conducted by facility Training Specialist [redacted], who testified on behalf of the Justice Center.

The Subject testified at the hearing on her own behalf and provided two documents as evidence. (Subject Exhibits A and B)

Allegation 1 of the substantiated report also includes a theory that the Subject committed physical abuse toward the Service Recipient. While the Subject's conduct did result in the Service Recipient suffering significant burns, consisting of two blisters, one of which was open with loose skin, red streaks and redness, the test for physical abuse under SSL § 488(1)(a), requires that the Subject's conduct must have "intentionally" or "recklessly" caused the physical injury to the Service Recipient. SSL § 488(16) indicates that the words "intentionally" and "recklessly" have the same meanings as provided in New York Penal Law § 15.05. Under New York Penal Law § 15.05(1), a person acts "intentionally" when a person has a "... conscious objective ..." to cause a result, in this case, the burns to the Service Recipient's back. Under New York Penal Law § 15.05(3), a person acts "recklessly" when a person is "... aware of and consciously disregards a substantial and unjustifiable risk ..." that the result will occur, again, in this case, the burns to the Service Recipient's back.

Upon hearing the Subject testify and after reviewing all of the evidence, it is found that the Subject did not commit physical abuse of the Service Recipient. There is no evidence in the record, nor can it be inferred, that the Subject had a conscious objective to burn the Service Recipient. Likewise, while the evidence shows that the Subject knew that the shower water temperature fluctuated, the evidence does not establish that the Subject consciously disregarded the risk of the water temperature fluctuating to a temperature that was hot enough to cause burns. The Subject was simply not careful enough to ensure that the water did not burn the Service

[redacted]

Recipient. The Subject's lack of care did not rise to the level of a conscious disregard, but it did constitute a breach of her duty to the Service Recipient.

The Subject testified that she was aware that the facility water temperature fluctuated. The Subject testified that before bathing the Service Recipient with the shower water, she let the water run to stabilize the temperature and she touch-tested the water temperature to ensure that it would be comfortable for the Service Recipient. The Subject testified that she first washed and rinsed the Service Recipient's front and then she shifted the Service Recipient onto her side to wash the Service Recipient's back. The Subject testified that as soon as she sprayed the shower water onto the Service Recipient's back, the Service Recipient immediately screamed. The Subject testified that she then turned the shower head away from the Service Recipient's back and touch-tested the shower water temperature again. The Subject testified that she realized at that point that the shower water temperature was too hot and, as a result of that conclusion, she adjusted the shower control to reduce the water temperature, waited again for the shower water temperature to stabilize and completed bathing the Service Recipient without further incident. The Subject testified that after she bathed the Service Recipient, she and DSP [redacted] both looked at her back and saw no sign of injury, that when she dressed the Service Recipient, she saw no sign of injury, that when she changed the Service Recipient's diaper several times later on during her shift, which required pulling the Service Recipient's shirt up, she saw no sign of injury, and that throughout the rest of her shift, which concluded at 9:30 p.m., she had no reason to think that the Service Recipient was suffering from pain or discomfort. The Subject testified that the following morning, she was told that the Service Recipient had burns on her back.

The evidence in the record is that it was only after the burns were noticed by another DSP

[redacted]

the day after the Subject bathed the Service Recipient that the Subject admitted the aforementioned incident to her supervisor.

It is clear from the convincing evidence in the record, which is supported by the Subject's own acknowledgement that the shower water temperature fluctuated and that it was too hot at the time that the Service Recipient screamed, that the burns to the Service Recipient's back were caused by the Subject's failure to adequately monitor the shower water temperature while she bathed the Service Recipient.

Counsel for the Subject argued that the Subject was not responsible for the burns that the Service Recipient sustained because there had been no formal policy or training on the topic of monitoring the shower temperature when bathing a service recipient. While the evidence did establish that the Subject had not received training and that there was no written procedure in place, the Subject admitted that she touch-tested the water temperature prior to wetting the Service Recipient as a matter of common sense. That same common sense should have operated to guide the Subject to monitor the water temperature, which she knew fluctuated, throughout the process of bathing the Service Recipient.

Counsel for the Subject argued that the Subject was not responsible for the burns that the Service Recipient sustained because the Subject's supervisor, [redacted], had assumed responsibility for the Service Recipient's burns, as she had the facility water heater temperature increased a few days before the incident and she had failed to advise the staff members of the adjustment. (Hearing testimony of the Subject and Justice Center Exhibit 2) While there was a written statement from Building Administrator [redacted] (Justice Center Exhibit 17) confirming that the water heater had been adjusted to a higher setting on [redacted] and back to a lower setting on [redacted], the maximum temperature setting on the water

[redacted]

heater is not the issue. The issue is the Subject's duty, while bathing the Service Recipient, to vigilantly monitor the water temperature, which she knew fluctuated. Because the Subject failed to do so, she failed to notice that the water temperature had increased, and the Service Recipient was burned as a result.

With respect to that part of the allegation that the Subject failed to notify medical personnel, which delayed the Service Recipient from receiving treatment for her burns, Counsel for the Subject argued that the Subject did not report the incident to medical staff because there was no evidence of burns after the Subject bathed the Service Recipient.

Counsel cited the statements of DSP [redacted] (Justice Center Exhibit 14), DSP [redacted] (Subject Exhibit A), and DSP [redacted] (Subject Exhibit B) as evidence that there had been no sign of burns on the Service Recipient's back on [redacted]. However, the three statements say nothing about whether the DSPs had looked specifically at the Service Recipient's back after the Subject bathed her and, accordingly, they do not support the Subject's contention that there were no burns to be seen on the Service Recipient's back after the bath.

On the other hand, there was no evidence in the record as to when the Service Recipient's burn marks became visible. The evidence establishes only that the Service Recipient had visible burns on her back the morning after the incident. The statements of Registered Nurse (RN) [redacted] (Justice Center Exhibit 13), Licensed Practical Nurse (LPN) [redacted] (Justice Center Exhibit 18), and LPN [redacted] (Justice Center Exhibit 15) and the Nursing Notes (Justice Center Exhibit 11) all contain descriptions of the burn marks on the Service Recipient's back, the day after the Subject bathed her. Absent any proof, and given the Subject's uncontroverted testimony that she repeatedly checked the Service Recipient's back, it cannot be

[redacted]

assumed that the burn marks were visible on the Service Recipient's back at any particular time prior to the time when they were first noticed the following day. Consequently, the Subject cannot be found to have committed neglect by failing to notify medical personnel. The credible evidence supports a reasonable conclusion that the Subject complied with her duty to ascertain if the Service Recipient had suffered a burn and, based on her examinations of the Subject's back, she concluded that the Service Recipient had not been injured.

In any case, it is found that the Subject did breach her duty to the Service Recipient under SSL § 488(1)(h) by failing to monitor the shower water temperature while bathing the Service Recipient, the result of which was physical injury to the Service Recipient.

Accordingly, in the final analysis, based on all of the evidence, it is concluded that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect under SSL § 488(1)(h), as specified in Allegation 1 of the substantiated report.

The report will remain substantiated. The next issue to be determined is whether the substantiated report constitutes the category of neglect set forth in the substantiated report**.** 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 3 act. A substantiated Category 3 finding of abuse and/or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to NY SSL § 496 (2). This report will be sealed after five years.

[redacted]

DECISION: The request of [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is denied in part and granted in part. The determination that the Subject committed neglect shall remain substantiated. The determination that the Subject committed physical abuse is unsubstantiated.

The substantiated report of neglect is properly categorized as a Category 3 act.

This decision is recommended by Sharon Golish Blum, Administrative Hearings Unit.

DATED: May 18, 2016
Plainview, New York

Sharon Golish Blum, Esq.
Administrative Law Judge