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: Todd Sardella, Esq.

[redacted]

By: Margaret J. Fowler, Esq.
Levene, Gouldin & Thompson, LLP
P.O. Box F-1706
Binghamton, New York 13902

[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], be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed abuse or 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: June 30, 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: John T. Nasci
Administrative Law Judge

Held at: New York State Office Building
44 Hawley Street, Room 1701
Binghamton, New York 13901
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 abuse and 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 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 neglect when you failed to inform nursing staff and seek appropriate medical attention for a service recipient who had fallen in the shower and who suffered a nose bleed and other injuries.

The allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493.

Allegation 2

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed abuse (obstruction of reports of reportable incidents) when you failed to inform nursing staff and the Justice Center that a service recipient had fallen in the shower and hit his head.

The allegation has been SUBSTANTIATED as Category 2 abuse (obstruction of reports of reportable incidents) pursuant to Social Services Law § 493.

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

4. The facility, located at [redacted], is a group home for adults with developmental disabilities, and was operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of OPWDD Investigator [redacted])

5. At the time of the alleged abuse and neglect, the Subject had been employed by the OPWDD for two years. The Subject worked as a Direct Support Assistant (DSA). (Hearing testimony of the Subject)

6. At the time of the alleged abuse and neglect, the Service Recipient was a thirty year old male and had been a resident of the facility since 2004. The Service Recipient had diagnoses of profound mental retardation, autism, mood disorder NOS, and pervasive developmental disorder. (Justice Center Exhibit 7) The Service Recipient required constant one-to-one supervision by facility staff and, due to his unsteady gait and history of falls, he wore a helmet to protect his head at all times except in bed and in the shower. (Justice Center Exhibits 7, 8 and 9)

7. On [redacted], the Subject worked the 7:30 a.m. to 3:30 p.m. shift at the facility and was assigned the duty of one-to-one supervision of the Service Recipient. At approximately 2:30 p.m., the Subject brought the Service Recipient to the shower and supervised him while he played in the shower. The Service Recipient regularly took showers for recreational purposes. While the Subject was preparing the Service Recipient's towel and/or clothes, and had his back to the Service Recipient, the Service Recipient sat down on the floor, making a splashing

sound. Sitting down on the shower floor and splashing water was common behavior of the Service Recipient. (Justice Center Exhibit 21 and Hearing testimony of the Subject)

8. When the Subject turned back to the Service Recipient to get him ready to be toweled off, he noticed a little bit of blood on his nose, which he described as a dry nose bleed. The Subject used a washcloth to blot-up the dried blood. (Justice Center Exhibit 21 and Hearing testimony of the Subject)

9. After blotting up the blood, the Subject yelled for someone to get a nurse. Staff B called the nurse and when the nurse came, Staff B escorted the nurse to the shower. After the nurse entered the shower, the Subject told her about the nose bleed. The nurse performed a body check on the Service Recipient and found no active bleeding. The nurse also directed the Subject to continue to monitor the Service Recipient and call her if bleeding recurs. (Justice Center Exhibits 15 and 21, and Hearing testimony of the Subject)

10. The nurse noted her observations and recommendations in the Staff Observations/Notes, including the notation "no HIP needed at this time." (Justice Center Exhibit 15) The Head Injury Protocol (HIP) was a procedure used by the facility and was initiated after any head injury and any unwitnessed fall of a service recipient. Implementation of the protocol involved taking vital signs at regular intervals for a period of time after the injury or fall. All DSAs are trained in HIP. (Hearing testimony of OPWDD Investigator [redacted])

11. At approximately 3:30 p.m., the Subject transferred one-to-one responsibility for the Service Recipient to Staff C. Sometime between 3:30 p.m. and 3:45 p.m., Staff C transferred one-to-one responsibility of the Service Recipient to Staff D while she got the Service Recipient a drink. While in her care, Staff D noticed that the Service Recipient's left eye appeared to be swollen. (Justice Center Exhibits 12 and 13, and Hearing testimony of the Subject)

12. At 4:20 p.m., a nurse arrived at the facility, examined the Service Recipient and found a one half inch purple bruise on his left eye. The nurse ordered the continuance of HIP. (Justice Center Exhibit 15) There is no evidence in the record of who actually initiated the HIP or when it was initiated.

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute abuse and/or neglect.
- Pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. (SSL § 492(3)(c) and 493(1) and (3)) Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse and neglect presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been made as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3(f))

The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1) (f) and (h), to include:

> (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.
>
> (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.

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category (2), which is defined as follows:

> Category two is substantiated conduct by custodians that is not otherwise described in category one, but conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Category two conduct under this paragraph shall be elevated to category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged in category two conduct. Reports that result in a category two finding not elevated to a category one finding shall be sealed after five years.

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

If the Justice Center proves the alleged abuse and 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 neglect cited in the substantiated report constitutes the category of abuse and neglect as set forth in the substantiated report.

If the Justice Center did not prove the abuse and 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, described as "Allegation 1" and "Allegation 2" in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents and photographs obtained during the investigation. (Justice Center Exhibits 1-20) The Justice Center also presented an audio recording of the Justice Center Investigator's interrogation of the Subject. (Justice Center Exhibit 21) The investigation underlying the substantiated report was conducted by the OPWDD Investigator, [redacted], who was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in his own behalf and provided no other evidence.

Allegation 1

The Justice Center contends that the Subject committed neglect by failing to inform nursing staff of and seek appropriate medical attention for the Service Recipient who had allegedly fallen in the shower. The Justice Center further contends that had the Subject reported the fall to the nurse, the nurse would have initiated the Head Injury Protocol (HIP) and, by not initiating the HIP, the Service Recipient was likely to have suffered physical injury. The Justice Center relies on two pieces of evidence: the statement of Staff A and the Subject's statement that he heard the Service Recipient sit down while he was briefly turned away from the Service Recipient. (Justice Center Exhibit 14 and Hearing testimony of the Subject)

The Subject contends that he did not report the Service Recipient's fall to the nurse because the Service Recipient did not fall while he was in the shower, or while he was in the Subject's care and supervision. (Hearing testimony of the Subject)

In his written statement, Staff A stated that he escorted the nurse to the bathroom where the Subject was assisting the Service Recipient with taking a shower. He further stated that while he and the nurse were present, the Subject reported that the Service Recipient was walking around in the bathroom, suddenly stopped walking, lost his footing, fell toward the wall, hit his head on the wall and started bleeding from his nose. (Justice Center Exhibit 14)

However, in the Staff Observations/Notes, which were written contemporaneously to her examination of the Service Recipient, the nurse wrote only about the Service Recipient's nose bleed and nothing about a report by the Subject of the Service Recipient falling. (Justice Center Exhibit 15) Furthermore, the nurse told the OPWDD Investigator that she did not hear anyone report that the Service Recipient fell against the wall and, if she had heard it, protocol would have dictated that she implement the HIP. (Justice Center Exhibit 6) The nurse's statement to the

Justice Center Investigator is corroborated by the note that she wrote contemporaneously in the Staff Observations/Notes: "no HIP needed at this time." (Justice Center Exhibit 15) Finally, allegations against the nurse were investigated by the OPWDD Investigator and were determined to be unsubstantiated because the OPWDD Investigator concluded that the nurse had no knowledge of the Service Recipient having fallen. (Hearing testimony of [redacted], OPWDD Investigator)

The nurse's statements and notes are further corroborated by the statement of Staff B, who told the OPWDD Investigator that she called the nurse and, when the nurse arrived, she escorted the nurse to the shower. Staff B also told the OPWDD Investigator that she did not hear anyone say anything about the Service Recipient falling in the shower. (Justice Center Exhibit 6)

Neither the nurse nor Staff B mentioned in either the Staff Observations/Notes or in their statements to the OPWDD Investigator that Staff A was in the bathroom. The only mention of Staff A by the nurse was that Staff A approached her about another Service Recipient when she left the bathroom. (Justice Center Exhibit 6)

Consequently, Staff A's statement, that the Subject reported that the Service Recipient fell, is in conflict with statements of the nurse, Staff B and the Subject who all deny hearing or making the statement. The Justice Center presented no evidence to explain this conflict. For these reasons, Staff A's statement is not credited evidence. The credible evidence in the record supports the conclusion that the Subject did not make any statement about the Service Recipient falling against the wall.

The Justice Center's remaining evidence in support of the allegation is the Subject's interrogation statements and hearing testimony in which the Subject stated that he heard the Service Recipient sit down on the shower floor while he was turned away from the Service

Recipient. The Subject testified that, although he heard but did not see the Service Recipient sit down on the shower floor, he gave it little thought because this was common behavior for the Service Recipient. (Justice Center Exhibit 21 and Hearing testimony of the Subject) Without any further evidence of what occurred while the Subject had his back turned to the Service Recipient, it cannot be concluded that the Service Recipient fell to the floor and hit his head on the wall while he was in the shower and in the care of the Subject.

In order to prove neglect, the Justice Center must prove by a preponderance of the evidence that the Subject's action, inaction or lack of attention breached a custodian's duty he owed to the Service Recipient, and that the Subject's breach resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Because the Justice Center did not establish by a preponderance of the evidence that the Service Recipient fell in the shower while he was in the Subject's care and supervision, the Subject had no duty to inform nursing staff of a fall by the Service Recipient or seek appropriate medical attention for the Service Recipient. Consequently, the Justice Center has not established that the Subject had a duty that he breached. Consequently, the Justice Center has not established that the Subject committed neglect.

Allegation 2

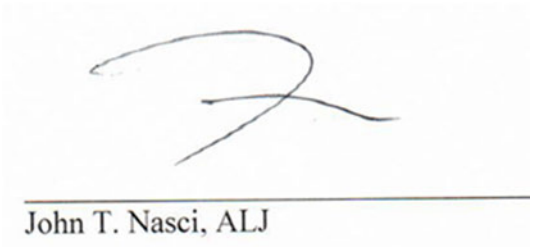
The Justice Center contends that the Subject committed abuse (Obstruction of reports of reportable incidents) by failing to inform nursing staff and the Justice Center that the Service Recipient had fallen in the shower and hit his head. Having determined that the Justice Center has not sufficiently established that the Service Recipient fell in the shower while he was in the Subject's care and supervision, it is consequently concluded that the Subject had no duty to report to the nursing staff or the Justice Center that the Service Recipient had fallen.

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 abuse and neglect alleged. The substantiated report will be amended or sealed.

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

This decision is recommended by John T. Nasci, Administrative Hearings Unit.

DATED: June 29, 2016
Schenectady, New York



John T. Nasci, ALJ