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: Eric E. Wilke, Esq.
CSEA, Inc.
143 Washington Avenue
Capitol Hill 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 substantiated report dated [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed psychological abuse and neglect.

The substantiated report is properly categorized as Category 2.

NOW, THEREFORE, IT IS DETERMINED that reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years. The record of these reports shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(b).

[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: July 29, 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: Louis P. Renzi
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
Administrative Hearing Unit
401 State Street
Schenectady, New York 12305
On: [redacted]

Parties: Vulnerable Persons' Central Register
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JURISDICTION

The New York State Vulnerable Persons' Central Register (VPCR) maintains a report substantiating [redacted] (the Subject) for psychological 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 that:

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 psychological abuse and/or neglect when you engaged in a loud and confrontational argument with a service recipient, in violation of her established Behavior Guidelines, and effects of the conduct included PTSD-related memories.
>
> These allegations have been SUBSTANTIATED as Category 2 psychological abuse and Category 2 neglect pursuant to Social Services Law § 493(4)(b).

3. The [redacted], located at [redacted], is a small co-ed residential treatment facility for adults, operated by the NYS Office for People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center. The investigation of this matter was conducted by former OPWDD Investigator [redacted], now retired. (Hearing testimony of Investigator [redacted]

[redacted]; Justice Center Exhibits 4 and 5)

4. On [redacted], the date of the alleged abuse and neglect (the incident), the Subject had been employed by OPWDD for eleven (11) years as a Direct Support Assistant (DSA). She worked at a different facility [redacted] for the most recent eight (8) years, spent about one month at [redacted], and then on [redacted] was transferred to the [redacted] for the stated purpose of easing the Service Recipient's transfer to that facility. (Hearing testimony of the Subject; Justice Center Exhibit 25)

5. At the time of the incident, the Service Recipient was a twenty year-old female, and had been a resident of the [redacted] facility for six days prior to the incident. The Service Recipient had just been transferred from [redacted], another [redacted] facility. The Subject had worked with the Service Recipient at [redacted] for approximately one month prior to the transfer. The Service Recipient had a long history of severe physical and sexual abuse and neglect by her biological parents and then by her foster parents, followed by multiple mental health related institutional placements; her diagnosis included post-traumatic stress disorder (PTSD) and behavior disorder. (Hearing testimony of OPWDD Psychologist [redacted]; Hearing testimony of the Subject; Justice Center Exhibit 4 and 6)

6. At the time of the incident, the Subject was acting as a custodian and was on duty. She had signed the Justice Center Code of Conduct on [redacted], several months prior to the incident. (Hearing testimony of Subject; Hearing testimony of Investigator [redacted]; Justice Center Exhibits 8 and 22)

7. Prior to the incident, the Subject had been trained in the proper techniques and protocols for addressing the needs of service recipients in crisis, including the proper types of active and reactive responses to negative, or challenging, behaviors exhibited by a service

recipient. According to her OPWDD training record, the Subject completed numerous training courses during her tenure with the agency prior to the incident. This included at least twelve (12) hours of core training in *Strategies for Crisis Intervention & Prevention – Revised* (SCIP-R) and three (3) annual refresher courses, which were completed between 2007 and 2009. (Hearing testimony of the Subject; Justice Center Exhibits 24, 25 and 27)

8. Upon her arrival and sign-in at the [redacted] on the day of the incident, the Subject encountered the Service Recipient inside the residence. The Service Recipient was exhibiting negative behaviors. She began to act aggressively towards the Subject, stomping her feet, getting very physically close to the Subject, and making disparaging statements such as "Why are you here?" in a demanding and challenging tone of voice. She also called the Subject names such as "black bitch" and "nigger bitch". (Testimony of Subject; Justice Center Exhibit 25)

9. In response, the Subject stood her ground and addressed the Service Recipient in an equally loud and threatening or challenging voice, repeating more than once: "What are you gonna do – are you gonna hit me?" or words to that effect. The Service Recipient at one point moved away from the Subject and walked toward the kitchen; the Subject followed her. (Testimony of Subject; Justice Center Exhibit 25)

10. Shortly thereafter, another staff member separated them and the Subject was escorted outside the residence. The Subject stated to the staff person with her that she "…would not be disrespected". (Testimony of Subject; Justice Center Exhibits 15 and 25)

11. The Service Recipient was seen and assessed the same day by OPWDD Psychologist [redacted]. He finally concluded that there was "…[a likelihood of a] greater negative impact on her mental status and well being than can be gleaned from her responses to questioning regarding the incident…" (Justice Center Exhibits 4 and 17)

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

The neglect of a person in a facility or provider agency is defined by SSL § 488(1)(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 two, which is defined by SSL § 493(4)(b) 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 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 proved the alleged abuse and/or neglect, the report will not be amended or 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 psychological abuse and neglect, described as "Allegation 1" in the substantiated report. Specifically, the evidence established that the Subject committed acts of psychological abuse and neglect by expressing her own anger and raising her voice in a challenging or threatening manner at the Service Recipient, in response to what the Subject justifiably deemed as aggressive and disrespectful conduct toward her by the Service Recipient. Nevertheless, the Subject failed to make any attempt to utilize proper procedures as set forth in SCIP-R, and therefore her conduct directly violated the agency's protocols, and the Service Recipient's IPOP and Behavior Guidelines, which required the Subject to attempt to de-escalate the Service Recipient who was visibly upset, displaying anger and frustration.

The elements of psychological abuse, as defined in SSL § 488(1)(c), were satisfied and proven by a preponderance of the evidence in that the Subject was shown to have been a custodian, whose intentional verbal conduct caused, or caused a likelihood of, a substantial diminution of the Service Recipient's emotional, social or behavioral condition, which diminution was supported by a clinical assessment performed by OPWDD Psychologist [redacted]. (Hearing testimony of Subject; Hearing testimony of OPWDD Investigator [redacted]; Hearing testimony of OPWDD Psychologist [redacted]; Justice Center Exhibits 4, 6, 7, 12, 13, 14, 17, 18, 22, 23, 24 and 25)

The elements of neglect, as defined in SSL § 488(1)(h), were also satisfied and proven by a preponderance of the evidence and under the same facts, in that the Subject's deliberate,

antagonistic conduct while acting as a custodian was a breach of her duty of care to the Service Recipient. That breach of duty resulted in, or caused the likelihood of, a serious or protracted impairment of the mental or emotional condition of the Service Recipient, or the likelihood of such impairment. (Hearing testimony of Subject; Hearing testimony of OPWDD Investigator [redacted]; Hearing testimony of OPWDD Psychologist [redacted]; Justice Center Exhibits 4, 6, 7, 12, 13, 14, 17, 18, 22, 23, 24 and 25)

In support of its substantiated findings, the Justice Center presented two witnesses and a number of documents obtained during the investigation. (Justice Center Exhibits 1-27) The investigation underlying the substantiated report was conducted by now-retired Investigator [redacted], Nurse Administrator, [redacted], who testified at the hearing on behalf of the Justice Center. The Justice Center also called to testify on its behalf Psychologist [redacted], Region 3 OPWDD.

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

Allegation of Psychological Abuse

In order to establish psychological abuse under SSL § 488(1)(c), the Justice Center must prove three elements: (1) that a custodian's intentional or reckless, verbal or non-verbal conduct (2) caused or was likely to cause a substantial diminution of a service recipient's emotional, social or behavioral development or condition, and (3) that diminution or likelihood of diminution is supported by a written clinical assessment performed by a competent professional as enumerated in the statute.

This incident occurred on [redacted], at approximately 3:30 p.m. It was the Subject's first day working at this particular facility. The Service Recipient had arrived only a few days prior. The Subject had worked with the Service Recipient for approximately one month at a

different OPWDD facility. During her interrogation and testimony, the Subject acknowledged being a custodian whenever she was on duty, and several months prior to the incident had signed the Justice Center Code of Conduct, further acknowledging such status. At the hearing, the Subject also admitted to her actions in responding to the challenging behaviors presented to her by the Service Recipient on the day of the incident. She credibly testified that upon reporting to work at the [redacted], the Service Recipient was immediately physically aggressive towards the Subject and spoke to her in a raised voice, in a very demeaning manner, including using racial slurs against her.

Under such circumstances, the Subject should have relied upon her SCIP-R[1] training, as well as the information contained in the Justice Center Code of Conduct, the Service Recipient's Individual Plan of Protective Oversight (IPOP) and the Service Recipient's Behavior Guidelines, which together provide a non-threatening framework for guiding the way the Subject should have responded to the Service Recipient in this case. This is particularly true given the Service Recipient's mental health history and her diagnosis of PTSD. (Hearing testimony of Subject; Justice Center Exhibits 4, 6, 7, 21, 23 and 24)

Unfortunately, the Subject chose to ignore her training and meet aggression with aggression, in violation of the above-mentioned framework. Direct care staff members on duty are not afforded the luxury of negatively acting out on their own emotions, as the Subject did here. The Subject deliberately yelled back at the Service Recipient, and challenged the Service Recipient

[1]SCIP-R is a program, sanctioned by OPWDD and other agencies, for training staff who work with service recipients to develop the skills for crisis prevention and intervention. In this context, a "crisis" includes challenging behaviors by service recipients; such behaviors are defined by SCIP-R as "[a] behavior that is determined by society to be unacceptable and may hinder a person's opportunity to live productively within the community." The strategies and protocols set forth in SCIP-R are expected to be followed and utilized by all staff interacting with service recipients in a [redacted] facility such as the [redacted]. (Hearing testimony of OPWDD Psychologist [redacted]; Hearing testimony of Investigator [redacted]; Justice Center Exhibit 23)

as to what she would do next. After a short period of yelling at each other, the Subject and the Service Recipient were separated by additional staff members, and the Subject was escorted outside, at which time the Subject stated that she "would not be disrespected". She was relieved of duty immediately following the incident. (Hearing testimony of Subject; Justice Center Exhibits 15 and 25)

The behavior of the Service Recipient immediately following the incident was "hysterical", as described by another staff member. A clinical assessment was performed the same day by Psychologist [redacted], who reported on [redacted] to Investigator [redacted] that he believed that there was a likelihood that the Service Recipient had suffered substantial diminution of her mental health and well-being.[2] (SSL § 488(1)(c); Justice Center Exhibits 12, 17 and 18)

Accordingly, the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed psychological abuse against the Service Recipient.

Allegation of Neglect

In order to sustain an allegation of neglect, the Justice Center must prove that the Subject was a custodian who owed a duty to the Service Recipient, that she breached that duty, and that the breach either 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. (SSL § 488(1)(h))

There is no doubt that the Subject was a custodian as defined in SSL § 488(2). She had been working for OPWDD for more than a decade when the incident occurred, and had worked with the Service Recipient for approximately one month immediately prior to being assigned to

[2] An earlier assessment (Justice Center Exhibit 18) had reached the opposite conclusion, but an intervening incident involving the Service Recipient caused the clinician to re-visit his assessment, resulting in the findings noted here.

continue working with her at the [redacted]. The Subject was a direct care staff member and, as such, had a duty to familiarize herself with the Service Recipient's care plan, despite her claims of ignorance on that subject while testifying. Furthermore, as noted above, despite the Subject's additional claims to the contrary in her recorded interrogation and her testimony, she had received significant training in the protocols required when working with emotionally fragile people, in particular the SCIP-R training. Given these facts, the Subject should have been adequately familiar with the Service Recipient's challenging behaviors well in advance of this incident. (Hearing testimony of the Subject; Justice Center Exhibits 23 p. 13-15, 24, 25 and 27)

The Subject breached her duty to the Service Recipient by engaging in behavior that was clearly contrary to the framework set forth by SCIP-R and the Service Recipient's Individual Plan of Protective Oversight (IPOP) and her Behavior Guidelines. (Justice Center Exhibits 6 and 7) The IPOP and Behavior Guidelines made it clear that the Service Recipient has a diagnosis of PTSD and a history of aggressive and possibly destructive behavior when agitated, challenged or asked to perform undesirable tasks. These care plan documents clearly describe the need for skillful de-escalation techniques in dealing with the Service Recipient's negative behaviors. Instead, when faced with the Service Recipient's demeaning comments, the Subject remained in position and raised her voice so as to demonstrate to the Service Recipient that she would not allow herself to be treated disrespectfully. The clinical assessment by Psychologist [redacted] supports the conclusion that the breach of duty by the Subject either 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. ((SSL § 488(1)(h); Hearing testimony of Subject; Justice Center Exhibit 17)

Accordingly, the Justice Center has likewise proven by a preponderance of the evidence that the Subject committed neglect against the Service Recipient.

Defense Offered by the Subject

In her own defense, the Subject testified to observing a pattern of numerous outbursts of negative verbal and physical behavior by the Service Recipient against herself and others, in particular another service recipient. She stated that she had reported these matters to her supervisor, and written them in "the log", which eventually was discovered to mean the Service Recipient's individual case log. She further claimed that she had requested to avoid the assignment to the [redacted] due to the Service Recipient's presence there. There is corroboration in the record regarding the written reports, but the preponderance of evidence shows that the Subject failed to add them to the general "communication log", which is the place where management would have readily seen it, or to make any other verbal report. A written statement by one of the house managers (Justice Center Exhibit 26) claims he has no recollection of any such verbal reports.

Subject's contentions, even if true, offer no defense to an allegation of psychological abuse and/or neglect, where a subject is charged with wholesale failure to employ any of the accepted protocols and techniques for de-escalating a challenging service recipient, and where instead, his or her intentional conduct could have no foreseeable result except to escalate the dispute even further.

Accordingly, the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the abuse and neglect as 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 set forth in the substantiated report**.** Here,

the finding of Category 2 conduct is justified where that conduct seriously endangers the health, safety or welfare of the Service Recipient, as described by Psychologist [redacted]. Based upon the totality of the evidence presented, it is determined that the Subject's conduct, as described in Allegation I of the substantiated report, is properly categorized as Category 2 conduct.

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

The substantiated report is properly categorized as Category 2.

This decision is recommended by Louis P. Renzi, Administrative Hearings Unit.

DATED: July 13, 2016
Schenectady, New York

Louis P. Renzi, ALJ