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: Juliane O'Brien, Esq.

[redacted]

By: Patricia Yvette Medina, Esq.
Kohan Law Group, PC
1180 Northern Boulevard
Suite 201
Manhasset, New York 11030

[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 Allegation 1 of the substantiated report dated [redacted] of neglect by the Subject of a Service Recipient be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

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

The request of [redacted] that Allegation 2 of the substantiated report dated [redacted] of neglect by the Subject of a Service Recipient be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

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

NOW, THEREFORE, IT IS DETERMINED that the record of this report shall be retained 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: September 2, 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: New York State 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
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: Juliane O'Brien, Esq.

[redacted]

By: Patricia Yvette Medina, Esq.
Kohan Law Group, PC
1180 Northern Boulevard
Suite 201
Manhasset, New York 11030

[redacted]

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for 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 neglect by the Subject of a Service Recipient.

2. The Justice Center's Report of Substantiated Finding 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 utilize an appropriate technique to transfer a service recipient while toileting and bathing her.

This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

Allegation 2

It was alleged that on [redacted], at the [redacted] located at [redacted], while acting as a custodian, you committed neglect when you failed to provide proper supervision by leaving a service recipient unattended on the toilet, during which time she fell onto the floor.

This allegation has been SUBSTANTIATED as 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 [redacted], a non-profit organization that is certified by the New York State Office for People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of [redacted] Quality Assurance Specialist [redacted])

5. The facility accommodates seven service recipients. At the time of the alleged neglect, the minimum staffing requirements were three staff to seven service recipients during the day shifts and two staff to seven service recipients during the overnight shifts. (Hearing testimony of [redacted] Quality Assurance Specialist [redacted] and Justice Center Exhibit 19)

6. At the time of the alleged neglect, the Service Recipient was a thirty seven year old female and had diagnoses that included mild mental retardation and cerebral palsy. The Service Recipient was able to verbally communicate and, although she generally used a wheelchair, she was able to ambulate short distances with difficulty. The Service Recipient commenced residing at the facility in 2007. (Justice Center Exhibits 5 and 22) The Service Recipient regularly wore an adult diaper, a "pull up," which she often soiled and/or urinated in. (Hearing testimony of the Subject)

7. On [redacted] the number of staff required to assist the Service Recipient with transferring from a wheel chair to standing, bathing or the toilet was increased from one to two, as the Service Recipient was having greater difficulty with moving, balancing and pivoting herself. Transfer Guidelines, Bathing Guidelines and Toileting Guidelines, all dated [redacted], contained orders that the Service Recipient be transferred, bathed, and toileted with the assistance of two staff members. The Subject signed an In-Service Training record on [redacted] acknowledging that she was aware of the requirement that two staff must assist the Service Recipient when she was being transferred, bathed, and/or toileted. (Hearing testimony of

[redacted]

the Subject and Subject Exhibit 3, pages 2 - 6)

8. At the time of the alleged neglect, the Service Recipient's operative Plan of Protective Oversight (POPO) dated [redacted] and updated on [redacted], stated that staff must remain near the bathroom to monitor the Service Recipient when she is using the toilet and, in a separate area on the POPO, it also stated that the Service Recipient was not to be left unattended in the bathroom. (Justice Center Exhibit 10)

9. At the time of the alleged neglect, the Subject had been employed as a Direct Support Professional (DSP) for fourteen years at another facility and she had also been employed on a part time basis at the facility for three or four years. (Hearing testimony of the Subject) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

10. On the evening of [redacted] the three staff who were assigned to supervise the seven facility service recipients were the female Subject, the female DSP [redacted] and the male substitute DSP [redacted]. From 5:58 p.m. until 8:37 p.m., DSP [redacted] had taken two service recipients out of the facility, leaving the Subject and DSP [redacted] to supervise the remaining five service recipients, including the Service Recipient. (Subject Exhibit 2 and Hearing testimony of the Subject)

11. At approximately 7:30 p.m., the Subject rolled the Service Recipient's wheelchair into the bathroom to prepare the Service Recipient for her evening shower, at which point the Service Recipient indicated that she needed to move her bowels. The Subject assisted the Service Recipient to a standing position, after which she pulled the Service Recipient's pants down, pivoted the Service Recipient to a position in front of the toilet, assisted the Service Recipient to sit down on the toilet and then finished removing the Service Recipient's clothing from the waist down. (Hearing testimony of the Subject)

12. The Subject had been waiting in the bathroom with the Service Recipient for approximately half an hour when she looked at her cell phone and noticed that it was 8:00 p.m.,

[redacted]

the time that diabetic service recipient A was due to have a blood glucose test performed. The Subject then clipped the toilet seat belt device around the Service Recipient's waist, against the Service Recipient's strong objections, and advised the Service Recipient that the Subject would be right back. (Hearing testimony of the Subject)

13. As the Subject left the bathroom, she heard DSP [redacted] call to her for assistance. The Subject went to the other bathroom, where she found DSP [redacted] with a male service recipient, who was undressed from the waist up in preparation for his shower. The Subject then helped DSP [redacted] undress that service recipient and transfer him to the apparatus upon which he was positioned for his shower. The Subject then proceeded to service recipient A's bedroom, where she found service recipient A seated in a chair watching television. The Subject told service recipient A that it was time for her blood test, assisted her out of the chair, helped her out of the bedroom and into the hallway, where the medication area was located, sat her down in a nearby chair, performed the blood test, wrote down the result and assisted her out of the chair, back into her bedroom, and back into a chair there. (Hearing testimony of the Subject)

14. While she was still in service recipient A's bedroom, the Subject heard someone outside of the room scream in pain. As the Subject exited service recipient A's bedroom, she yelled out asking who had made the noise, and the Service Recipient responded that it had been her. When the Subject returned to the bathroom eight minutes after having left the Service Recipient belted onto the toilet, she found the Service Recipient lying face down on the floor in front of the toilet. (Hearing testimony of the Subject and Justice Center Exhibit 2)

15. The Subject called to DSP [redacted], who did not respond, and she immediately assisted the Service Recipient up off of the floor by hoisting her up from behind. After satisfying herself that, although there were marks on the Service Recipient's cheek and knee, she was not seriously injured, the Subject proceeded to bathe her and thereafter took her back to her bedroom. (Hearing

[redacted]

testimony of the Subject)

16. A short while later, the Subject contacted the nurse to advise her that the Service Recipient had marks on her cheek and her knee as a result of having fallen. The nurse told her to apply ice to the areas and to give the Service Recipient Tylenol, which she did. The following day, the Service Recipient was taken to an urgent care clinic where a doctor determined that the Service Recipient's face had an abrasion and swelling. Diagnostic testing was performed and no further diagnosis was made. (Hearing testimony of the Subject and Justice Center Exhibit 16)

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 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 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...

[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 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 the acts described as Allegations 1 and 2 in the substantiated report.

In support of its substantiated findings, the Justice Center presented evidence obtained during the investigation. (Justice Center Exhibits 1-22) The investigation underlying the substantiated report was conducted by [redacted] Quality Assurance Specialist [redacted].

The Subject testified at the hearing on her own behalf and provided five documents as

[redacted]

evidence. (Subject Exhibits 1-5)

Allegation 1: Improper Transfer of the Service Recipient

A finding of neglect requires, firstly, that a preponderance of the evidence establishes that the Subject engaged in conduct that breached her duty to the Service Recipient. Regarding Allegation 1, the Subject's duty to the Service Recipient included adhering to the Transfer Guidelines (Subject Exhibit 3, page 3), Bathing Guidelines (Subject Exhibit 3, page 5), and Toileting Guidelines (Subject Exhibit 3, page 6), which were all in effect on the date of the incident. All of the Guidelines dictated that the Service Recipient have the assistance of two staff when she is transferred, bathed and/or toileted.

The Subject acknowledged that, at the time of the incident, she was aware of the requirement that two staff assist the Service Recipient with transfers, bathing, and toileting, but she argued that she alone transferred the Service Recipient to the toilet and thereafter for bathing because she had no other choice.

The Subject testified that, at the time of the incident, the facility was understaffed. On [redacted] the minimum staffing for the facility was three staff to seven service recipients during the days, and two staff to seven service recipients during the overnights. (Justice Center Exhibit 19) As DSP [redacted] had taken two service recipients out of the facility from approximately 6:00 p.m. until approximately 8:40 p.m., there were only two staff on duty at the time of the incident; however, they were supervising the reduced number of five service recipients. [redacted] Quality Assurance Specialist [redacted] testified that she was told by [redacted] Assistant Director of Quality Assurance [redacted] that [redacted] Senior Director of Quality Assurance [redacted] had reviewed the matter and had stated that the ratio of two staff to five service recipients was within the minimum staffing requirements. Based on the evidence in the record, the Subject's argument of inadequate staffing is not credited.

[redacted]

The Subject testified that, at the time of the incident, there was a verbal facility policy that male staff were not permitted to assist with the toileting and bathing of female service recipients, but that female staff were permitted to assist with the toileting and bathing of male service recipients. The Subject testified that this alleged policy prevented her from seeking assistance from DSP [redacted] with the Service Recipient, but that she was, nonetheless, able to help DSP [redacted] with the transfer and undressing of a male service recipient on the same date. The Subject testified that this facility policy was changed subsequent to and as a result of this incident.

[redacted] Quality Assurance Specialist [redacted] testified that, while it was generally preferred that service recipients be assisted with toileting and bathing by DSPs of the same gender, there was no policy prohibiting male DSPs from assisting female service recipients. [redacted] Quality Assurance Specialist [redacted] testified that at the time of this incident, DSP [redacted] was allowed to assist the Subject with the Service Recipient. The Subject's explanation of this alleged policy, that such a policy would have been so strictly enforced to the extent that a service recipient's safety and welfare would have been compromised as a result, defies logic. Based on the evidence in the record, the Subject's argument that she could not have asked the only other staff who was present in the facility to assist her because he was a male is not credited.

The Subject testified that, even though she had signed the In-Service Training record dated [redacted] acknowledging that the Service Recipient was to have two staff assisting her with transfers, bathing and toileting, she did not actually receive any training on this subject matter. This line of defense was unpersuasive, primarily because the Subject acknowledged in her testimony that, at the time of the incident, she knew that the Service Recipient was required to have two staff assist her with transfers, bathing and toileting.

Accordingly, it is found that the Subject breached her duty to the Service Recipient to

[redacted]

adhere to the written facility policies that require that the Service Recipient be assisted by two staff whenever she was being transferred, bathed or toileted.

A finding of neglect also requires that a preponderance of the evidence establishes that the Subject's breach of duty 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. While there was an injury to the Service Recipient that was caused by the Subject's breach of duty described in Allegation 2, there was no evidence that the Subject's breach of duty described in Allegation 1 resulted in any physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. However, such evidence is not necessary for a finding of neglect. The reason that the Service Recipient's Guidelines changed to require that she have a second staff assisting her with transfers, bathing, and toileting, was to ensure her physical safety, as her ability to move, balance and pivot had deteriorated. Under these circumstances, it is clear that the Subject's breach of duty described in Allegation 1 was likely to result in physical injury of the Service Recipient.

Allegation 2: Failure to Provide Proper Supervision

Regarding Allegation 2, the Subject's duty to the Service Recipient included providing proper supervision to the Service Recipient when she was using the bathroom. The Service Recipient's POPO (Justice Center Exhibit 10) refers to the Service Recipient's bathroom supervision requirements in two places. Under the heading of Personal Hygiene, it states that "...staff must remain near the bathroom to monitor" and under the heading of Adequate Supervision, it states that the Service Recipient is "not to be left unattended in bathroom." [redacted] Quality Assurance Specialist [redacted] testified that she was told by [redacted] Director of Residential Services [redacted] that the word "near" means that staff could wait outside the bathroom, with the door ajar for privacy. While there is some ambiguity

[redacted]

raised by the two different references to the Service Recipient's bathroom supervision requirements, there can be no reasonable interpretation of either one of the provisions that it was authorized for the Subject to walk away from the bathroom and attend to other duties for at least eight minutes, while the Service Recipient was belted to the toilet.

The Subject testified that the Service Recipient had been taking a very long time to move her bowels and when she looked at the time, she realized that she had to test service recipient A's blood glucose level immediately. The Subject testified that DSP [redacted] the only other staff present, was not trained to perform the blood glucose test and that she was anxious to ensure that the testing be done on time because the meter displayed the exact time that the test was performed and she did not want to "get in trouble" for failing to test service recipient A's blood sugar as prescribed. The Subject testified that DSP [redacted] was occupied with another service recipient, and, further that because he was a male, he could not have supervised the female Service Recipient in any case. The Subject testified that she did not want to remove the Service Recipient from the toilet before attending to her other duties because she had already undressed the Service Recipient and she was afraid that the Service Recipient might "poop," which presumably would have caused some inconvenience.

The Subject testified that prior to exiting the bathroom, she strapped a safety seat belt around the Service Recipient's waist to ensure that the Service Recipient was securely seated on the toilet and she told the Service Recipient that she would return shortly. The Subject testified that she knew prior to the incident that the Service Recipient had a strong aversion to being strapped onto the toilet. The Subject testified and her Request for Amendment (Justice Center Exhibit 2) states that the Service Recipient reacted very unhappily when she was strapped onto the toilet, by complaining loudly and forcefully.

As it happened, the Subject did not return to the Service Recipient right away, as she had

promised the Service Recipient she would. The Subject initially became sidetracked by DSP request for assistance with transferring and undressing another service recipient before she even started to test service recipient A's blood.

When she finished assisting DSP the Subject began the process of taking service recipient A from her room to the medical area, testing her blood and returning her to her room, and she did not return to the Service Recipient until she heard her cry out after falling to the floor. Although the length of time that the Service Recipient was unsupervised was not proven, the Subject's Request for Amendment (Justice Center Exhibit 2) states that the Subject left the unsupervised Service Recipient belted onto the toilet for eight minutes.

The Subject's counsel argued that, because the Subject was the only staff present who was trained in blood glucose testing and the only female staff present to assist the Service Recipient with toileting, she was stuck between two competing duties and she had no alternative to the course chosen by her. The Subject's counsel argued further that the Service Recipient's POPO did not explicitly state that the Service Recipient must be supervised directly and continuously when she used the toilet, and also that the Subject had never seen the POPO in any case, and therefore should not be held accountable for any inadvertent noncompliance with its provisions.

In short, the Subject's position, as stated in her testimony and through the submissions of her counsel, was that the Subject had no choice but to leave the Service Recipient strapped to the toilet unsupervised while she met the needs of other service recipients, and that the Service Recipient's bathroom supervision requirements had not been clear to the Subject in any case.

The Subject's explanation for her haste in leaving the Service Recipient to perform service recipient A's blood test on time was unconvincing, as both the Subject and Quality Assurance Specialist testified about a window of time for the administration of medication. Regardless of whether or not there was a window of time with respect to the blood

glucose test, it is impossible to imagine that the Subject did not have sufficient opportunity to ensure that the Service Recipient was safely transferred from the bathroom, before leaving her unsupervised.

The Subject's explanation that she had already removed all of the Service Recipient's clothes from the waist down and that she was afraid that the Service Recipient would defecate, had she ensured that the Service Recipient was safely transferred from the bathroom, is also meritless. The Subject testified that the Service Recipient always wore an adult diaper into which she often urinated and defecated. The Subject had the option of ensuring that the Service Recipient was safely transferred from the bathroom and appropriately accommodated with a pull up diaper before leaving her alone.

While it may be true that the Subject was the only staff present qualified to test service recipient A's blood sugar, it does not follow that she had no choice but to leave the Service Recipient strapped to a toilet unsupervised. It has already been accepted evidence that DSP [redacted] could have assisted in the Service Recipient's supervision, despite the fact that he was a male.

Similarly, even if the Subject had not read the Service Recipient's POPO, and therefore was not aware of the specifics of her supervision needs, it is obvious that leaving the Service Recipient strapped to a toilet unsupervised and under her vociferous protests, for at least eight minutes, was a failure to provide proper supervision which constituted a breach of the Subject's duty to the Service Recipient.

The evidence that the Service Recipient fell and suffered physical injury to her face, and possibly to her knee, when the Subject left her unsupervised was undisputed. The Service Recipient was seen by a doctor on the day following the incident and the Medical/Clinic Visit Summary (Justice Center Exhibit 16) states that the Service Recipient was prescribed Tylenol for the abrasion and swelling to her face.

[redacted]

Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged in Allegations 1 and 2 of the substantiated report. The substantiated report will not be amended or sealed.

The last issue to be decided 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 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.

DECISION: The request of [redacted] that Allegation 1 of the substantiated report dated [redacted] of neglect by the Subject of a Service Recipient be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

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

The request of [redacted] that Allegation 2 of the substantiated report dated [redacted] of neglect by the Subject of a Service Recipient be amended and sealed is denied. The

[redacted]

Subject has been shown by a preponderance of the evidence to have committed neglect.

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

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

DATED: August 23, 2016
Plainview, New York

Sharon Golish Blum, Esq.
Administrative Law Judge