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: Laurie Cummings, Esq.

[redacted]

By: Connor J. Burke, Esq.
O'Neil & Burke, LLP
135 North Water Street
Poughkeepsie, New York 12601

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 neglect.

The substantiated report is properly categorized as a Category 2 act.

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).

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: April 11, 2017
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: Elizabeth M. Devane
Administrative Law Judge

Held at: Administrative Hearings Unit
New York State Justice Center for the Protection of People With Special Needs
4 Burnett Boulevard, Second Floor
Poughkeepsie, New York 12601
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: Laurie Cummings, Esq.

[redacted]

By: Connor J. Burke, Esq.
O'Neil & Burke, LLP
135 North Water Street
Poughkeepsie, New York 12601

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], [redacted] of 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 provide proper supervision to a service recipient, during which time she fell in the bathroom and sustained a fractured leg.
>
> This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law §493(4)(b).

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

4. The facility, [redacted], located at [redacted], is an Individualized Residential Alternative (IRA) that is operated by the [redacted], an agency that is operated by the 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 Justice Center Investigator I[redacted])

5. [redacted] provides residential care to service recipients with developmental disabilities. [redacted] is able to accommodate 10 permanent and 4 respite service recipients. (Hearing testimony of Justice Center Investigator I[redacted]; Hearing testimony of the Subject; Justice Center Exhibit 6)

6. At the time of the alleged neglect, the Subject had been working at [redacted] since 2007 as a Direct Support Assistant (DSA). The Subject's duties included the care and supervision of service recipients and their needs. (Hearing testimony of Justice Center Investigator I[redacted]; Hearing testimony of the Subject)

7. At the time of the alleged neglect, the female Service Recipient was 84 years old. The Service Recipient has diagnoses including mild intellectual disorder, schizoaffective disorder, Parkinson's disease and osteoporosis. The Service Recipient resided at a family care residence and stayed at [redacted] for respite care on occasion. The Service Recipient arrived at [redacted] for a respite stay on [redacted]. (Hearing testimony of Justice Center Investigator I[redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6, 10, 11, 13, 14, 16 and 17)

8. A respite packet for the Service Recipient was provided to [redacted] to identify the Service Recipient's needs and included information set forth in the Service Recipient's Individualized Service Plan (ISP). It was noted that the Service Recipient had difficulty ambulating, an unsteady gait and a history of falling. Staff was required to stay within arm's length of the Service Recipient when she walked. It was further noted that, although the Service Recipient can toilet independently, the Service Recipient was not to be left alone in the bathroom due to her history of falling. (Hearing testimony of Justice Center Investigator I[redacted]; Hearing testimony

of the Subject; Justice Center Exhibit 6, 10, 11, 16, 17)

9. On Wednesday[redacted], the Subject was scheduled to work from 3:00 p.m. to 11:00 p.m. The Subject's duties that shift included line of sight supervision for three or four service recipients, showering the Service Recipient and taking care of laundry. (Hearing testimony of Justice Center Investigator I[redacted]; Hearing testimony of the Subject; Justice Center Exhibit 6, 12)

10. The Subject asked staff to monitor the other service recipients assigned to her while the Subject went into the bathroom with the Service Recipient for showering. After showering, the Subject placed the Service Recipient on the toilet. The Subject then left the bathroom and went to take care of laundry in the laundry room. The bathroom the Service Recipient was in was not visible from the laundry room. (Hearing testimony of Justice Center Investigator I[redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6, 7, 13, 19)

11. The Subject was out of the bathroom and the Service Recipient was alone in the bathroom for about three minutes. The Subject was on her way back to the bathroom when the Subject heard a thud coming from the bathroom. Upon entering the bathroom, the Subject saw the Service Recipient lying on her left side on the floor and trying to get up. (Hearing testimony of Justice Center Investigator I[redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6, 7, 13)

12. The Subject called a coworker for assistance and then called 911. The Subject accompanied the Service Recipient to the hospital in the ambulance and took the Service Recipient's respite package to the hospital. The Subject notified those in the chain of command including the Treatment Team Leader, Acting House Manager and Nurse Administrator on duty. (Hearing testimony of Justice Center Investigator I[redacted]; Hearing testimony of the Subject;

Justice Center Exhibits 6, 7, 8, 13, 14, 21)

13. While at the hospital, the Subject reviewed the respite plan and saw that the Service Recipient was not to be left alone in the bathroom. (Hearing testimony of Justice Center Investigator I [redacted]; Hearing testimony of the Subject; Justice Center Exhibit 6)

14. As a result of the fall, the Service Recipient sustained an upper femur fracture which required surgery, a left total hip replacement. The Service Recipient had complications with the healing process, including infection and additional surgeries and will most likely never ambulate again. As a result, the Service Recipient could not return to the family care residence where she had resided and was admitted into a nursing home (Hearing testimony of Justice Center Investigator I [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6, 13, 18)

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 neglect.
- Pursuant to Social Services Law § 493(4), the category of 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) as follows:

> "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 neglect shall be categorized into categories including Category 2 pursuant to SSL § 493(4)(b), 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 committed the act of neglect alleged in the substantiated report that is the subject of the proceeding and that such act constitutes the category of neglect as set forth in the substantiated report. (Title 14 NYCRR § 700.10(d))

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

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

DISCUSSION

In support of its substantiated findings, the Justice Center presented a number of documents (Justice Center Exhibits 1-21), as well as an audio recording of interviews (Justice Center Exhibit 22), obtained during the investigation. The investigation underlying the substantiated report was conducted by Justice Center Investigator I [redacted], who was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf.

Allegation 1 - Neglect

The Justice Center has proved by a preponderance of the evidence that the Subject committed neglect as described in "Allegation 1" in the substantiated report.

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 her 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 dispute that the Subject was a custodian of the Service Recipient as that term is defined in Social Services Law §488(2). The Subject was described by coworkers and her superiors as a very good employee who has good interactions with service recipients.

It is alleged that the Subject breached her duty as a custodian by failing to provide proper

supervision for the Service Recipient, during which time the Service Recipient fell and sustained a fractured leg.

The Subject argued that she was not properly notified of the Service Recipient's needs and was not aware that staff were to remain with the Service Recipient while she was in the bathroom until after the Service Recipient fell. The Subject argued that there were issues at the management level and that [redacted] was understaffed. The Subject saw the respite packet for the Service Recipient in a drawer in the kitchen when she began her shift on the day in question. However, she did not have time to review the information. She was very busy and had many responsibilities, including line of sight supervision for a number of service recipients in addition to showering the Service Recipient and taking care of laundry. The Subject added that the respite packets at [redacted] were often missing or contained incomplete information. She noted that a "read and sign" policy was put into place for respite packets after the incident. While [redacted] was busy and likely could have benefitted from additional staff and additional precautions, such as "read and sign", these arguments fail.

The evidence established that the respite packet detailing the necessary supervision for the Service Recipient was on site at [redacted] and contained complete information when the incident occurred. Specifically noted was the fact that the Service Recipient should not be alone in the bathroom due to her unsteady gait and history of falling. The Subject agreed that it was incumbent on staff to be aware of the supervision requirements of service recipients in their care. While the Service Recipient was in the bathroom, she was the only service recipient the Subject was caring for. The Subject was familiar with the Service Recipient from previous respite stays as well as the respite stay during which the incident occurred.

By leaving the Service Recipient alone in the bathroom, the Subject failed to provide proper

supervision to the Service Recipient. As a result of the breach, the Service Recipient suffered an actual injury, a fractured femur. The weight of evidence in the record and hearing testimony support a finding by a preponderance of the evidence that the Subject committed neglect as described in "Allegation 1" in the substantiated report.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of neglect set forth in the substantiated report**.** To reach the level of a Category 2 act, the conduct of the Subject would have had to seriously endanger the health, safety or welfare of the Service Recipient. The Service Recipient was 84 years old, required supervision while in the bathroom due to her unsteady gait and falls in the past and, among other diagnoses, had osteoporosis. The Service Recipient suffered a femur fracture with ongoing complications including surgeries, infection and loss of ambulation. The Service Recipient was unable to return to the family care residence where she had resided. This incident seriously endangered the health, safety and welfare of this Service Recipient.

Based upon the totality of the circumstances, the testimony presented, and the witnesses' testimony, it is determined that the substantiated report is properly categorized as a Category 2 act.

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. The substantiated report will not be amended and sealed.

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 neglect.

The substantiated report is properly categorized as a Category 2 act.

This decision is recommended by Elizabeth M. Devane, Administrative Hearings Unit.

DATED: April 4, 2017
Schenectady, New York

Elizabeth M. Devane
Administrative Law Judge