

**STATE OF NEW YORK  
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE  
WITH SPECIAL NEEDS**

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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**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: Theresa Wells, Esq.

[REDACTED]  
[REDACTED]  
[REDACTED]

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

**ORDERED:**

The request of [REDACTED] that the substantiated report dated [REDACTED]  
[REDACTED] be amended and sealed is denied.

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).

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 27, 2017  
Schenectady, New York

  
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David Molik  
Administrative Hearings Unit

**STATE OF NEW YORK  
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE  
WITH SPECIAL NEEDS**

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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**RECOMMENDED  
DECISION  
AFTER  
HEARING**

**Adjudication Case #:**

[REDACTED]

Before:

Mary Jo Lattimore-Young  
Administrative Law Judge

Held at:

New York State Justice Center for the Protection  
of People With Special Needs  
1200 East and West Road  
West Seneca, New York 14224  
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: Theresa Wells, Esq.

[REDACTED]  
[REDACTED]  
[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], [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 adequate care and proper supervision to a service recipient, during which time she was left sitting on the toilet for hours covered in fecal matter.

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, located at [REDACTED], is an Individual Residential Alternative (IRA) for developmentally disabled individuals operated by [REDACTED], which is certified by the New York State

Office for People With Developmental Disabilities (OPWDD) and, as a result, is a provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the Subject had been employed by [REDACTED] since [REDACTED] 2012. The Subject worked as a relief Direct Support Professional (DSP). As a DSP, the Subject's job duties involved the supervision and day-to-day care of the Service Recipients, which included assisting with personal hygiene activities.

6. On [REDACTED], the Subject had worked her first shift from 7:00 a.m. to 3:00 p.m. and then began working a second shift from 3:00 p.m. until 11:00 p.m. During the second shift, the Subject was re-assigned to supervise and to provide care for the Service Recipient. Prior to the alleged incident, the Subject had been trained on the Service Recipient's Behavior Support Plan (BSP) requirements. (Hearing testimonies of the Subject and the QIS; Justice Center Exhibits 6-7, 12, 14 and 22)

7. At the time of the alleged neglect, the Service Recipient was an articulate fifty-four year old female, who could independently ambulate in a wheelchair and transfer from her wheelchair into a shower chair. The Service Recipient attended a day habilitation program on the weekdays from approximately 9:00 a.m. until 3:00 p.m. The Service Recipient had diagnoses of a moderate intellectual disability, cerebral palsy, epilepsy, intermittent explosive disorder, depression and other medical conditions. (Hearing testimony of the QIS and Justice Center Exhibits 14 and 15)

8. The Service Recipient's Individual Plan of Protective Oversight (IPOP) was last revised on [REDACTED]. Her Behavior Support Plan (BSP) had been revised on [REDACTED]. The Service Recipient's BSP noted known targeted behaviors such as her history of refusing to address personal hygiene issues, which was also addressed as a part of her rights restriction

regarding her access to the community. The Service Recipient's BSP further stated that when she became verbally aggressive and upset, staff was to use non-verbal and verbal calming techniques and remain positive. The Service Recipient's BSP had written in bold lettering that, in addressing her verbal aggression, if the Service Recipient "is not able to be redirected or continue[d] to escalate," then the site manager or on-call manager was to be contacted for further instructions. The Service Recipient's BSP also directed staff to track and document skin assessments as well as her behavior on the computerized Therap notes (or T-logs). (Justice Center Exhibits 14 and 24)

9. With respect to the Service Recipient's personal hygiene refusals, staff guidelines directed staff to visually check for a skin breakdown each time staff changed, washed or showered the Service Recipient. If a skin breakdown was noted, then staff was required to contact the nurse for further instructions. Staff guidelines also noted that, after the Service Recipient had been in the bathroom for more than fifteen minutes, staff was to ask the Service Recipient if she would like to address her personal hygiene matters. If the Service Recipient refused after thirty minutes had passed, then staff was to encourage the Service Recipient to shower in order to avoid an infection. It was further noted in the guidelines that staff should be ready to assist the Service Recipient when thirty-minutes had passed so that the Service Recipient would not be discouraged or frustrated. (Justice Center Exhibit 24)

10. At about 7:00 p.m. on [REDACTED], the Service Recipient had to use the bathroom and called for staff assistance. When staff did not respond, the Service Recipient then wheeled herself into the bathroom and sat on the toilet. Shortly thereafter, the Subject entered the bathroom. At that time, the Subject had observed that the Service Recipient had already soiled on herself and tried to assist her. The Subject then moved the wheelchair from the bathroom into the hallway. When the Subject asked the Service Recipient if she wanted to shower, the Service

Recipient refused, threatened to throw herself onto the floor and became upset because she wanted to watch a television show and the Subject had removed the wheelchair from the bathroom. The Subject then telephoned the on-call manager who suggested that the Service Recipient could be cleaned with baby wipes or a wet wash towel. The Subject continued to ask the Service Recipient to let the Subject clean her. The Service Recipient became verbally upset, cursed at the Subject and remarked that the overnight staff will shower her. Afterwards, the Subject made no further attempts to contact the on-call manager or the nurse regarding the situation and left the soiled Service Recipient on the toilet. (Hearing testimony of the QIS, the Subject; Justice Center Exhibits 6, 8-9, 20 and 23)

11. While the Service Recipient remained on the toilet, there were occasions when the Subject checked on the Service Recipient by standing at the door and looking into the bathroom. Afterwards, the Subject returned to the office to attend to other tasks. The Subject documented the situation on the tracking sheets by drawing an arrow in the fifteen minute intervals column from 7:00 p.m. to 11:00 p.m. The Subject further noted on the tracking sheets that the Service Recipient was sitting on a toilet waiting for the overnight staff and initialed each fifteen minute interval on the sheet. (Hearing testimony of the Subject and Justice Center Exhibit 18)

12. Four hours later, sometime at about 11:00 p.m., staff beginning their overnight shift found the soiled Service Recipient asleep on the toilet with her head in the bathroom sink. The on-call manager was notified and staff monitored the Service Recipient for any appearances of sores or skin breakdowns. None were found. (Hearing testimony of the QIS, Justice Center Exhibits 6, 11, 14, 17, 20 and 24)

13. At 11:11 p.m., the Subject entered a computerized Therap note regarding the incident that all staff could access. The Therap note entered by the Subject specifically stated that

the Service Recipient “remained on the toilet until the overnight staff came in to assist her as she requested.” (Justice Center Exhibit 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 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 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 neglect of a person in a facility or provider agency is defined by SSL § 488(1)(h) that states:

"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 3, which is defined under SSL §493(4)(c) as follows:

Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a category three finding shall be sealed after five years.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject(s) committed the act or acts of neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute 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**

The Justice Center has established by a preponderance of the evidence that the Subject committed an act, described as “Allegation 1” in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-26) The investigation underlying the substantiated report was conducted by the QIS, who was the only witness who testified at the

hearing on behalf of the Justice Center.<sup>1</sup> The Service Recipient was interviewed as a part of the investigation. (Justice Center Exhibit 8)

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

The facts are mostly undisputed.

At the hearing, the Subject testified that the Service Recipient had a history of refusing personal hygiene assistance. On the evening in question, the Service Recipient had a bowel mishap and soiled on herself inside of her underwear. The Subject testified that she did not neglect the Service Recipient because she had removed the Service Recipient's soiled underwear then conducted and documented the required fifteen minute checks as per the Service Recipient's plans. The Subject also testified that she telephoned the facility manager one time to report that the Service Recipient refused to be cleaned up. The Subject testified that when she attempted to follow the manager's instructions to clean the Service Recipient with baby wipes, the Service Recipient refused. During her hearing testimony, the Subject admitted that leaving the Service Recipient on the toilet covered in fecal matter for a four-hour period was not proper and could have caused the Service Recipient harm. The Subject also testified that she is aware that feces left on the Service Recipient's skin may have caused sores, infection or skin breakdown. (Hearing testimony of the Subject, Justice Center Exhibits 2 and 12)

The Subject further argued at the hearing that, although she left the soiled Service Recipient sitting on the toilet, the Service Recipient was the one who had refused assistance and that she had a right to do so.

The Service Recipient was interviewed on [REDACTED] and provided a written statement. The Service Recipient's account of what happened differs somewhat from the Subject's

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<sup>1</sup> At the time of the incident, the investigation was conducted by the QIS for [REDACTED], who now has a new job title of site manager for a different [REDACTED]

version of events. The Service Recipient told the investigator that, on the day of the incident, by the time she made it to the bathroom she had soiled herself. The Service Recipient stated that she would have preferred to have been cleaned with baby wipes so she would have been able to watch a television show that came on at 9:00 p.m. The Service Recipient further told the investigator that the Subject told her that she had to take a full shower. She told the investigator that she had wanted to get back into her wheelchair and to go to her bedroom but that the Subject had removed the wheelchair from the bathroom. The Service Recipient also told the investigator that while she was on the toilet, she received her medication from a different staff person and that no-one else came to check on her. (Justice Center Exhibits 6 and 8)

At the hearing, the Subject raised assertions that were unpersuasive. The Subject even agreed that it was not proper to have left the Service Recipient sitting on the toilet for a four-hour period.

The credible evidence contained in the record establishes that the Subject was responsible for the care and supervision of the Service Recipient at the time of the incident. The Subject failed to clean the Service Recipient and ensure that she was left in a safe place. Although the Service Recipient became verbally upset and refused to allow the Subject to clean up her bowel mishap, the Subject had the duty to continue to follow through to ensure a proper resolution of the situation.

Here, the Subject telephoned the on-call manager only one time to try to address the situation. The Subject failed to call the manager a second time or even attempt to contact the on-call nurse for further instructions and failed to clean the Service Recipient. Instead, the Subject left feces on the Service Recipient, knowing that it can cause sores, infection or skin breakdown. While under the Subject's supervision, the Service Recipient was also left in a position of peril as she sat on the toilet for a long time and eventually fell asleep. Additionally, given the Service

Recipient's age and known history of epilepsy, she could have fallen to the floor and injured herself. (Justice Center Exhibit 14)

Consequently, the Subject breached her custodian's duty of care and proper supervision owed to the Service Recipient. The Subject's conduct was likely to have caused physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

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 or sealed.

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. 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 Category 3 act.

Substantiated Category 3 findings 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 SSL § 496 (2). The report will be sealed after five years.

**DECISION:**

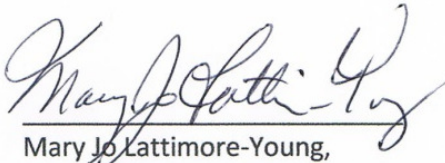
The request of [REDACTED] that the substantiated report dated [REDACTED]  
[REDACTED] be amended and sealed is denied.

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

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

This decision is recommended by Mary Jo Lattimore-Young,  
Administrative Hearings Unit.

**DATED:** April 24, 2017  
West Seneca, New York



Mary Jo Lattimore-Young,  
Administrative Law Judge