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 AFTER HEARING

Adjud. Case #: [redacted]

Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived

Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Heather Abissi, Esq.

[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] received and dated dated [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse.

The substantiated report is properly categorized, or should be categorized as a Category 3.

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: May 26, 2015
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: Gerard Serlin
Administrative Law Judge

Held at: New York State Office Building
333 East Washington Street, Room 115
Syracuse, New York 13202
On: [redacted]

Parties: Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived.

Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Heather Abissi, Esq.

[redacted]

JURISDICTION

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

2. On or about [redacted], the Justice Center substantiated the report against the Subject. The Justice Center concluded that:

Offense 1

> It was alleged that on [redacted], in the upstairs hallway and bedroom of the [redacted], located at [redacted], while acting as a custodian (DSP I), you committed an act of abuse (deliberate inappropriate use of restraint) when you utilized an unapproved method of restraint on a service recipient.
>
> This offense has been SUBSTANTIATED as a Category 3 offense pursuant to Social Services Law § 493.

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

4. [redacted] (the Facility), located at [redacted], is an [redacted] and is operated by the

[redacted], which is a facility or provider agency that is subject to the jurisdiction of the Justice Center. (See testimony of [redacted])

5. At the time of the alleged abuse, the Subject was employed by [redacted] at the Facility, as a Direct Support Professional I (DSP I), and had been employed at the Facility since at least [redacted] 2012. (Justice Center Exhibit 7; and testimony of the Subject)

6. At the time of the alleged abuse, the Service Recipient was a young person who was 15 years of age and was diagnosed with autism, ADHD, bipolar NOS, mild mental retardation and hypothyroidism. The Service Recipient required visual checks every five minutes when he was in the residence and once every hour when he was in his room. (Justice Center Exhibit 2 pages 1 and 11; and testimony of [redacted])

7. On [redacted] the Subject, Staff [redacted] Staff [redacted] Shift Charge [redacted] and Site Supervisor [redacted] were assigned and on duty for the 3:00 p.m. to 11:00 p.m. shift at the Facility. (Justice Center Exhibit 3; testimony of [redacted]; testimony of [redacted]; and testimony of the Subject)

8. On [redacted] at the beginning of her shift, the Subject was sitting in the second floor hallway of the Facility monitoring a youth who she was assigned to monitor. Staff [redacted] was assigned to monitor the Service Recipient but at the time she had left the Facility to purchase groceries. At approximately 3:30 p.m., the Service Recipient came out of his room and told the Subject that he was going to take a shower and needed soap.

9. In response to the Service Recipient's request, the Subject went to a hall closet and proceeded to dispense soap into a cup from a larger one gallon container, in accordance with the Facility protocol for this Service Recipient. As the Subject was attempting to pour the soap into the cup, the Service Recipient came up behind the Subject flailing his arms at her, grabbing

her and trying to get the soap from her. In response to the Service Recipient's actions, the Subject turned around and faced the Service Recipient, who then started punching her and flailing his arms at her. The Subject attempted to push away from the Service Recipient while telling the Service Recipient to calm down. The Subject had difficulty getting herself away from the Service Recipient due to the confinement of the hallway so she called for help.

10. Staff [redacted] responded to the Subject's call from the lower level and attempted to put the Service Recipient in a standing wrap. As a result of Staff [redacted] actions, the Service Recipient became angrier and thwarted Staff [redacted] efforts to restrain him. Staff [redacted] became angry as a result and attempted a second standing wrap which was again unsuccessful. Thereafter, the Service Recipient continued to throw punches and flail his arms. Staff [redacted] then called for Staff [redacted] to assist. (Testimony of the Subject)

11. Upon hearing a call for help from Staff [redacted], Staff [redacted] went upstairs and found the Service Recipient seated on the floor holding the gallon container of soap which the Subject and Staff [redacted] were attempting to take away. Staff [redacted] helped remove the container from the Service Recipient's grasp, then ran to the bathroom and put it in the trash. While Staff [redacted] was away from the scene, Staff [redacted] attempted to put the Service Recipient in a seated wrap and as he did, the Service Recipient cocked his head back and hit Staff [redacted] head with his head.

12. When Staff [redacted] returned to the scene the Service Recipient was continuing to scream and flail his arms and had rolled to his stomach. Staff [redacted] was on top of the Service Recipient's upper body holding the Service Recipient's arms. In response to Staff [redacted] request, the Subject held the Service Recipient's legs with her arms. Staff [redacted] determined that the restraint was not proper and told Staff [redacted] to get off the Service Recipient. Staff

[redacted] got off the Service Recipient after Staff [redacted] repeated his directive a second time. (See testimony of [redacted]; and testimony of the Subject).

13. After Staff [redacted] and the Subject got off the Service Recipient, the Service Recipient got up from the floor and became physically aggressive with the Subject and the other two staff. The Subject and Staff [redacted] then escorted the Service Recipient to his room. Shortly thereafter the Service Recipient came out of his room and started hitting Staff [redacted]. Staff [redacted] then attempted unsuccessfully to put the Service Recipient in a one person standing wrap and, as a result, Staff [redacted] fell on top of the Service Recipient into a chair in the Service Recipient's room. Staff [redacted] got up, followed by the Service Recipient who then attempted to leave the room and continued to flail his arms at the Subject and other staff. The Subject along with Staff [redacted] attempted to keep the Service Recipient from leaving his room by pushing him back a couple of times with her hands on his neck. The Service Recipient pushed back against the Subject causing her to fall back against the hallway wall and sprain her ankle. Staff [redacted] then went downstairs and returned with a full gallon container of soap which he gave to the Service Recipient. The Service Recipient then threw the soap at the Subject and the other two staff and went in the shower, ending the incident. (See testimony of [redacted]; and testimony of the Subject)

14. As a result of the [redacted] incident, the Service Recipient received red marks, scrapes and bruises on various parts of his body. (Justice Center Exhibits 14 to 21; and testimony of [redacted])

15. The State of New York Office of Mental Retardation and Developmental Disabilities Guidelines for Strategies for Crisis Intervention and Prevention – Revised (SCIP-R) is the accepted restraint practice utilized by the Facility. (Justice Center Exhibit 8) The Subject

completed SCIP-R training on May 24, 2013. (Justice Center Exhibit 7)

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.
- Pursuant to Social Services Law § 493(4), the category of abuse 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 evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3(f))

Pursuant to SSL §§ 494(1)(a)(b) and (2), and Title 14 NYCRR § 700.6(b), this hearing decision will determine: 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, and if there is a finding of a preponderance of the evidence; whether the substantiated allegations constitute abuse and/or neglect; and pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488:

> 1 "Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:

(a) "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.

(b) "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.

(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.

(d) "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit

the ability of a person receiving services to freely move his or her arms, legs or body.

(e) "Use of aversive conditioning," which shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the absence of a person-specific authorization by the operating, licensing or certifying state agency pursuant to governing state agency regulations. Aversive conditioning may include but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.

(f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.

(g) "Unlawful use or administration of a controlled substance," which shall mean any administration by a custodian to a service recipient of: a controlled substance as defined by article thirty-three of the public health law, without a prescription; or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article thirty-three of the public health law, at the workplace or while on duty.

(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.

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).

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493:

4. Substantiated reports of abuse or neglect shall be categorized into one or more of the following four categories, as applicable:

   (a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:

   > (i) intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur;
   >
   > (ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, 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 is likely to result in either;

(iii) threats, taunts or ridicule that is likely to result in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

(iv) engaging in or encouraging others to engage in cruel or degrading treatment, which may include a pattern of cruel and degrading physical contact, of a service recipient, that results in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

(v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;

(vi) any conduct that is inconsistent with a service recipient's individual treatment plan or applicable federal or state laws, regulations or policies, that encourages, facilitates or permits another to engage in any conduct in violation of article one hundred thirty of the penal law, with a service recipient;

(vii) any conduct encouraging or permitting another to promote a sexual performance, as defined in subdivision one of section 263.00 of the penal law, by a service recipient, or permitting or using a service recipient in any prostitution-related offense;

(viii) using or distributing a schedule I controlled substance, as defined by article thirty-three of the public health law, at the work place or while on duty;

(ix) unlawfully administering a controlled substance, as defined by article thirty-three of the public health law to a service recipient;

(x) intentionally falsifying records related to the safety, treatment or supervision of a service recipient, including but not limited to medical records, fire safety inspections and drills and supervision checks when the false statement contained therein is made with the intent to mislead a person investigating a reportable incident and it is reasonably foreseeable that such false statement may endanger the health, safety or welfare of a service recipient;

(xi) knowingly and willfully failing to report, as required by paragraph (a) of subdivision one of section four hundred ninety-one of this article, any of the conduct in subparagraphs (i) through (ix) of this paragraph upon discovery;

(xii) for supervisors, failing to act upon a report of conduct in subparagraphs (i) through (x) of this paragraph as directed by regulation, procedure or policy;

(xiii) intentionally making a materially false statement during an investigation into a report of conduct described in subparagraphs (i) through (x) of this paragraph with the intent to obstruct such investigation; and

(xiv) intimidating a mandated reporter with the intention of preventing him or her from reporting conduct described in subparagraphs (i) through (x) of this paragraph or retaliating against any custodian making such a report in good faith.

(b) 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.

(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.

(d) Category four shall be conditions at a facility or provider agency that expose service recipients to harm or risk of harm where staff culpability is mitigated by systemic problems such as inadequate management, staffing, training or supervision. Category four also shall include instances in which it has been substantiated that a service recipient has been abused or neglected, but the perpetrator of such abuse or neglect cannot be identified.

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 evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has established by a preponderance of evidence that the Subject committed a prohibited act, described in the substantiated report. The act committed by the Subject constitutes abuse. The category of the affirmed substantiated abuse that such act constitutes is Category 3.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation (See Justice Center Exhibits 1-23). The investigation underlying the substantiated report was conducted by [redacted] investigator [redacted], who testified on behalf of the Justice Center. The Justice Center also presented Staff [redacted] as a witness in their case.

The Subject testified on her own behalf and presented no other witnesses. The Subject presented one exhibit. (See Subject Exhibit 1)

The Justice Center proved by a preponderance of the evidence that the Subject committed abuse by deliberately executing an inappropriate restraint on the Service Recipient.

There is no substantial disagreement concerning the facts surrounding the use of the restraint on the Service Recipient. The Justice Center contends that the Subject and Staff [redacted] deliberately restrained the Service Recipient in a prone position, a method of restraint that is not authorized by the SCIP-R guidelines. (Justice Center Exhibit 8 pages 116 and 117). The Subject agrees that the restraint she used together with Staff [redacted] was not authorized by

the SCIP-R guidelines. However, the Subject contends that the restraint was necessary as a reasonable emergency intervention to prevent imminent risk of harm to the Service Recipient and Staff, and therefore her participation in the use of the restraint falls under an exception allowed by law. [See Social Service Law § 488(1)(d).]

It is clear from the SCIP-R guidelines that Staff is not authorized to restrain a resident on the floor in a prone position or to place any pressure on the child's back. It is also clear from the guidelines that if the resident rolls to his or her stomach during a restraint in which the resident is on the floor, Staff is to release and roll away from the child (Justice Center Exhibit 8 pages 116 and 117).

The Subject was trained in the SCIP-R guidelines less than two months before the incident and therefore knew or should have known that restraining the Service Recipient in a prone position on the floor was not authorized by the guidelines. However, instead of instructing Staff [redacted] to release the Service Recipient, the Subject affirmatively and actively participated in the restraint by holding the Service Recipient's legs while Staff [redacted] was positioned on the Service Recipient's back.

The Subject testified that she became involved in the restraint at the request of Staff [redacted] who was already on the Service Recipient's back while the Service Recipient was on the floor in a prone position, and that her involvement was necessary to prevent the Service Recipient, herself and other staff from being physically harmed.

However, the Subject's evidence does not establish that, at the time she became involved in the restraint, the Service Recipient's actions were an imminent threat to his safety or the safety of anyone else, especially in light of the fact that Staff [redacted] was on top of the Service Recipient.

Furthermore, the record reflects that Staff [redacted] recognized that Staff [redacted] restraint of the Service Recipient was not as prescribed, and [redacted] directed Staff [redacted] to release the Service Recipient. The record reflects that the Subject knew the restraint was unauthorized. However, the Subject chose to participate in the restraint; therefore the Subject's behavior was clearly deliberate.

Consequently, the Justice Center proved, by a preponderance of the evidence that the Subject deliberately executed an inappropriate restraint of the Service Recipient. The evidence in the record does not support the Subject's claim that the non-prescribed restraint was a necessary emergency intervention

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 abuse 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. It is concluded that this report is properly categorized as Category 3 abuse.

A substantiated Category 3 finding of abuse or neglect will not result in the Subject 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.

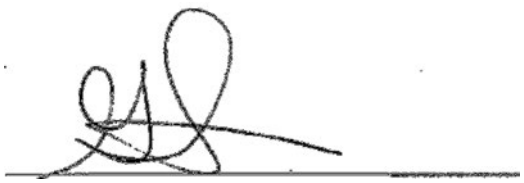
DECISION: The request of [redacted] that the substantiated report dated [redacted], [redacted]; received and dated dated [redacted]

[redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse.

The substantiated report is properly categorized, or should be categorized as a Category 3.

This decision is recommended by Gerard Serlin, Administrative Hearings Unit.

DATED: May 12, 2015
Schenectady, New York



Gerard Serlin, ALJ