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]

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]

By: Clair A. Montroy, III, Esq.
4213 N. Buffalo Road, Suite 3, Rear
P.O. Box 816
Orchard Park, New York 14217

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 abuse (deliberate inappropriate use of restraints) and neglect.

The substantiated report with respect to abuse (deliberate inappropriate use of restraints) is properly categorized as a Category 2 act and with respect to neglect is properly categorized as a Category 3 act.

NOW, THEREFORE, IT IS DETERMINED that the record of this report for neglect shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(c).

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 this report for abuse (deliberate inappropriate use of restraints) 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: June 28, 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: Mary Jo Lattimore-Young
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People With Special Needs
Administrative Hearings Unit
[redacted]
On: [redacted]

Parties: 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]
By: Clair A. Montroy, III, Esq.
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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for abuse and neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a "substantiated" report dated [redacted], [redacted] of abuse and neglect by the Subject of a Service Recipient.

2. The Justice Center substantiated the report against the Subject. The Justice Center concluded that:

Allegation 1

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed abuse (deliberate inappropriate use of restraints) when you conducted a restraint with excessive force and improper technique, which included holding a service recipient down in an unauthorized prone position, causing bruising and a wound on her knee.

This allegation has been SUBSTANTIATED as Category 2 abuse (deliberate inappropriate use of restraints) pursuant to Social Service Law § 493(4)(b).

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 ensure that a service recipient received medical attention or a body check post-restraint.

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 Individualized Residential Alternative (IRA) for developmentally disabled persons and is operated by the New York State Office for Persons With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged abuse and neglect, the Subject was employed by the [redacted].[1] The Subject worked for the agency since [redacted] 2012 and was assigned as the IRA Manager on [redacted]. On [redacted], the Subject and Direct Support Aide (DSA) 1 were working at the facility. The Subject was trained in Strategies for Crisis Intervention and Prevention Revised (SCIP-R), having received her last training on [redacted]. The Subject was a custodian as that term is so defined in Social Services Law § 488(2). (Hearing testimony of the Subject and Justice Center Exhibit 24)

6. At the time of the alleged abuse and neglect, the Service Recipient was an ambulatory, verbal thirty-three year old female (although at times difficult to understand), who wore braces on both legs. She attended the prevoc program and day habilitation service through the agency. The Service Recipient had diagnoses of moderate intellectual disability, cerebral palsy, epilepsy (seizure disorder), Grand mal seizures, anxiety, impulse control disorder, and other medical conditions. She was approximately five feet three inches tall and weighed about one hundred and sixty-five pounds. (Hearing testimonies of Justice Center Investigator [redacted]

[1] The [redacted] provides local staffing for state operations.

(hereinafter referred to as the Justice Center Investigator), [redacted], [redacted] Director of Compliance and Quality Improvement (hereinafter referred to as Director of QI) and the Subject; Justice Center Exhibits 7, 13-14 and 16)

7. The Service Recipient's Behavior Support Plan (BSP) indicated that, the Service Recipient's targeted behaviors were screaming loudly, throwing objects and physical aggression. The Service Recipient's BSP indicated that, because she was prescribed medication to address her anxiety symptoms and seizure disorder, there was a history of using less restrictive interventions to manage her behaviors and it specifically described a variety of de-escalation strategies available for staff to use to address her behaviors. The Service Recipient's BSP did not sanction the use of any SCIP-R core techniques to address the Service Recipient's behaviors. (Hearing testimonies of the Justice Center Investigator and Director of QI; Justice Center Exhibits 7 and 13)

8. The Service Recipient's Individual Plan of Protective Oversight (IPOP) indicated that in response to the Service Recipient engaging in targeted behaviors, staff was mandated to use non-verbal and verbal calming techniques. (Hearing testimonies of the Justice Center Investigator and Director of QI; Justice Center Exhibits 7 and 16)

9. The only SCIP-R related interventions allowed under the Service Recipient's BSP and IPOP were a "bite release" and a "deflect" maneuver. (Hearing testimony of Director of QI and Subject's Exhibit A; Justice Center Exhibits 13-14 and 16)

10. According to facility policy, after a behavioral/restraint incident, staff was required to notify the nurse, check the service recipient for injuries, report any injuries using the Body Check form and complete a General Event Report form (GER). (Hearing testimonies of Director of QI and the Justice Center Investigator; Justice Center Exhibits 7, 21 and 30-32)

11. During the afternoon of [redacted], the Service Recipient was lying down

on a couch in the living room at the IRA. She was wearing her leg braces. The Subject approached the Service Recipient and asked her to take a shower. The Service Recipient did not comply, quickly became upset, stood up and began swinging her arms and engaging in screaming, biting, throwing objects and grabbing at the Subject and DSA 1. (Hearing testimonies of the Justice Center Investigator and the Subject; Justice Center Exhibits 7 and 33, an audio CD of the Service Recipient's interview and interrogation of the Subject and DSA 1)

12. At some point during the behavioral episode, the Subject and DSA 1 attempted to conduct a SCIP-R two-person escort of the Service Recipient back to the couch. The Subject approached the Service Recipient from behind on her right back side and grabbed her right forearm. DSA 1 approached the Service Recipient's left side and grabbed her left forearm. Then, while holding both of the Service Recipient's forearms, the Subject and DSA 1 attempted to escort her to the couch. However, the Service Recipient was thrashing about and biting, then drew up her legs while still being held by them. The Subject and DSA 1 then lowered the Service Recipient to the floor on her knees while they continued to hold her as she struggled. The Service Recipient then dropped her torso, assuming a prone position with the right side of her face on the floor, while staff continued their hold of her. As the Subject continued her hold of the Service Recipient, she held down the back of the Service Recipient's neck with her right hand and DSA 1 held down the Service Recipient's arms. At some point thereafter, the Subject and DSA 1 released the Service Recipient who began crawling on the floor and trying to reach nearby objects. Eventually, the Service Recipient arose from the floor then sat down on the couch and calmed down. (Hearing testimonies of the Justice Center Investigator and the Subject; Justice Center Exhibits 7 and 33, an audio CD of the Service Recipient's interview, the Subject's and DSA 1's interrogations and interview of the service recipients)

13. Following the incident, the Subject and DSA 1 did not perform a body check of the Service Recipient for injuries, nor did they contact the nurse to conduct a body check/medical assessment. Also, neither the Subject nor DSA 1 documented the incident by completing a GER form. (Hearing testimonies of the Subject and the Justice Center Investigator; Justice Center Exhibits 7 and 30-32)

14. The next day, the Subject verbally reported the incident to her supervisor and her supervisor's superior. The Subject also showered the Service Recipient, who complained of pain in her knee, but the Subject did not observe any bruising at that time. (Hearing testimony of the Subject)

15. Over the [redacted], the Service Recipient visited her home at which time her mother reportedly noticed some black and blue marks on her arms, legs and a big chunk/wound on her right knee, which bled and was extremely sore. The Service Recipient's mother took photographs of these injuries. (Hearing testimony of the Justice Center Investigator; Justice Center Exhibits 7, 18 and 34)

16. From the first week of [redacted] through [redacted], medicine administration staff conducted regular body checks of the Service Recipient's legs, torso and arms in order to apply a topical crème prescribed by her medical provider to treat her bed bug bites. (Hearing testimonies of the Subject and the Residential Trainer[2]; Justice Center Exhibits 7)

17. On [redacted], the Service Recipient had another behavioral episode while on a van where she was screaming, grabbing at another service recipient and staff, hitting and

[2] [redacted] (hereinafter referred to as the Residential Trainer) was the medication administration certified Residential Trainer who testified at the hearing that during the aforementioned time frame that she conducted body checks of the Service Recipient once or twice per week and applied medicine to her bed bug bites. She also testified that during her body checks of the Service Recipient that she did not observe any bruising. However, there was no documentary evidence provided to corroborate what she actually observed during her body checks or which days she conducted the body checks on the Service Recipient during the relevant time frame.

biting staff and crawling on the van floor. DSA 1 grabbed the Service Recipient's forearm during the episode and at some point she fell in between the door and the seats. Staff reported the incident to the nurse, who indicated that she would complete a body check/assessment of the Service Recipient. (Justice Center Exhibits 7 and 33, audio CD of DSA 1's interrogation and interviews of service recipients and other staff)

18. During the Service Recipient's next home visit on [redacted], the Service Recipient's mother reportedly observed fresh bruises and the Service Recipient informed her these injuries were from the recent behavioral incident on the van. (Hearing testimony of Director of QI and Justice Center Exhibit 18)

19. On or about the morning of [redacted], the facility nurse conducted a body check of the Service Recipient.. In her assessment, the nurse listed the following as old injuries ("previously reported"): four small bruises (the "size of fingertips" or finger prints), two small bruises on the left forearm and several bruises across the back of her left upper arm. The new injuries observed on the Service Recipient by the nurse was as follows: two small bruises and a scab above the right knee. (Justice Center Exhibit 15)

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute abuse and/or neglect.
- Pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. (SSL § 492(3)(c) and 493(1) and (3)) Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse and 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 abuse (deliberate inappropriate use of restraints) and/or neglect of a person in a facility or provider agency is defined by SSL§ 488(1)(d) and by SSL§ 488(1)(h) as:

> "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.
>
> "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 2 and Category 3, which are defined under SSL § 493(4)(b) and (c) 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.
>
> 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 abuse and 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 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 "Allegation 1" and "Allegation 2" 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 1-33, an audio CD of interviews and interrogations and Justice Center Exhibit 34, photographs of the Service Recipient's injuries) The investigation underlying the substantiated report was conducted by the Justice Center Investigator, who testified at the hearing on behalf of the Justice Center. [redacted], [redacted] Director of Compliance and Quality Improvement (QI) Coordinator (hereinafter referred to as QI Director) also testified on behalf of the Justice Center.

The Subject testified in her own behalf and provided Subject's Exhibit A, which was received into evidence. The Residential Trainer also testified at the hearing on the Subject's behalf.

Allegation 1- Abuse (deliberate inappropriate use of restraints)

The Justice Center contends that the Subject committed abuse (deliberate inappropriate use of restraints) when she conducted a restraint with excessive force and improper technique, that included holding the Service Recipient down in an unauthorized prone position and causing bruising and a wound on her knee.

In order to prove abuse (deliberate inappropriate use of restraints) the Justice Center must establish that the Subject used a restraint in which the technique used, the amount of force used or the situation in which the restraint was used, was deliberately inconsistent with the Service Recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies. The statutory definition of "restraint" includes any manual measure used to immobilize or limit the ability of a service recipient to freely move his or her arms, legs or body. The statute allows, as an exception, the use of an unauthorized restraint as a reasonable emergency intervention in order to prevent imminent risk of harm to the Service Recipient or to any other person. (SSL §488(1)(d))

In analyzing the evidence, the credible facts in the record establish that the Subject and DSA 1 engaged in a "restraint" as defined under SSL §488(1)(d). During the course of the incident, the Subject and DSA 1 held the struggling Service Recipient's arms while she was standing. The Service Recipient then drew up her legs and staff continued to hold her to lower her to the floor. While staff continued to maintain their hold of the struggling Service Recipient, the Service Recipient dropped her torso, where she was face down on the floor and the Subject held the back of her neck while DSA 1 held her arms as the Service Recipient continued to struggle.

In her defense, the Subject denied that she used excessive force to restrain the Service Recipient. The Subject argued that the Service Recipient had told someone that she had it in for the Subject and was going to get her fired because a relative was on the agency's board. The Subject also argued that there was no proof that the Service Recipient was injured on [redacted] as no injuries had been documented at that time. Furthermore, the Subject argued that the noted injuries on the Service Recipient's Body Check form were caused exclusively by the [redacted] incident in the van and the Subject was not with her at that time. Yet, the Service Recipient's mother observed the extent of Service Recipient's injuries after each of the two behavioral incidents and she reported that around [redacted], she observed bruising on the Service Recipient's arms and legs and a "big chunk/wound on her right knee." In comparing the Service Recipient's mother's [redacted] observations with the nurse's body check assessment following the Service Recipient's [redacted] behavioral incident and past reported injuries, the mother's observations are consistent with the Service Recipient's account of the incident. (Justice Center Exhibits 7, 13 and 15)

Given this, together with all of the other evidence in the record, the Subject's defenses and assertions lack merit and were not sufficiently supported by the credible evidence contained in the

record. Having had the opportunity to observe the Subject and to weigh her credibility, it is found that the Subject's testimony was unpersuasive.

While the Subject and DSA 1 may have intended to use a SCIP-R Core Technique, known as a two-person seated escort, they improperly executed the technique and, in any event, the technique was not authorized by the Service Recipient's BSP or IPOP.

Therefore, it is determined that the Subject engaged in an unauthorized physical restraint involving excessive force that was deliberately inconsistent with the Service Recipient's plans.

Furthermore, the unauthorized restraint used by the Subject did not fall within the SSL §488(1)(d) reasonable emergency exception as there was no credible imminent risk of harm posed by the Service Recipient's conduct. The Service Recipient was engaged in her usual targeted behaviors, which staff should and could have addressed through the strategies set out in her BSP and IPOP.

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 (deliberate inappropriate use of restraints) 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 as set forth in the substantiated report.

In this case, the Subject engaged in physical contact with the Service Recipient during a behavioral episode by using an unauthorized restraint on the Service Recipient, exposing her to serious harm, given her medical conditions and frailties. The physical restraint and the amount of force used was unnecessary, excessive and caused bruising to the Service Recipient's arms and legs as well as a knee wound. It is clear that the Subject's conduct seriously endangered the health, safety and welfare of the Service Recipient. 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 2 act.

Substantiated Category 2 findings will be disclosed to OPWDD providers during pre-employment inquiries with the Justice Center. Category 2 conduct shall be elevated to Category 1 conduct when such conduct occurs within three years of a previous finding that Subject engaged in Category 2 conduct. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

Allegation 2 - Neglect

The Justice Center further contends that the Subject committed neglect when she failed to ensure that a service recipient received medical attention or a body check post-restraint.

In order to prove neglect, the Justice Center must establish that the Subject breached a custodian's duty that 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))

The record establishes that facility policy stated that, after a behavioral/restraint incident, staff were required to notify the nurse, check the service recipient for injuries and report the injuries on an injury Body Check form and complete a General Event Report form (GER). The Subject should have been aware this facility policy and did not take any steps to ensure that the Service Recipient was assessed for injury and provided treatment if necessary.

Consequently, it is found that the Subject breached her duty to the Service Recipient. (Hearing testimony of Justice Center Investigator, Director of QI and Justice Center Exhibits 7, 21,30-32)

Furthermore, the Subject's breach of duty was likely to result in physical injury or serious

or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Here, the Service Recipient's injuries from the incident went improperly tracked and documented. Additionally, her injuries from the incident were untreated from [redacted] until [redacted], at which time her mother discovered them. The wound was described as a "chunk" missing from the Service Recipient's right knee that "bled" and was "extremely sore," and if left untreated and unreported, could have become infected. (Justice Center Exhibits 7, 13 and 34)

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 a Category 3 act.

Substantiated Category 3 findings of abuse and/or 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.

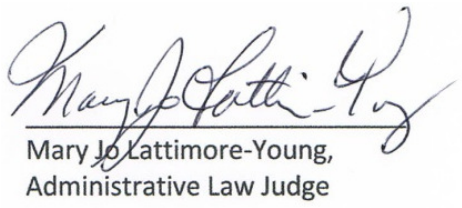
DECISION: The request of [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is denied.

The Subject has been shown by a preponderance of the evidence to have committed abuse (deliberate inappropriate use of restraints) and neglect.

The substantiated report with respect to abuse (deliberate inappropriate use of restraints) is properly categorized as a Category 2 act and with respect to neglect is properly categorized as a Category 3 act.

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

DATED: June 21, 2017
West Seneca, New York



Mary Jo Lattimore-Young,
Administrative Law Judge