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: William G. James, Esq.
1283 Middle Road
PO Box 565
Willsboro, New York 12996

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 granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

NOW, THEREFORE, IT IS DETERMINED that the record of this report shall be amended and sealed by the Vulnerable Persons' Central Register, pursuant to SSL § 493(3)(d).

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 17, 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: Louis P. Renzi
Administrative Law Judge

Held at: [redacted]
On: [redacted]

Parties: Vulnerable Persons' Central Register
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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], in the commons area of [redacted], located at [redacted], while acting as a custodian, you committed neglect when you she did not ensure that cake provided to a service recipient was served as required by his dietary guidelines, as a result of which the service recipient choked and required use of the Heimlich maneuver.
>
> 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, the [redacted] located in [redacted], is a secure facility for developmentally disabled adults and is operated by the NYS Office for People With Developmental Disabilities (OPWDD), which is a facility or

provider agency that is subject to the jurisdiction of the Justice Center. (Justice Center Exhibits 6, 8)

5. At the time of the alleged neglect, the Subject had been employed by OPWDD for approximately twenty years. The Subject is a Registered Dietician and worked as a Nutrition Services Administrator 1. (Hearing testimony of the Subject)

6. On [redacted], the date of the alleged neglect, the Service Recipient was 32 years of age, and had been a resident of the facility since [redacted] 2010. The Service Recipient is a developmentally disabled adult male diagnosed with a number of mental health disorders. The Service Recipient had difficulty swallowing food with a propensity for choking. Extensive medical testing ultimately revealed that the Service Recipient has no physiological abnormality which would interfere with his ability to swallow food. The evidence showed that the Service Recipient had difficulty swallowing and had choked on occasion because he becomes distracted, attempts to eat too much at once, eats too quickly and attempts to talk while eating. (Hearing testimony of OPWDD Investigator [redacted]; Hearing testimony of the Subject; Hearing testimony of OPWDD Physician Assistant [redacted]; Justice Center Exhibits 6, 9, 13, 14)

7. The Service Recipient's "Dining Guidelines" in effect at the time were dated [redacted], and called for his food to be cut into one-inch, bite-sized pieces. Dining Guidelines are written placards containing instructions for staff that are assisting service recipients with meals and snacks, and are written by the Subject and others in her department to be consistent with the dietary orders of facility medical staff. (Hearing testimony of OPWDD Investigator [redacted]; Hearing testimony of the Subject; Hearing testimony of OPWDD Physician Assistant [redacted]; Justice Center Exhibits 6, 9, 13, 14)

8. On [redacted], the facility hosted a congratulatory party for a service recipient who had successfully completed a program. The party took place in a common area ("the commons") of the facility, and was attended by approximately eighty-five (85) people, comprised of approximately forty-five (45) service recipients and forty (40) direct care staff, managers and administrators of the facility. The Subject and the Service Recipient were present. The direct care staff assigned to the Service Recipient's residence unit ("house") were present. The Service Recipient's house was comprised of approximately nine (9) service recipients and six (6) staff. Each house baked one or more cakes and delivered them to the commons at the beginning of the celebration. (Hearing testimony of the Subject; Hearing testimony of OPWDD Physician Assistant [redacted])

9. As a Nutrition Services Administrator I, the Subject's duty as it relates to this matter was to ensure that the Service Recipient's written Dining Guidelines were in place, consistent with the orders of the facility physician, and that direct care staff had been made aware of the guidelines and were properly trained. The Subject performed those tasks prior to the time of the incident. The Subject was not assigned to supervise the Service Recipient or any of the staff present at the time of the issue. (Hearing testimony of the Subject; Hearing testimony of OPWDD [redacted] Active Treatment Coordinator (ATC) [redacted])

10. At the time of the relevant events, the Subject was one of four staff involved in cutting, plating and serving the several cakes. The Subject was cutting cake with a kitchen knife at the time of the incident. The Service Recipient obtained and ate a portion of a slice of cake that had not first been cut into 1" pieces as required by his Dining Guidelines. It was not determined how he obtained the cake. (Hearing testimony of OWDD Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibit 6, 10, 13, 14, 15) However, the Subject did not

serve the piece of cake to the Service Recipient. (Hearing testimony of the Subject; Justice Center Exhibits 6, 10, 13, 14, 15, 16, 17, 18)

11. While cutting cake, the Subject observed the Service Recipient across the room in distress, apparently choking. The Subject called for help, secured the knife, and went to assist the Service Recipient. A medical emergency was called. Another staff member performed the Heimlich maneuver. The Service Recipient spit out a small portion of cake and resumed breathing, although he was shaken up. OPWDD Facility Physician [redacted], M.D. attended to the Service Recipient and within twenty minutes, the Service Recipient was resting quietly and speaking with [redacted].

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):

> (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.

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 2, which is defined as follows:

> (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.

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 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 not 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, along with an audio recording of the interrogation of the Subject. (Justice Center Exhibits 1-18) The investigation underlying the substantiated report was initially conducted by OPWDD Treatment Team Leader [redacted], and then assigned to the OPWDD Internal Affairs Unit based in [redacted]. OPWDD Investigator [redacted] and Lead Investigator [redacted] concluded the investigation. Investigator [redacted] testified for the Justice Center. No other witnesses were called by the Justice Center.

The Subject testified in her own behalf and called OPWDD Physician Assistant (PA) [redacted] and OPWDD [redacted] Active Treatment Coordinator (ATC) [redacted] as witnesses. The Subject provided no other evidence.

In order to prove neglect, the Justice Center must prove that the Subject was a custodian at the time of the incident, that she owed a duty, that she breached that duty, and that such breach 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.

It is uncontroverted that the Subject was a custodian and was present at the time of the incident on [redacted], that the Service Recipient did obtain a piece of cake during the large celebratory gathering described herein, and that the cake was a 'whole' piece or slice that had not been cut into one-inch bite-sized pieces as required by his Dining Guidelines dated [redacted].

It is also uncontroverted that the Service Recipient had a choking incident as a result, which caused him to become anxious and upset. (Justice Center Exhibits 6, 9, 13)

The issues which remain to be decided are: 1) whether the Subject owed a duty to this Service Recipient, and 2) whether that duty was breached, and, if both questions are answered in the affirmative, then 3) whether the Subject's conduct resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. If those elements are satisfied, thereby proving neglect, then finally it must be determined whether the conduct of the Subject seriously endangered the health, safety or welfare of the service recipient, such that the substantiation of neglect at category level 2 should be affirmed.

Here, the Justice Center did not prove by a preponderance of the evidence that the Subject committed the act alleged in "Allegation 1".

Issue #1

As a member of the administrative staff of the facility, the Subject clearly owed a general duty of care to all service recipients in the facility. That duty involved making determinations as to dietary matters including food consistency pursuant to orders by the facility physician. The Subject acknowledged responsibility for properly converting the physician's orders into written Dining Guidelines for each service recipient, preparing the dining cards containing that information for use by direct care staff during meals, and properly training direct care staff as to the requirements of food preparation consistent with those guidelines. It is uncontroverted that with respect to the incident here, the Subject properly performed those tasks. (Hearing testimony of OPWDD Physician Assistant (PA) [redacted]; Hearing testimony of OPWDD Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibit 9)

The Justice Center argued that the Subject's failure of duty was in serving the cake to the Service Recipient in violation of his Dining Guidelines which were known to her. (Hearing testimony of OPWDD Investigator [redacted]; Justice Center Exhibit 6)

At the time of the incident, the Subject was not assigned to perform direct care of the Service Recipient, nor was she the supervisor of those staff members who were so assigned.[1] (Hearing testimony of OPWDD ATC [redacted]; Hearing testimony of the Subject) Based upon the facts and circumstances in this record, which includes the fact that the Service Recipient's assigned direct care staff were present for the obvious purpose of supervising him, coupled with the fact that the Subject was not assigned to supervise direct care staff, it cannot be concluded that the Subject owed a particular duty to the Service Recipient on this occasion. (Hearing testimony of the Subject; Hearing testimony of OPWDD Physician Assistant [redacted]; Hearing testimony of OPWDD [redacted] ATC [redacted])

Thus, it is concluded that the Subject did not owe a particular duty to the Service Recipient at the time of the incident.

Issue #2

Even if one concludes that a particular duty was actually owed to the Service Recipient by the Subject, the preponderance of the evidence does not prove that the Subject is guilty of breaching that duty, unless it is also proven that the Subject actually served the cake to the Service Recipient, despite his Dining Guideline restriction.

The Justice Center took the position that the Subject served the piece of the improperly prepared cake to the Service Recipient, and offered two items of evidence in support of that position: 1) the statement by the Service Recipient that the Subject gave him the cake, and 2) the

[1] The direct care staff members are unidentified in this record.

verbal statement by the Subject that she likely may have done so. (Justice Center Exhibit 6 at paragraph 5, and Exhibit 18) Statements were collected from non-party witnesses to the incident during the investigation; none of the witnesses saw the Subject hand the cake to the Service Recipient, nor had any recollection of how he came into possession of the cake. (Hearing testimony of OPWDD Investigator [redacted]; Hearing testimony of OPWDD Physician Assistant [redacted]; Justice Center Exhibits 14, 15, 16)

On [redacted], the Service Recipient stated to Investigator [redacted] that the Subject handed him the piece of cake. (Justice Center Exhibit 6 at paragraph 4) The Service Recipient's written statement dated [redacted] states the opposite, that he did not recall who served him the cake. (Justice Center Exhibit 12) OPWDD Investigator [redacted] acknowledged during his testimony that the Service Recipient had a known inability to correctly recall facts, and here had given two statements which were entirely inconsistent. OPWDD Physician Assistant [redacted] also testified on the topic; she explained that the Service Recipient's infirmities make it very difficult for him to recall facts, and his antisocial traits create in him a tendency to tell falsehoods. PA [redacted] testified further that the Service Recipient has a documented history as an unreliable and untruthful reporter. Based upon the sworn hearing testimony of these witnesses, both statements by the Service Recipient are deemed unreliable and should be disregarded.

In determining the veracity or accuracy of a witness' statement, it is necessary to consider the time at which the statement was made, its relation to other consistent or inconsistent statements, the context in which it was made, and the self-interest, or lack thereof, of the speaker. The Subject's written notes (Justice Center Exhibit 10) made immediately following the incident describe the Subject seeing the Service Recipient in distress and her conduct in response. She made no admission or suggestion that she had served the cake to the Service Recipient. During an

interview on the following day, [redacted], the Subject repeated the same version of events, again making no admission against her own interests. (Justice Center Exhibit 6 at paragraphs 7 and 9)

During an interview on [redacted], the Subject was told of the statement by the Service Recipient wherein he stated that that the Subject had served the cake to him, and replied that "If he said so, I must have done it." (Justice Center Exhibit 6 at paragraph 2) Investigator [redacted] notes of the interview interpret this as the Subject saying "[I] may likely have served him the cake." (Justice Center Exhibit 18) During her formal interrogation on [redacted], the Subject stated that she had no recollection whatsoever of who served the cake to the Service Recipient, that she did not recall doing it, and that her first sighting of the Service Recipient having cake was when she observed him in distress. The Subject described the scene as "a free for all, with a herd of people just grabbing cake." (Hearing testimony of the Subject; Justice Center Exhibit 6 at paragraph 11, and Exhibit 17)

The Subject's [redacted] statement to Investigator [redacted], to which the Justice Center points as an admission of guilt, was made almost six weeks after the incident, and followed two other statements made by her which clearly indicate she was otherwise occupied at the time the Service Recipient obtained his piece of cake. The Subject's statement must also be looked at in context: she testified credibly that by the time she made the statement to Investigator [redacted] on [redacted], she had been under investigation for several weeks, had already reported what she knew of the incident to the facility administration and investigators, was frustrated, was upset that she was being interviewed by a peer who she believed was not objective, and made the comment intending to be sarcastic or disingenuous, implicitly referring to the Service Recipient's well-known tendency to be inaccurate in his recitations of fact.

However ill-advised her comment may have been, it is concluded on the basis of this record that the Subject did not intend her remark to be taken literally. Moreover, at the time of the incident, the Subject was cutting cakes with a large knife and, because of that, was unlikely to have been handing out plates to service recipients at the same time, if for no other reason than the presence of the knife itself and proximity to service recipients. The serving was being handled by three other staff members who acknowledged working with her and who had stated they did not see the Subject hand cake to the Service Recipient. (Justice Center Exhibit 6 at paragraphs 14, 15 and 16; Justice Center Exhibit 16) The Subject testified that when she looked up and observed the Service Recipient across the room in distress, she had to take extra time to properly secure the knife as required before she could step away from her work station to his aid. In addition, the credible evidence indicates that the celebration was so disorganized that the Service Recipient could easily have helped himself to the cake without any assistance or awareness by the Subject or anyone else. Further, the Service Recipient's direct care staff – approximately six of them – were present at the function, and it was clearly they, and not the Subject, who had the specific duty to ensure that the appropriate Dining Guidelines were followed by the Service Recipient.

The Subject's sworn testimony was self-interested by definition. Nevertheless, assessing credibility is directly within the purview of the administrative law judge. There is no testimony or statement in the record by any witness to the incident which contradicts the Subject's testimony. The Subject's testimony is determined to be credited evidence.

Therefore, it is concluded that the Subject did not serve the cake to the Service Recipient and, even if a duty was owed, the Subject did not breach the duty and this question, too, is answered in the negative. Since the two threshold elements of neglect which are in issue here have not been proven by a preponderance of the evidence, it is not necessary to discuss the third and final issue

which cannot stand alone and is now moot; i.e., whether the Subject's conduct 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.

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

DECISION: The request of [redacted] that the substantiated report dated. [redacted], [redacted] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

This decision is recommended by Louis P. Renzi, Administrative Hearings Unit.

DATED: April 13, 2017
Schenectady, New York

Louis P. Renzi, ALJ