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]

The attached Recommended Decision After Hearing (Recommended Decision) is incorporated in its entirety including but not limited to the Findings of Fact, Conclusions of Law and Decision section.

ORDERED: The attached and incorporated Recommended Decision in its entirety is hereby adopted by the Executive Director.

ORDERED: The Vulnerable Persons' Central Register shall take action in conformity with the attached Recommended Decision, specifically the Decision section.

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: July 31, 2017
Schenectady, New York

David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[redacted], Subject, Pro se

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: Eleanor Roosevelt State Office Building
4 Burnett Blvd., 2nd Fl.
Poughkeepsie, New York 12601
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: Kristin Kopach, Esq.

[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] 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 directed two staff members to use an unwarranted restraint to escort a service recipient out of the residence in order to get her to go to a doctor's appointment.
>
> 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 a day habilitation (dayhab) center for developmentally disabled adults, operated by [redacted], and is certified by the NYS Office for People With Developmental

Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of [redacted] Assistant Executive Director [redacted] (Assistant Director [redacted]); hearing testimony of the Subject)

5. At the time of the alleged neglect (the incident), the Subject had been employed by [redacted] for approximately 18 years. During the two years preceding the incident, the Subject was the Assistant Director of Day Programs at the [redacted]. (Hearing testimony of the Subject)

6. At the time of the incident, the Service Recipient was a female, approximately 30 years of age, and had attended the facility since [redacted] 2012. The Service Recipient lived in the nearby [redacted] Independent Residential Alternative (IRA) home which was also operated by [redacted] and was transported to the dayhab facility each day. The Service Recipient had diagnoses of affective schizophrenic disorder and mild intellectual disability. She had a history of verbal and physical aggression, was occasionally delusional, was ambulatory, verbally communicative and was entirely capable of making her needs and preferences known to staff. She was also aware of her rights as a service recipient, specifically, as relevant here, the right to refuse medical attention. (Hearing testimony of Assistant Director [redacted]; hearing testimony of the Subject; Justice Center Exhibits 6, 7, 28, 29)

7. At the time of the incident, the facility had adopted SCIP-R as the protocol for addressing service recipient behaviors and well-being, and had issued a guidance document dated [redacted] about the use of physical intervention in addressing service recipient behaviors. (Justice Center Exhibit 27) The Subject was trained in and familiar with the procedures and techniques taught by SCIP-R, including those with respect to physical interventions. The primary tenet of SCIP-R, as relevant here, is that a restrictive physical intervention (restraint) with a service

recipient is to be performed only as a very last resort after all other de-escalation techniques had been attempted and failed, and only then in a situation where a service recipient's behavior threatened imminent physical injury to self or others. In addition, the Behavior Support Plan for the Service Recipient authorizes the use of SCIP-R restraints, but only after a significant enumerated list of non-restrictive de-escalation techniques are attempted. (Hearing testimony of Assistant Director [redacted]; hearing testimony of the Subject; Justice Center Exhibit 28 at pp. 2, 3)

8. On [redacted], the two days prior to the incident, the Service Recipient presented with negative behaviors, but was not "in crisis". (Hearing testimony of Assistant Director [redacted]) The facility Director of Nursing (Staff [redacted]) determined that the Service Recipient would benefit significantly from a visit to her outside psychiatrist, Dr. [redacted], after the Service Recipient calmed down. Staff [redacted] contacted Dr. [redacted] office and made an appointment for [redacted] at 11:00 a.m. The time of the appointment was not firm; the psychiatrist agreed to see the Service Recipient at any time she appeared in his/her office. The Service Recipient was not consulted about this or advised of the appointment until shortly before she was to be transported from the dayhab facility to the doctor's office. (Hearing testimony of Assistant Director [redacted]; hearing testimony of [redacted] Psychologist-I [redacted] (Psychologist [redacted]); Justice Center Exhibits 6, 7)

9. On the date of the incident, the Service Recipient was calm and had arrived at the dayhab facility at her usual time. She was having a "good day". Staff [redacted] (from her residence IRA) was dispatched to the facility to transport the Service Recipient to the doctor's office. Staff [redacted] was aware that the Service Recipient might not want to go to the appointment. (Justice Center Exhibits 21) When the Service Recipient was informed by Staff [redacted] that she had an appointment that day with Dr. [redacted], she reacted negatively - she became upset and verbally refused to go. Staff

[redacted], Staff [redacted] and Psychologist [redacted] consulted with the Subject and a series of phone calls were made to administrators. The results of such calls were directives that the Service Recipient had to go to the appointment even if she didn't want to, and to "make it happen". The group proactively removed other service recipients from the immediate area to avoid risk to them by the possible reactions of the Service Recipient. (Hearing testimony of the Subject; hearing testimony of Psychologist [redacted])

10. The Subject and the other staff mentioned above believed that it was extremely necessary for the Service Recipient to go to her appointment, based upon instructions they had all received from their superiors.

11. The Service Recipient continued to escalate, spitting at staff and throwing objects. The Subject determined that the appointment was critical and that she had to follow instructions. She directed Staff [redacted] and Staff [redacted] to utilize an escort (a SCIP-R physical intervention technique) to force the Service Recipient to exit the facility and board the transport van. (Hearing testimony of the Subject; Justice Center Exhibits 6, 7, 21, 34)

12. The Service Recipient was forcibly removed from the facility by Staff [redacted] and Staff [redacted], using the escort. The Service Recipient was seen being dragged by her arms toward the exit. She eventually stood up and walked out of the facility with Staff [redacted] and Staff [redacted]. (Justice Center Exhibits 17, 18)

13. The Service Recipient later complained of pain in her wrist but refused medical treatment. She was given a psychological assessment by Psychologist [redacted], who determined that no mental or emotional harm had been sustained by the Service Recipient. (Hearing testimony of Psychologist [redacted]).

14. [redacted] then reported the incident to the Justice Center, stating that [redacted] believed

[redacted] had unwillingly participated in abuse of the Service Recipient. (Justice Center Exhibit 21)

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) "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 as follows:

> (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.

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(s) of neglect cited in the substantiated report constitute 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 the acts, 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 1-36) The investigation underlying the substantiated report was conducted by [redacted] Assistant Director of Quality Improvement [redacted], who prepared the investigative reports but did not testify because she had left her employment prior to the hearing. [redacted] Assistant Executive Director [redacted]

appeared in her stead and was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and called as an additional witness former [redacted] Psychologist [redacted]. The Subject provided no other evidence.

In order to prove neglect, the Justice Center must prove that the Subject was a custodian who owed a duty to the Service Recipient, and breached that duty by any action, inaction or lack of attention, and that the 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.

At the time of the incident, the Subject was a custodian as that term is defined by SSL 488(2). The Subject was employed by the facility as the Assistant Director, and had been in that title for approximately one and one-half to two years. She had been with the [redacted] for some 16 years prior to that, assigned to other facilities. The Subject was on duty at the facility at the time of the alleged neglect.

The Subject owed a duty of care to the Service Recipient which involved ensuring that the Service Recipient's behavior support plan was followed appropriately while the Service Recipient was at her day program and that the Service Recipient was not neglected or abused while under the Subject's supervision.

This incident, investigation and the record of the hearing, produced no controverted facts of relevance to the determination to be made here. At the time of the incident, the Service Recipient was initially presenting no substantial risk of harm to herself or anyone else at the time. By all accounts, she had been having a good day. She had presented with some difficult behaviors on the two days previous, but at the time in question she was calm and stable. (Justice Center

Exhibits 6, 7) Relying upon communications from her superiors, the Subject made decisions and directed staff to perform the physical restraint. Those facts are not in controversy here.

Based upon the SCIP-R protocol, the physical restraint was not warranted in the first instance. First, it was Staff [redacted] who prompted the Service Recipient's outburst in the first place, knowing or suspecting for good reason that the Service Recipient would become upset at the sudden news of an appointment with her psychiatrist. Second, once the Service Recipient began to escalate, the verbal and non-physical de-escalation techniques of SCIP-R were never attempted, according to the evidence presented here. The Subject and others had cleared the area of other service recipients, in anticipation of just such a reaction by the Service Recipient. Lastly, as the Service Recipient escalated further to verbal and physical aggression toward staff, the Subject ordered the physical restraint. It is concluded that this decision and order by the Subject was a breach of her duty of care to the Service Recipient.

It must also be determined whether the Service Recipient suffered or was likely to suffer any physical injury or serious or protracted impairment of her physical, mental or emotional condition, as a result of the Subject's conduct. There is evidence that the Service Recipient complained of pain in her wrist after the restraint; the is no corroboration of this since she refused medical exam or treatment. Nevertheless, the statement of one witness, Staff [redacted] (Justice Center Exhibits 17, 18) describe the Service Recipient being "dragged" down the hall toward the exit. It is not inconceivable that a wrist injury, no matter how slight, could and would result from such conduct. Staff [redacted] statement is deemed reliable, in the absence of any proof to the contrary in the record. It is therefore concluded that the Service Recipient did sustain a slight injury to her wrist resulting from the restraint.

In addition, the Service Recipient was given an evaluation after the restraint by Psychologist [redacted]. As noted, Psychologist [redacted] determined that no mental or emotional harm - indeed, no harm whatsoever - had befallen the Service Recipient as a result of this incident. However, there is evidence in the record calling Psychologist [redacted] judgment into question, and her determination must then be weighed accordingly. (Justice Center Exhibit 26)

After considering Psychologist [redacted] testimony, evaluation and determination, and after considering the diagnoses of this Service Recipient, and after further considering the conduct of the Subject and those staff who were looking to the Subject for guidance at the critical moment, and after further considering that the Subject and staff chose to incite most of the Service Recipient's target behaviors rather than treat her according to her own Behavior Support Plan and their SCIP-R training, it is further concluded that it was likely that the Service Recipient suffered serious or protracted emotional impairment as a result of the aforesaid conduct by the Subject and others.

The Subject claims in her own defense that the Service Recipient's aggression justified a physical intervention, due to the risk of harm to staff or to the Service Recipient herself. This claim is unsupported by the facts. There were no service recipients in the immediate area, since staff had moved them away, and staff at the scene were all ambulatory and could easily have moved away, as they had all been trained. It is therefore concluded that there was no emergency and no situation that otherwise called for the use of a physical intervention.

The Subject further claims that she had no choice; that she had been directed by her superiors to act with a certain purpose, feared being disciplined for insubordination and that her actions are therefore to be excused, if not justified. This claim is also unpersuasive and unsupported by this record.

The Subject, as the Assistant Director of the day program, was for all practical purposes the last line of defense for this Service Recipient in her care. The Subject should have used her common sense, her training, her eighteen years of experience working with vulnerable people, and concluded that no matter what directive she was given, she should never order a physical restraint performed for the purpose of forcing a service recipient to accept medical treatment that the service recipient did not want, had the absolute right to refuse, and the capability to communicate that choice to staff. It is concluded that the Subject committed neglect by this clear breach of her duty to protect the Service Recipient from exactly the type of conduct that the Subject had herself ordered.

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.

A substantiated Category 3 finding 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] 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 Louis P. Renzi, Administrative Hearings Unit.

DATED: July 27, 2017
Schenectady, New York

Louis P. Renzi, ALJ