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: August 15, 2017
Schenectady, New York

David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
AAU
SUBJECT

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: John T. Nasci
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
2165 Brighton Henrietta Town Line Road
Rochester, New York 14623
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: Robert DeCataldo, 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 a custodian, you committed neglect when you failed to provide proper supervision to a service recipient by not ensuring his toileting safety protocol was followed, and he fell and hit his head.
>
> This allegation has been SUBSTANTIATED a 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 at [redacted], is a group home for adults with developmental disabilities and is operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is an agency that is subject to the jurisdiction of the

Justice Center. (Hearing testimony of [redacted], Justice Center Investigator, hereinafter referred to as "the Investigator")

5. At the time of the alleged neglect, the Subject was employed by the OPWDD as a Direct Support Assistant (DSA) and had been employed by the facility for twenty-nine years. (Justice Center Exhibit 22: audio recording of Justice Center interview of the Subject and interrogation of the Subject; and Hearing testimony of the Subject) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

6. At the time of the alleged neglect, the Service Recipient was fifty-eight years old, and had been a resident of the facility for several years. The Service Recipient was an adult male with pertinent diagnoses of profound mental retardation, seizure disorder, epilepsy and osteoporosis. The Service Recipient required a wheelchair to ambulate, a shower chair for bathing and a Hoyer lift or two staff to transfer him to and from his wheelchair, shower chair and toilet. The shower chair was equipped with a seat belt and wheels with wheel locks. While toileting, the Service Recipient used a Columbia seat, which was a high-backed toilet attachment that was equipped with a waist belt and two shoulder straps that were used to secure the Service Recipient and prevent him from falling forward while sitting on the toilet. While toileting, periodic observation of the Service Recipient by staff was required every fifteen minutes. (Justice Center Exhibits 9, 16, 17, 18A, 18B and 20)

7. The IRA had two bathrooms, one with a shower and one with a bathtub. The shower bathroom did not have a Columbia seat to use for toileting the Service Recipient, while the bathtub bathroom did. The shower bathroom toilet had a seat belt that was attached to the toilet. (Justice Center Exhibit 18D; Justice Center Exhibit 22: audio recording of Justice Center interviews of [redacted] (Staff A), [redacted] (Staff B), [redacted] (Staff C), and the Subject and interrogation of the Subject; and Hearing testimony of the Subject)

8. On [redacted], the evening shift at the IRA was staffed with the Subject, Staff A and Staff B. The Subject was the senior staff on duty, and Staff A and Staff B were DSA trainees. All three staff were assigned to care for specific service recipients and the Subject was additionally assigned to administer medication to all of the IRA service recipients. Staff A was assigned to care for four service recipients including the Service Recipient. (Justice Center Exhibit 15; Justice Center Exhibit 22: audio recording of Justice Center interviews of Staff A, Staff B, Staff C, and the Subject and interrogation of the Subject; and Hearing testimony of the Subject)

9. On [redacted], during the evening shift, Staff A and the Subject prepared the Service Recipient for a shower in the shower bathroom and transferred him from his wheelchair to the shower chair. While Staff A proceeded to shower the Service Recipient, the Subject exited the shower bathroom, entered the medication room directly across from the shower bathroom, and proceeded to prepare medication for administration to the IRA service recipients. (Justice Center Exhibit 2; Justice Center Exhibit 22: audio recording of Justice Center interviews of Staff A, Staff B, and the Subject and interrogation of the Subject; and Hearing testimony of the Subject)

10. A short time later, Staff A called for the Subject to assist him in the bathroom because the Service Recipient was having explosive diarrhea. The Subject entered the bathroom and instructed Staff A to move the Service Recipient, while still in the shower chair, over the toilet. After Staff A moved the Service Recipient and positioned him in the shower chair over the toilet, the Subject and Staff A locked three of the four shower chair wheels leaving the left rear wheel, which was not reachable, unlocked. The Subject then attempted to secure the Service Recipient to the toilet with the toilet seatbelt, but was unable to do so due to the large size of the Service Recipient's stomach and waist. While sitting in the shower chair over the toilet, the Service Recipient was secured only to the shower chair with the shower chair seatbelt, and the shower chair was not secured to the toilet. (Justice Center Exhibits 2, 7, 8, 12, and 13; Justice Center

Exhibit 22: audio recording of Justice Center interviews of Staff A and the Subject and interrogation of the Subject; and Hearing testimony of the Subject)

11. After placing the Service Recipient over the toilet, the Subject exited the shower bathroom and went into the medication administration room which was located directly across the hall from the shower bathroom. Staff A also exited the shower bathroom leaving the door six to twelve inches ajar. (Justice Center Exhibits 2, 7, 8, 12, and 13; Justice Center Exhibit 22: audio recording of Justice Center interviews of Staff A and the Subject and interrogation of the Subject; and Hearing testimony of the Subject)

12. A short time later, while Staff A was standing outside the shower bathroom door and the Subject was in the medication administration room, Staff A and the Subject heard a loud noise come from the shower bathroom. Both the Subject and Staff A entered the shower bathroom and found that the Service Recipient had fallen forward face-first to the floor. The Service Recipient was still attached to the shower chair which had fallen with him and was on top of him. The Subject and Staff A lifted the Service Recipient up with the shower chair and repositioned him and the shower chair over the toilet. Because the Subject suspected that the Service Recipient was having a seizure, in order to counteract the seizure, she grabbed the Service Recipient's Vagus Nerve Stimulation (VNS) magnetic device from his wheelchair and swiped it across his chest where he had a VNS implant. Within a short period of time, the Service Recipient appeared to Staff A and the Subject to be coming out of the seizure. The Subject then called 911, took the Service Recipient's vital signs and checked him for injuries, finding a scrape on his knee and a red spot on his head. The Service Recipient was then transported to the hospital where no further injuries from the fall were found. (Justice Center Exhibits 2, 7, 8, 12, 13, 16, and 17; Justice Center Exhibit 22: audio recording of Justice Center interviews of Staff A, Staff B, and the Subject and interrogation of the Subject; and Hearing testimony of the Subject)

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 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) as:

> "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 neglect shall be categorized into categories pursuant to SSL § 493(4), including Category (3), which is defined as follows:

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

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the act or acts of neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of neglect as set forth in the substantiated report. (Title 14 NYCRR § 700.10(d))

If the Justice Center proves the alleged neglect, the report will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the act of neglect cited in the substantiated report constitutes the category of neglect as set forth in the substantiated report.

If the Justice Center did not prove the neglect by a preponderance of the evidence, the substantiated report must be amended and sealed.

DISCUSSION

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

In support of its substantiated findings, the Justice Center presented a number of documents and photographs obtained during the investigation. (Justice Center Exhibits 1 through 21) The Justice Center also presented audio recordings of the Justice Center Investigator's interview of witnesses and interrogation of the Subject. (Justice Center Exhibit 22) The investigation underlying the substantiated report was conducted by the Investigator, who was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and presented two documents. (Subject Exhibits A

and B)

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 Justice Center contends that the Subject breached her duty to the Service Recipient by failing to follow the Service Recipient's toileting protocol and treatment plan requirements and, as a result of the Subject's breach, the Service Recipient fell off the toilet and hit his head. The Justice Center argues specifically that the Subject failed to use the Columbia seat in the bathtub bathroom and that the Subject failed to strap the Service Recipient more securely onto the toilet in the shower bathroom.

The Subject contends that because the Service Recipient was having continuing explosive diarrhea, it was not safe to move the Service Recipient eight feet down the hall to the bathtub bathroom where the Columbia seat was located, and that moving the Service Recipient while having explosive diarrhea would have placed other IRA service recipients (who were moving about the IRA) at risk of harm. The Subject contends that the IRA protocol and the Service Recipient's treatment plans required only that the Columbia seat may be used, not that it shall be used.

The record reflects that the Subject had a duty to follow IRA toileting protocol and the specific toileting requirements of the Service Recipient's treatment plans. Whether or not the Service Recipient's plans required staff to use the Columbia seat, it is clear that, due to the Service Recipient's risk of seizure, he was to be secured to the toilet in a manner that would protect him from falling off the toilet. The Subject demonstrated that she was cognizant of this risk by attempting to secure the Service Recipient to the toilet with the toilet seatbelt. However, the record

reflects that the Subject did not attempt to secure the shower chair to the toilet which could have been accomplished using the toilet seatbelt. Doing so would have most likely prevented the Service Recipient from falling to the floor and hitting his head. The Subject provided no explanation for her omission.

Consequently, the record establishes that the Subject breached her duty to properly secure the Service Recipient to the toilet and that her breach of duty resulted in the Service Recipient falling to the floor and hitting his head sustaining a scrape on his knee and a red spot on his head.

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. Category 2 conduct is defined as conduct in which the Subject seriously endangered the health, safety or welfare of the Service Recipient. (SSL § 493(4)(b))

The record establishes that the Service Recipient suffered from a developmental disability as well as various physical ailments which, coupled with a fall on his head, seriously endangered the Service Recipient's health and safety. Consequently, 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.

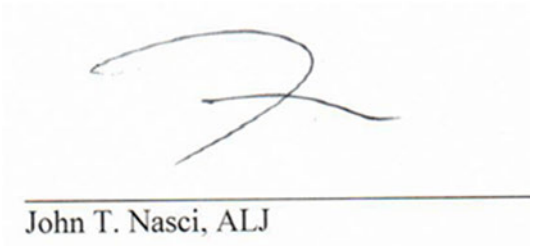
A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

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 2 act.

This decision is recommended by John T. Nasci, Administrative Hearings Unit.

DATED: August 7, 2017
Schenectady, New York



John T. Nasci, ALJ