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 18, 2017
Schenectady, New York

David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[redacted], Subject
Eric E. Wilke, Esq.

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: Elizabeth M. Devane
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People With Special Needs
9 Bond Street, 3rd Floor
Brooklyn, New York 11201
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: Todd M. Sardella, Esq.

[redacted]
By: Eric E. Wilke, Esq.
CSEA, Inc.
143 Washington Avenue
Capitol Station, Box 7125
Albany, New York 12224-0125

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for neglect and abuse (obstruction of reports of reportable incidents). 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 and abuse (obstruction of reports of reportable incidents) 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 from [redacted] at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you breached a duty by performing your duties in a knowing, reckless or criminally negligent manner by not familiarizing yourself with the Individualized Service Plan and/or Plan of Protective Oversight for a service recipient before providing him with one to one supervision, and not following said plans for two-person transfers, which led to the service recipient falling in the hallway on [redacted] and sustaining fractures.

This allegation has been SUBSTANTIATED as Category 1 serious conduct pursuant to Social Services Law § 493(4)(a)(ii).

Allegation 2

It was alleged that between [redacted], during an investigation into events of [redacted] at the [redacted], located at [redacted], while acting as a custodian, you committed abuse (obstruction of reports of reportable incidents) when you intentionally made a false statement and/or falsified records and/or intentionally withheld material information during the investigation into a fall sustained by a service recipient.

This allegation has been SUBSTANTIATED as Category 1 serious conduct pursuant to Social Services Law § 493(4)(a)(x) and/or 493(4)(a)(xiii).

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

4. The facility, [redacted], [redacted] located at [redacted], is an Individualized Residential Alternative (IRA) for adults with developmental disabilities and is operated by the 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 Justice Center Investigator and Quality Care Facility Review Specialist 1 [redacted])

5. At the time of the alleged abuse and neglect, the Subject was employed as a Direct Support Assistant (DSA) for OPWDD since 2001. The Subject's duties included supporting service recipients with activities of daily life and being aware of the specific needs of any service recipient whom he assists. The Subject was a custodian as that term is defined in Social Services Law § 488(2). (Hearing testimony of Justice Center Investigator and Quality Care Facility Review Specialist 1 [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 5, 8 and 32)

6. At the time of the alleged abuse and neglect, the Service Recipient was a 72-year-old non-verbal male with diagnoses including profound intellectual disability and Parkinson's

disease. He required staff support with all activities of daily living and had difficulty ambulating. The Service Recipient had been residing at [redacted] since 1995. (Hearing testimony of Justice Center Investigator and Quality Care Facility Review Specialist 1 [redacted]; Justice Center Exhibits 5, 9, 10, 11, 30, 32 and 33)

7. In [redacted], the Service Recipient fell while entering the shower and was diagnosed with a neck fracture. (Hearing testimony of Justice Center Investigator and Quality Care Facility Review Specialist 1 [redacted]; Justice Center Exhibits 5, 6, 9, 10, 30 and 33)

8. The Service Recipient's Individualized Service Plan (ISP) dated [redacted] noted that since the fall, staff was being trained to provide, and was providing, a two-person escort for the Service Recipient any time he was on his feet. (Hearing testimony of Justice Center Investigator and Quality Care Facility Review Specialist 1 [redacted]; Justice Center Exhibits 5, 9 and 28)

9. The Service Recipient's Individualized Plan Of Protective Oversight (IPOP) dated [redacted], stated that, in addition to receiving constant one-to-one arm's length supervision 24 hours per day, the Service Recipient must have a two person assist for all ambulation and transport. (Hearing testimony of Justice Center Investigator and Quality Care Facility Review Specialist 1 [redacted]; Justice Center Exhibits 5 and 33)

10. [redacted] staff was trained regarding two-to-one supervision for the Service Recipient. [redacted] was not the Subject's primary work location and the Subject never received that training. (Hearing testimony of Justice Center Investigator and Quality Care Facility Review Specialist 1 [redacted]; Hearing testimony of the Subject; Justice Center Exhibit 5)

11. On [redacted], the Subject was working overtime, filling in on the evening shift at [redacted] from 3:00 p.m. to 11:30 p.m. The Subject had worked at [redacted] in the past

and had also previously provided one-to-one supervision to the Service Recipient. (Hearing testimony of Justice Center Investigator and Quality Care Facility Review Specialist 1 [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 5, 29 and 32)

12. At 3:30 p.m., the Subject drove the Service Recipient, another Direct Support Assistant (DSA1) and the nurse to a medical appointment for the Service Recipient. They returned to [redacted] at 10:00 p.m. (Hearing testimony of Justice Center Investigator and Quality Care Facility Review Specialist 1 [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 5, 8, 24, 28, 29 and 32)

13. The DSA1 left [redacted] at 10:30 p.m. The Supervisor, Subject, DSA2 and DSA3 remained at [redacted] with the 12 service recipients. (Hearing testimony of Justice Center Investigator and Quality Care Facility Review Specialist 1 [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 5, 8, 14, 24, 27, 28, 29 and 32)

14. After DSA1 left, the Supervisor told the Subject to toilet and change the Service Recipient. The Subject did so without assistance from any other staff. (Hearing testimony of Justice Center Investigator and Quality Care Facility Review Specialist 1 [redacted]; Hearing testimony of the Subject, Justice Center Exhibits 5, 29, 32)

15. After changing the Service Recipient, the Subject and the Service Recipient walked into the hallway, where the Supervisor directed the Subject to bring Service Recipient back into his room and put different pants on him. The Subject and Service Recipient began to return to the bedroom when the Service Recipient tensed, lunged forward and fell. DSA2 was called and the Subject and DSA2 attended to the Service Recipient. Emergency Services were called at 11:17 p.m. (Hearing testimony of Justice Center Investigator and Quality Care Facility Review Specialist 1 [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 5, 8, 18,

27, 29 and 32)

16. That evening, immediately after the incident, the Supervisor directed both the Subject and DSA2 to write in their statements that the Subject was in the Service Recipient's bedroom transferring the Service Recipient to his wheelchair when the Subject's leg buckled and the Service Recipient fell, hitting his head on a dresser. They both did so and gave the written statements to the Supervisor. Soon thereafter, both the Subject and DSA2 asked the Supervisor to retract those statements to accurately reflect that the Service Recipient fell in the hallway. (Hearing testimony of Justice Center Investigator and Quality Care Facility Review Specialist 1 [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 5, 16, 17, 18, 19, 20, 27, 29 and 32)

17. The Service Recipient was admitted to the hospital and diagnosed with several facial fractures. (Hearing testimony of Justice Center Investigator and Quality Care Facility Review Specialist 1 [redacted]; Justice Center Exhibits 5 and 30)

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 and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1)(f) and (h) to include:

> (f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.
>
> (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 1 and Category 2, which are defined, in pertinent part, as follows:

> (a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:
>
> > (ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;
>
> (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 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 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 neglect cited in the substantiated report constitutes the category of abuse and neglect as set forth in the substantiated report.

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

DISCUSSION

In support of its substantiated findings, the Justice Center presented several documents obtained during the investigation (Justice Center Exhibits 1- 30, 33 and 34) as well as an audio

recording of the Justice Center Investigator's interrogations. (Justice Center Exhibit 32) The investigation underlying the substantiated report was conducted by Justice Center Investigator and Quality Care Facility Review Specialist 1 [redacted] who was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in his own behalf and presented no other evidence.

Allegation 1 - Neglect

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

In order to prove neglect, the Justice Center must prove by a preponderance of the evidence that the Subject's action, inaction or lack of attention breached a custodian's duty that he owed to the Service Recipient, and that the Subject's 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

Certain facts are not in dispute. At the time of the alleged neglect, the Subject was working in his capacity as a DSA at [redacted] and was a custodian as defined in SSL § 488(2). The Subject alone was assisting the Service Recipient as he walked in the hallway at [redacted] when the Service Recipient fell. (Hearing testimony of the Subject; Justice Center Exhibits 5, 8, 18, 27, 29 and 32) The Service Recipient's most recent IPOP required that two staff assist him whenever he was ambulating as he was very unsteady and was injured in a prior, [redacted], fall. (Justice Center Exhibit 33) The Service Recipient was badly injured as a result of this fall on [redacted]. (Justice Center Exhibits 5 and 30)

The Subject testified that he thought one-to-one supervision was required for the Service Recipient as he had provided one-to-one supervision for the Service Recipient in the past, had no

knowledge that requirement had changed, and thought that he was following the Service Recipient's IPOP. The Supervisor told the Subject to care for the Service Recipient himself, having made no mention of any requirement for additional staff support and when the Supervisor observed the Subject and Service Recipient in the hallway, the Supervisor told the Subject to take the Service Recipient back to his room. The Subject took care of the Service Recipient as he was directed and as he thought was appropriate. (Hearing testimony of the Subject; Justice Center Exhibits 29 and 32)

The Subject's testimony is found to be credible. The Subject was filling in at [redacted], which was not his normally assigned location, and he was not trained on or informed of the two-person supervision requirements for the Service Recipient. There was some question as to whether or when the Supervisor assigned the Subject to the Service Recipient and the accessibility of the Service Recipient's plans, however those issues are moot as the Subject did take on the supervision of the Service Recipient.

However, the Subject had a duty to review and be aware of the Service Recipient's most recent IPOP before he took on supervision of the Service Recipient and he did not do so. The Subject escorted the Service Recipient while providing one-to-one supervision, as opposed to two-to-one supervision, in violation of the Service Recipient's IPOP. The Subject's failure to review the Service Recipient's most recent IPOP before he took on supervision of the Service Recipient on that date constitutes a breach of his duty to the Service Recipient. The Service Recipient fell while being inappropriately supervised, resulting in physical injury.

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. Allegation 1 will not be amended or sealed.

Allegation 2 – Abuse (obstruction of reports of reportable incidents)

The Justice Center has not established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 2", in the substantiated report.

In order to prove abuse (obstruction of reports of reportable incidents) as it is alleged, the Justice Center must prove that the Subject impeded the Justice Center's investigation by intentionally making a false statement and/or falsifying records and/or intentionally withholding material information during the investigation. (SSL § 488(1)(f)) Social Services Law § 488(16) defines "intentionally" as having the same meaning as provided in New York Penal Law § 15.05. Under New York Penal Law § 15.05(1), a person acts "intentionally" with respect to a result or conduct when a person has a "... conscious objective ..." to cause a result or engage in such conduct.

This allegation revolves around the statement that the Subject gave to the Supervisor on [redacted], indicating that the Service Recipient fell when the Subject was transferring the Service Recipient from his bed to his wheelchair in the Service Recipient's bedroom.

There is no dispute that the statement is false. Both the Subject and DSA2 stated the Supervisor directed each of them to provide false statements immediately after the incident indicating that the Service Recipient's fall occurred in his bedroom. DSA2 stated that she wrote two statements, one that was factually accurate and one at the direction of the Supervisor, and did not know what the Supervisor did with the statements. The Subject testified that he wrote the inaccurate statement under duress and in the heat of the moment and was fearful of retaliation from the Supervisor if he did not write it. The Subject testified that he immediately retracted the false statement, that he thought the incident was an accident and he did not want to lie about it, and he wrote an accurate statement. The Subject gave both statements to the Supervisor and asked for the inaccurate statement back. The Subject left in an ambulance with the Service Recipient and

did not get the statement back. The next time the Subject was questioned about the incident, on [redacted] by the Justice Center Investigators, he was cooperative and gave factual details of the incident. (Hearing testimony of Justice Center Investigator and Quality Care Facility Review Specialist 1 [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 5, 18, 20, 27, 29 and 32)

While the Subject provided a false statement, it is not evident that the statement was made knowingly with the intent to obstruct the investigation, nor is it evident that the Subject's statement impeded the discovery, reporting or investigation of the treatment of the Service Recipient. The false statement in fact implicates the Subject as being neglectful and acting in violation of the Service Recipient's IPOP. The accounts of the Subject and DSA2 of how they were directed to falsify statements are similar and both describe an attempt by the Supervisor to exculpate herself by showing that she was not aware that the Subject was providing one-to-one instead of two-to-one supervision of the Service Recipient as the Service Recipient was transferred or ambulated. Because the Subject immediately retracted his original statement and asked for it back, and when next questioned regarding the incident the Subject gave factual details, it is determined that his original false statement was given under duress. It is noteworthy that the Supervisor forwarded only the false statements to investigators and withheld the factual statements.

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 abuse alleged. Allegation 2 will be amended and sealed.

Although Allegation 1 of the report will remain substantiated, the next issue to be decided is whether Allegation 1 constitutes the category of abuse and neglect set forth in the substantiated report. The Justice Center substantiated this allegation of neglect as Category 1 conduct, which is

the most serious category determination and will result in barring the Subject from future employment with vulnerable persons in New York State. The Report of Substantiated Findings specifically alleges that the Subject's conduct falls under Social Services Law § 493(4)(a)(ii), which requires in relevant part "a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part ..." There was no evidence to support the contention that the Subject acted either knowingly, recklessly or with criminal negligence, as defined by New York State Penal Law § 15.05. Such a showing is required to support Category 1 conduct.

The record reflects that the Subject provided one-to-one supervision to the Service Recipient in the past and that, based on his prior experience, he did so on the date of the neglect and did so with the knowledge of, and at the direction of, the Supervisor. It is evident that the Subject was not aware of the recently added two-to-one supervision requirement when the Service Recipient was being transferred or was ambulating, as described above. The record reflects that the Subject did not act knowingly. Likewise, there is no evidence in the record that supports the conclusion that the Subject was aware of and consciously disregarded a substantial and unjustifiable risk which constitutes a gross deviation from a reasonable standard of care thereby acted recklessly, or that the Subject was criminally negligent. Consequently, the Subject's actions do not rise to the level of Category 1 conduct.

While the Subject's conduct did not meet the test of serious conduct under SSL § 493(4)(a)(xii), the record reflects that his actions seriously endangered the health, safety or welfare of a service recipient. The two-to-one requirement was put into place as the Service Recipient was fragile, unsteady and was diagnosed with a fracture due to a fall. The Subject's breach of duty, by

failing to review the Service Recipient's IPOP, seriously endangered the health, safety and welfare of the Service Recipient. It is determined that the category of the affirmed substantiated neglect should properly be substantiated as a Category 2 act.

Category 2 conduct shall be elevated to Category 1 conduct when such conduct occurs within three years of a previous finding that such custodian 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.

DECISION: The request of [redacted] that Allegation 1 of 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.

Allegation 1 should be properly categorized as Category 2 conduct.

The request of [redacted] that Allegation 2 of the substantiated report dated [redacted], be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed abuse (obstruction of reports of reportable incidents).

This decision is recommended by Elizabeth M. Devane, Administrative Hearings Unit.

DATED: August 10, 2017
Schenectady, New York

Elizabeth M. Devane
Administrative Law Judge