STATE OF NEW YORK
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS

In the Matter of the Appeal of [redacted]	**FINAL DETERMINATION AND ORDER AFTER HEARING**
Pursuant to § 494 of the Social Services Law	**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 22, 2017
Schenectady, New York

David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[redacted], Subject
Jason Jaros, 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: Mary Jo Lattimore-Young
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People With Special Needs
Administrative Hearings Unit
2630 North America Drive
West Seneca, New York 14224
On: [redacted]

Parties: New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Theresa Wells, Esq.

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By: Jason Jaros, Esq.
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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 2[1]

> It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to provide proper supervision, during which time a service recipient left the room unnoticed and sustained injuries.
>
> This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

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

4. The facility, located at [redacted], is an Individualized Residential Alternative (IRA) that provides day habilitation services for developmentally disabled

[1] Allegation 1 of the said report was unsubstantiated.

individuals, and is operated by the New York State 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 the Justice Center Investigator [redacted], hereinafter referred to as the Justice Center Investigator)

5. At the time of the alleged neglect, the Subject was employed at the day habilitation facility in a [redacted] capacity as a Licensed Practical Nurse (LPN) and a [redacted]. As a LPN, the Subject was responsible for administering medical care/first aid to the service recipients and at times she would be assigned to perform medication administration duties, which included completing documentation. The Subject's medication administration duties also included distributing medication at different times and locations within the building to those service recipients whose Medication Administration Record (MAR) indicated that they were to receive medication at scheduled times. There was a total of sixty-two service recipients that attended the day habilitation program at the facility. They were divided into different program rooms; however, not all the service recipients were scheduled to receive medication while attending program. The Subject was a custodian as that term is so defined in Social Services Law § 488(2). (Hearing testimony of the Subject; Justice Center Exhibits 6 and 32-33)

6. At the time of the alleged neglect, the Service Recipient was a non-verbal fifty-seven-year-old female who communicated by using gross vocalizations, facial expressions and a few manual signs. The Service Recipient could follow simple familiar directions. Although the Service Recipient was independently ambulatory, sometimes staff needed to assist her when she had difficulty ambulating on stairs because of her poor depth perception. (Hearing testimony of the Justice Center Investigator; Justice Center Exhibits 6, 9-10 and 30)

7. The Service Recipient resided at the [redacted] and was transported back and

forth from her residence to the facility's day habilitation program each weekday. The Service Recipient was transported by the [redacted], an independent bus service. The Service Recipient had diagnoses of profound intellectual disability, osteoporosis/osteopenia, seizure disorder and other medical conditions. Per the Service Recipient's Plan of Protective Oversight (POPO), staff were required to provide periodic observations of her every five minutes, while she attended the program. The Service Recipient's POPO and her [redacted] Plan of Nursing Supervision stated that, due to her history of osteoporosis/osteopenia, any falls were required to be reported to the nurse. (Justice Center Exhibit 30) The Service Recipient's treatment plans do not list a behavioral history of sitting on, or dropping to, the floor. Staff involved in the Service Recipient's care were trained on her treatment plans and knew that the Service Recipient liked to wander around the room and open and close doors. (Hearing testimonies of the Subject, Staff A and the Justice Center Investigator; Justice Center Exhibits 6, 9-10, 30-31 and 48)

8. On [redacted], the Subject was assigned to medication administration duties. When the Subject was not performing medication administration duties that day, she was also assigned to work [redacted] in the Service Recipient's day habilitation program room #[redacted] (hereinafter referred to as room #[redacted]) where the Subject assisted with craft and cooking activities. The Subject's co-workers that day were Staff A, a Habilitation Specialist 1 (Hab Spec 1) and Staff B, a Direct Support Assistant (DSA).[2] At that time, staff were equally responsible to supervise all the service recipients assigned to their program rooms. Program room #[redacted] was an open classroom where all activities were held, including lunch. There was only one door to room #[redacted] that led to an indoor hallway. The medication room was located on the other side of the building and took a few minutes to walk there from room #[redacted]. (Hearing testimony of the Subject; Justice Center Exhibits

[2] Hereinafter [redacted] (Hab Spec 1) is referred to as Staff A and [redacted] (DSA) is referred to as Staff B.

6, 32, 48 and 49)

9. Sometime that morning, the Service Recipient was transported to her day habilitation program at the facility by the [redacted]. Transportation staff noticed the Service Recipient entering the bus without issues. When the Service Recipient arrived to program that morning, facility Staff A and Staff B were in the room providing supervision to the service recipients. The Subject performed her medication administration duties in different parts of the building. At various times throughout the day, the Subject left room #[redacted] to go to the medication room (Med Room) to review the MAR which listed the medications to be distributed to ten service recipients attending program. Medications were scheduled to be dispensed that day around 10:00 a.m., 12:00 p.m. and 1:30 p.m. At other times that day, the Subject administered medications to several other service recipients who were not listed on the schedule. The process included the Subject retrieving the medication, then proceeding to the program room where the individual service recipient was located to administer his or her medication. At some point, after administering the medication, the Subject would document her activities in the facility books. Each time the Subject had to leave room #[redacted] to perform medication administration duties, she informed a staff member.[3] Although there were times when the Subject did return to the room to perform her program duties, for most of that day she was absent from the room performing medication administration duties. Per the schedule, Staff B was scheduled to leave room #[redacted] at approximately 11:30 a.m. to work in program room #[redacted], which left Staff A alone in the room much of the time with the remaining service recipients. (Hearing testimonies of the Subject, Staff A and the Justice Center Investigator; Justice Center Exhibits 6, 32-33 and 48, audio interview of the Subject, Staff A and Staff B)

[3]The exact times the Subject distributed medications to the program service recipients would have been noted on each service recipient's MAR which was not a part of the hearing record.

10. During noontime lunch, the Subject saw the Service Recipient sitting in a chair in the room #[redacted]. (Hearing testimony of the Subject)

11. Sometime before 1:30 p.m., the Subject left room #[redacted] to go to the medication room to check the MAR for the service recipient who was scheduled to receive medication at that time. After retrieving the medication, the Subject then proceeded to program room #[redacted] (next to room #[redacted]) to distribute the medication to a service recipient attending program there. At some point prior to 2:00 p.m., the Subject briefly returned to room #[redacted], at which time Staff A informed her that one of the service recipients had cut his finger. The Subject checked the injured finger of the service recipient, then informed Staff A that she had to leave the room to obtain first aid supplies to treat him and to perform some of her documentation duties. The Subject then left room #[redacted] prior to 2:00 p.m., leaving Staff A as the only staff person in the room to supervise the Service Recipient and approximately six other service recipients. As noted above, Staff B had left room #[redacted] earlier.

12. At approximately 2:00 p.m., Staff A observed the Service Recipient sitting on the couch in the room. Shortly thereafter, while Staff A was continuing to attend to the injured service recipient and awaiting the Subject's return to the room, the Service Recipient left the room unnoticed by Staff A and fell in the hallway near the room. (Hearing testimony of the Subject, Staff A; Justice Center Exhibits 6, 32 and 48, audio interviews of the Subject, Staff A and Staff B)

13. Sometime about 2:10 p.m., Staff B was walking down the hallway on his way out of the building. Staff B discovered the Service Recipient sitting on the floor in the hallway near room #[redacted] with her back against the wall. Staff B assisted the Service Recipient from the floor to a standing position, and then escorted her back to room #[redacted] where Staff A was the only staff person in the room at that time. Staff B reported to Staff A that he found the Service Recipient sitting on the hallway floor outside of room #[redacted]. Sometime after 2:10 p.m., the Subject proceeded to return

to room #[redacted] and did not see the Service Recipient in the hallway. The Subject entered the room to administer first aid to the injured service recipient. Staff A never reported to the Subject, nor anyone else, that Staff B discovered the Service Recipient sitting in the hallway unsupervised. There were no witnesses to the non-verbal Service Recipient's fall. Staff A did not conduct a body check of the Service Recipient after she was returned to room #[redacted] and did not notify the nurse to perform a medical assessment. (Hearing testimonies of the Subject, Staff A and the Justice Center Investigator; Justice Center Exhibits 6 and 13; Justice Center Exhibit 48, audio interviews of the Subject, Staff A and Staff B)

14. After being returned by Staff B to room #[redacted], the Service Recipient engaged in her usual activities. At the end of program day, Staff A escorted the Service Recipient outside at which time she walked without assistance onto the bus that transported her to her residence. (Hearing testimony of Staff A and Justice Center Exhibits 6, 15-16 and 48)

15. Upon returning to her residence, the [redacted] Monitor[4] and the residential staff DSA[5] noticed that the Service Recipient, while exiting the bus, was not using her right arm to hold onto the railing as she would normally do. Thereafter, when the DSA escorted her to the bathroom inside the residence, she noticed that the Service Recipient did not use her right arm to pull her pants down. Staff then visually checked the Service Recipient and observed that her right arm appeared to be "slightly swollen," that she had a lump the size of a "goose egg" on her right temple and a small laceration above the right eyebrow. Staff also observed that the Service Recipient could bend her right arm at the wrist and elbow and did not appear to be in any discomfort. The facility's registered nurse (RN) was notified. The RN took the Service Recipient's vital signs, conducted a full body check and confirmed staff's findings from their

[4] [redacted] is the [redacted] Monitor, hereinafter referred to as the transportation monitor.
[5] [redacted] was the staff DSA referred to who observed the Service Recipient exiting the bus after program.

visual check. The Direct Assistant 1 (DA 1) was notified and took the Service Recipient to an urgent care center where she was examined and x-rays were taken. The Service Recipient was diagnosed with a hematoma on the right side of the forehead, a fractured humerus bone in her right arm and was provided with a sling to immobilize her arm. The Service Recipient was then referred that same day to a hospital for further treatment. At the hospital, the Service Recipient was seen by an orthopedic surgeon who did not recommend surgery at that time. (Justice Center Exhibits 6, 11, 20, 22-25 and 48, audio recording of interviews of the [redacted] Monitor and the residential staff DSA)

16. On the date of the incident, the Service Recipient did not fall or sustain any injuries while she was being transported to or from the day habilitation facility. (Justice Center Exhibits 6 and 48, audio recording of interviews of the [redacted] Monitor and the staff DSA)

17. On the day following the incident, the Subject learned for the first time that the Service Recipient had left room # [redacted] unnoticed, fell and sustained injuries. (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 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)(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 abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 3, which is defined under SSL § 493(4)(c) 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(s) committed the act or acts of abuse and/or 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/or neglect as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

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

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

DISCUSSION

The Justice Center has 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. (Justice Center Exhibits 1-49) The investigation underlying the substantiated report was conducted by the Justice Center Investigator, who was the only witness who testified at the hearing on behalf of the Justice Center. Although the Service Recipient was interviewed during the investigation, she was unable to provide any information.

The Subject testified in her own behalf and provided no other evidence.

To sustain an allegation of neglect, the Justice Center must prove that the Subject was a custodian who owed a duty to the Service Recipient, that she breached that duty, and that her breach either resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. (SSL § 488(1)(h))

The record establishes that when the Subject was in present in room #[redacted], she had a duty to

supervise the Service Recipient and conduct five minute periodic observations of her. However, when the Subject was performing her medication administration duties out of room #[redacted], she was to be relieved of her supervisory responsibilities and the staff remaining in the room were responsible to supervise the service recipients.

The record further establishes that the Service Recipient apparently left room #[redacted] unnoticed sometime between 2:00 p.m. when Staff A last saw her and 2:10 p.m. when she was discovered out of the room sitting on the hallway floor. During that time period, it appears that the Subject was out of room #[redacted] obtaining first aid supplies and documenting the injury to the other service recipient's finger. (Hearing testimonies of the Subject and Staff A)

In this case, the record lacks sufficient proof that the Subject was present in room #[redacted] at the time the Service Recipient initially eloped or remained missing. As such, the evidence contained in the record does not establish that the Subject breached her duty to supervise the Service Recipient.

The Subject credibly and adamantly testified that she was not in the room at 2:00 p.m., having left the room to obtain first aid supplies. Staff A testified at the hearing that he last observed the Service Recipient at about 2:00 p.m. sitting on a couch in room #[redacted] and that he was attending to another service recipient who had cut himself. Staff A also confirmed during his testimony that the Subject had left the room to obtain first aid supplies. Sometime after the Subject left the room and had not yet returned, the Service Recipient was discovered out of the room by Staff B around 2:10 p.m. Nevertheless, the record clearly establishes that Staff A was the only staff member that continually worked in room #[redacted] that afternoon.

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 will be amended and sealed.

Since the report will be unsubstantiated, there is no need to address the next question as to whether the substantiated report constitutes the category of neglect set forth in the substantiated report.

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 Mary Jo Lattimore-Young, Administrative Hearings Unit.

DATED: August 11, 2017
West Seneca, New York

Mary Jo Lattimore-Young,
Administrative Law Judge