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 is hereby adopted in its entirety.

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: March 30, 2018
Schenectady, New York

David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[redacted], Subject
Alek L. Felstiner, 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: Susanna Requets
Administrative Law Judge

Held at: Administrative Hearings Unit
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: Kristin L. Kopach, Esq.

[redacted]
By: Alek L. Felstiner, 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], 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][1], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to search a service recipient's room and/or failed to notify a nurse upon discovering a razor in a service recipient's room, after which time the service recipient cut herself with the razor.
>
> 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 [redacted] at the facility, [redacted]

[1] It was stipulated on the record that the Report of Substantiated Finding contained a scrivener's error and the neglect allegedly occurred on [redacted], not on [redacted].

[redacted], located at [redacted], is a detoxification facility, licensed by the New York State Office of Alcoholism and Substance Abuse Services (OASAS), which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of [redacted], Justice Center Investigator (Investigator); Justice Center Exhibit 2)

5. At the time of the alleged neglect, the Subject was employed by the facility as a Certified Nursing Assistant (CNA) and had been employed by the facility for 5 years, including 4 years in the [redacted]. (Hearing testimony of the Subject; Justice Center Exhibits 2 and 11) The Subject was a custodian as that term is defined in Social Services Law § 488(2).

6. At the time of the alleged neglect, the Service Recipient was a 50-year-old adult female with diagnoses of major depressive disorder and benzodiazepine withdrawal. (Hearing testimony of the Investigator; Justice Center Exhibits 5 and 16)

7. The Service Recipient was admitted to the facility on [redacted] for detoxification and relapse prevention. (Justice Center Exhibits 6 and 16) On [redacted], the Service Recipient was placed on one-to-one (1:1) observation for exhibiting suicide ideation. In pertinent part, the facility policy and procedure for 1:1 observation of an "acutely suicidal patient" required nursing personnel to: (i) never leave the patient unattended; (ii) have a directed view of the patient at all times; and (iii) "[e]valuate [the] environment each shift for any potentially harmful items [and/or] conditions (i.e., medications, belt, unlocked windows) and notify [the] Primary Nurse/Head Nurse, so corrective actions may be taken." (Hearing testimony of the Investigator; Justice Center Exhibits 11, 16, and 17: audio recording of Justice Center interview of the Assistant Director, and Justice Center Exhibit 18)

8. The Subject worked the [redacted] shift at the facility on [redacted] and was assigned 1:1 observation of the Service Recipient. Prior to beginning the shift,

another nurse told the Subject that the Service Recipient was placed on 1:1 observation because she threatened to commit suicide. (Hearing testimony of the Subject; Justice Center Exhibits 11, 12 and 17: audio recording of Justice Center interview of the Subject)

9. At the beginning of the Subject's shift, the Service Recipient was taking a shower in the shower room located directly across from her bedroom. After the Service Recipient finished her shower, the Subject combed and braided the Service Recipient's hair. The Subject opened all three drawers of the nightstand when she looked for the comb. (Hearing testimony of the Subject; Justice Center Exhibit 17: audio recording of Justice Center interview with the Subject)

10. Between 10:00 a.m. and 11:00 a.m., the Service Recipient asked the Subject if she could shave. The Subject denied the Service Recipient's request because suicidal patients were not allowed to have razors. The Service Recipient then told the Subject that she had a razor on the nightstand. The Subject located and confiscated the blue and orange disposable razor, wrapped it in a paper towel, and put it in her pocket. The Subject testified at the hearing that she saw both the stick and the head of the razor, but admitted that she did not pay attention to see if the blade was inside the head of the razor. (Hearing testimony of the Subject; Justice Center Exhibits 2, 7, and 17: audio recording of Justice Center interview with Charge Nurse [redacted] and the Subject)

11. At some point, either during her 15-minute break or during lunch, the Subject took the confiscated razor from her pocket and threw it in the garbage located in the basement locker room of the facility. (Hearing testimony of the Subject; Justice Center Exhibit 2)

12. Throughout the Subject's shift, the Service Recipient walked between the cafeteria, nursing station and her bedroom, repeatedly stating that she was going to kill herself if she was not transferred to the [redacted] Unit. (Hearing testimony of the Subject; Justice Center Exhibits 7, 8 and 17: audio recording of Justice Center interview with Charge Nurse [redacted])

13. The Subject asked three nursing assistants at 2:15 p.m. to be relieved, but they were busy. The Subject asked the charge nurse at 2:45 p.m. to be relieved, but he requested that she finish her shift. (Hearing testimony of the Subject; Justice Center Exhibit 2)

14. At approximately 3:00 p.m., the Service Recipient, while lying in bed, took out a quarter of an inch piece of razor blade hidden in her bra and cut her left wrist. The Subject saw the Service Recipient cutting herself and asked what she was doing. The Service Recipient showed the Subject her hands and the razor blade. Upon request, the Service Recipient gave the razor blade to the Subject and the Subject flushed the blade in the toilet. The Subject walked with the Service Recipient to the nurse's station and sought help. (Hearing testimony of the Subject; Justice Center Exhibits 2 and 17: audio recording of Justice Center interviews of the Service Recipient and the Subject)

15. The Service Recipient sustained a superficial cut on her left wrist that was treated with a band aid and medication. (Justice Center Exhibits 16 and 17: audio recording of Justice Center interview with the Assistant Director of Nursing (Assistant Director))

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), as follows:

> "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 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 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 through 16 and 18) The Justice Center also presented audio recordings of the Justice Center Investigator's interviews of witnesses and the Subject. (Justice Center Exhibit 17) The investigation underlying the substantiated report was conducted by the Investigator, who testified at the hearing on behalf of the Justice Center. The Subject testified in her own behalf and presented no other evidence.

In order to prove neglect, the Justice Center must establish by a preponderance of the evidence that the Subject's action, inaction or lack of attention breached a 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 Recipients. (SSL § 488(1)(h))

The Justice Center contends that the Subject had a duty to search the Service Recipient's bedroom and to report her discovery of a razor to a nurse, that the Subject breached her duty by

failing to search the bedroom and by failing to report her discovery to the nurse, and that the Subject's breach of duty was likely to result in physical injury to the Service Recipient.

The Subject argues that there was no policy to immediately report the confiscated razor and that she did not have an opportunity to report such finding. The Subject also argues that her failure to report the confiscated razor did not result in any increased risk of serious injury to the Service Recipient because the Subject acted immediately when she saw the Service Recipient injuring herself. The Subject also argues that she did not have a duty to search the room at a specific time or immediately after she found the first razor because razors were allowed and not considered a contraband at the time, and a search of the room would not have revealed the razor blade hidden in the Service Recipient's bra.

The facts, concerning the description of the razor confiscated by the Subject in the morning and how the Service Recipient was able to retrieve a blade from a razor hours later to cut her left wrist, are in dispute. The Service Recipient stated that she took an orange razor from the top drawer of the dresser and asked the Subject if she was allowed to have the razor. The Subject said "no" in response, but did not immediately confiscate the razor. While the Subject was in the room behind a curtain, the Service Recipient smashed a book over the razor. The Subject inquired about the slamming sound and the Service Recipient said she just dropped her book. According to the Service Recipient, the Subject then confiscated only the handle stick of the razor. (Justice Center Exhibit 17: audio recording of Justice Center interview of the Service Recipient and audio recording of the VPCR call)

The Subject testified during the hearing that she confiscated and placed in her pocket a disposable razor after the Service Recipient told her it was on top of the nightstand. The razor, according to the Subject, had both the handle stick and the head of the razor, but the Subject did

not check if the blade was inside the razor. In the Subject's request for an amendment of the Substantiated Report, she stated that she confiscated, and placed in her pocket, a razor blade that was removed from the handle of a safety razor.

However, regardless of how the Service Recipient obtained the blade that she used to cut her wrist and regardless of what part of the razor the blade came from, it is undisputed that the Service Recipient used a razor blade to cut herself while on 1:1 observation for suicide ideation four to five hours after the Subject confiscated a razor without reporting it to the charge nurse. (Hearing testimony of the Subject; Justice Center Exhibits 2, 17: audio recording of Justice Center Interview of the Subject)

The evidence in the record establishes that the Subject had a duty to notify the Primary Nurse or Head Nurse of any "potentially harmful items" so that corrective action could be taken. The razor discovered in the morning was a "potentially harmful item" to the Service Recipient because she was suicidal. (Justice Center Exhibit 11) The Subject's performance assessment includes her ability to maintain a "safe environment" and report "unsafe conditions as necessary." (Justice Center Exhibit 14) While not in writing, the nurses, including the Subject, adhered to the practice of disallowing suicidal patients the possession and use of razors. While [redacted] patients were generally allowed to have razors, the facility policy required the nurse to stay with the patient while he or she shaves and then return the razor to the nursing station. (Justice Center Exhibits 2, 11, 14, and 17: audio recording of Justice Center interviews of Assistant Director, Subject; and Justice Center Exhibit 18)

The Subject admitted, in her request for amendment, that she had a duty to report finding the razor, but failed to do so:

> "I knew that the razor needed to be reported, and I planned to report it. But I did not get a chance right away. I understood that my main responsibility was to

> confiscate the item, remove the danger, and continue monitoring the patient. Then I would report it at a later time." (Justice Center Exhibit 2)

The Subject's claim that she did not have an opportunity to report to the nurse in charge that she found a razor in the Service Recipient's room is not credited evidence because it is contradicted by her own testimony. The Subject had one fifteen-minute break and one one-hour lunch break when another CNA relieved her from her assigned 1:1 duty with the Service Recipient. The Subject had an opportunity to discard the razor in the basement of the facility, and could have taken the opportunity to report the razor to the charge nurse. The Subject also had an opportunity to ask three assistant nurses and the charge nurse to be relieved and could have told any one of those nurses about finding the razor and the risk it posed to the Service Recipient. However, the Subject did not take advantage of these opportunities. (Hearing testimony of Subject; Justice Center Exhibits 2 and 17: audio recording of Justice Center interview of the Subject)

The Subject admitted that she had a duty to search the room at least once each day, but that she did not do so on [redacted]. The Subject opined that searching the room was unnecessary because she checked the nightstand drawers when looking for the comb and conducted a visual check of the room. However, the search was patently insufficient because when the Subject looked inside the drawers of the nightstand for the comb, she did not see the razor on top of the nightstand until the Service Recipient told her that it was there. The Subject also admitted that she "would have conducted a full search of the entire room" if she had more time. The Subject had four to five hours, after finding the razor in the morning and before the Service Recipient cut her wrist, to conduct a more thorough search. (Hearing testimony of Subject; Justice Center Exhibits 2 and 17: audio recording of Justice Center interview of the Subject)

The Justice Center proved by a preponderance of the evidence that the Subject breached her duty when she failed to search the Service Recipient's bedroom and notify a nurse after

discovering a razor in the Service Recipient's bedroom.

Based on the facts and circumstances, the Justice Center also proved by a preponderance of the evidence that the Subject's breach of duty was likely to result in physical injury to the Service Recipient. Four to five hours after the Subject was already aware that the Service Recipient was suicidal and had a razor in her possession that she was not supposed to have, the Service Recipient cut her left wrist with a blade. (Justice Center Exhibit 17: audio recording of Justice Center interview of the Assistant Director and audio recording of the VPCR call)

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 and 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)) It is common knowledge that razors are inherently dangerous, especially to suicidal individuals. The Subject's conduct allowed the Service Recipient, who was on 1:1 observation for suicidal ideation, the opportunity to use a razor blade to cut herself. Therefore, the Subject's conduct seriously endangered the Service Recipient's health, safety and welfare.

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 Susanna Requets, Administrative Hearings Unit.

DATED: March 19, 2018
Brooklyn, New York

Susanna Requets
Susanna Requets, ALJ