

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

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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**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 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:** April 17, 2018  
Schenectady, New York



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David Molik  
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register  
Administrative Appeals Unit  
[REDACTED], Subject  
Paul E. Levitt, Esq.

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

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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**RECOMMENDED  
DECISION  
AFTER  
HEARING**

**Adjud. Case #:**

[REDACTED]

Before:

Mary B. Rocco  
Administrative Law Judge

Held at:

New York State Justice Center for the Protection  
of People with Special Needs  
125 E. Bethpage Road, Suite 104  
Plainview, New York 11803  
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: Amanda Smith, Esq.

[REDACTED]

By: Paul E. Levitt, Esq.  
Vitale and Levitt, P.C.  
445 Broad Hollow Road, Suite #400  
Melville, New York 11747

### **JURISDICTION**

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [REDACTED] (the Subject) for abuse and 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 abuse and 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 and/or physical abuse when you dragged a service recipient along the floor by her arm, causing contusions.

These allegations have been SUBSTANTIATED as Category 2 neglect and Category 2 physical abuse 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, located at [REDACTED], is a mental health treatment facility, and is operated by the Office of Mental Health (OMH), which is a provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged abuse and neglect, the Subject had been employed by [REDACTED] as a Mental Health Therapy Aide (MHTA) for approximately two years. Duties of a MHTA included assisting service recipients with their activities of daily living. The Subject was assigned to building [REDACTED] ward [REDACTED], an in-patient ward which housed twenty-six female geriatric service recipients with varying psychiatric diagnoses. The Subject worked a regular day shift on Saturdays through Wednesdays. (Hearing testimony of the Subject)

6. At the time of the alleged abuse and neglect, the Service Recipient was a sixty-three-year-old verbal female with relevant diagnoses of bipolar disorder, neurocognitive disorder and borderline personality disorder. The Service Recipient had a history of throwing herself on the floor when she was frustrated, as well as a history of false reporting. (Justice Center Exhibits 6, 12, and 19; Hearing testimony of the Subject)

7. On [REDACTED], a facility psychologist [REDACTED] [REDACTED] witnessed an unknown staff member drag an unknown service recipient, by the arm, out of the day hall. The psychologist thereafter identified the Subject and the Service Recipient following a review of photographs of staff and service recipients. (Justice Center Exhibits 6, 7 and 19)

8. On [REDACTED], the Service Recipient was evaluated by the facility physician and psychiatrist, and both confirmed that the Service Recipient denied any trauma, injury or incident. The physician noted two old bruises on Service Recipient's upper left arm. (Justice Center Exhibit 8, 16, 17, 18)

### **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 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 neglect of a person in a facility or provider agency is defined by SSL § 488(1) to include:

(a) "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.

(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 physical abuse and neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 2, which is defined as follows:

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 acts of physical abuse and neglect alleged in the substantiated report that is the subject of the proceeding and that such acts constitute the category of physical abuse and neglect as set forth in the substantiated report. (Title 14 NYCRR § 700.10(d))

If the Justice Center proves the alleged physical 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 physical abuse and neglect as set forth in the substantiated report.

If the Justice Center did not prove the physical abuse and 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. Specifically, the



[REDACTED]

evidence did not establish that the Subject committed physical abuse or neglect.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-19) The investigation underlying the substantiated report was conducted by [REDACTED], Justice Center 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 provided six documents as evidence. (Subject Exhibits A-F)

### **Allegation 1 - Physical Abuse**

In order to sustain an allegation of physical abuse, the Justice Center must prove that the Subject was a custodian and intentionally or recklessly caused, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient or caused the likelihood of such injury or impairment. (SSL § 488(1)(a))

The Justice Center relied primarily on the [REDACTED] psychologist in support of the allegation. In his interview, the psychologist stated that it was his first time on ward [REDACTED] and that he was not familiar with the staff or service recipients. The psychologist further stated that he witnessed an unknown staff member drag an unknown service recipient by the arm out of the day hall, but was unable to definitively describe the event. During his interview, the psychologist could not remember what position the Service Recipient was in when he witnessed her being dragged or what arm she was being held by; nor could he recall whether the Subject utilized one or two hands. The psychologist stated that he was not entirely focused on the situation, as he was distracted trying to prepare for his group therapy to begin. [REDACTED]

[REDACTED]

[REDACTED] (Justice Center Exhibits 6 and 19)

The Subject vehemently denied dragging, pulling or any physical contact with the Service Recipient. The Subject credibly testified, and both the facility nurse and a fellow MHTA corroborated, that the Service Recipient had a history of falsely accusing staff and other service recipients of abuse and, therefore, staff would avoid any physical contact with the Service Recipient. If physical contact was required, a nurse was called and the nurse would provide physical assistance to the Service Recipient, not a MHTA. The Subject testified, and the facility nurse and MHTA further corroborated, that it was common practice for the Service Recipient to respond to frustration by dropping to the floor and that verbal redirection and encouragement were the only procedure staff followed in response to that behavior. The Subject testified that on that particular day, she turned the television off in the day room and the Service Recipient became upset and slid off the couch and down onto the floor with the magazines she had in her possession. The Subject stated that she approached the Service Recipient, squatted down in front of her and began to gather up the magazines while verbally directing the Service Recipient to stand. The Subject testified that at no time did she have any physical contact with the Service Recipient. (Justice Center Exhibit 19 and Hearing testimony of the Subject)

Moreover, the Service Recipient denied any incident of pulling or dragging. In fact, the Service Recipient stated to both evaluating physicians when questioned as to the origin of the two old bruises noted, that it was most likely from another service recipient. Both the facility nurse and fellow MHTA expressed their disbelief of the allegation because it was not behavior that the Subject would ever engage in, especially with the Service Recipient, and corroborated that the bruises were most likely inflicted by another service recipient. (Justice Center Exhibits 6, 8 and



19)

The evidence in the record does not support the allegation that the incident occurred as alleged. The psychologist's tenuous statement is not credited evidence. 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 physical abuse alleged.

**Allegation 1 - Neglect**

In order to sustain an allegation of neglect as alleged, the Justice Center must prove that the Subject was a custodian who owed a duty to the Service Recipient, that she breached that duty by dragging the Service Recipient along the floor by her arm, 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 Subject was a custodian of the Service Recipient as that term is defined in Social Services Law § 488(2).

For the reasons set forth above, it cannot be determined by a preponderance of the evidence that the Subject breached a duty owed to the Service Recipient. 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 shall be amended and sealed.

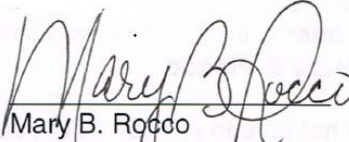
**DECISION:**

The request of [REDACTED] that the substantiated report dated [REDACTED]  
[REDACTED] be amended and sealed is granted.

The Subject has not been found to have committed abuse or neglect.

This decision is recommended by Mary B. Rocco, Administrative Hearings Unit.

**DATED:** April 9, 2018  
Plainview, New York



Mary B. Rocco  
Administrative Law Judge