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 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: August 22, 2018
Schenectady, New York

David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[redacted], 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: 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: Amanda Smith, 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], while waiting for transportation back to the [redacted], located at [redacted], while a custodian, you committed neglect when you failed to report that a service recipient had fallen to the ground several times.

This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

Allegation 2[1]

It was alleged that on [redacted], while waiting for transportation back to the [redacted], located at [redacted], while a custodian, you committed neglect when you denied a service recipient access to the bathroom.

This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to

[1] The Report of Substantiated Finding contains a typographical error and states that the second allegation is Allegation 1.

Social Services Law § 493(4)(c).

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

4. The facility, [redacted], located at [redacted][2] is a psychiatric center. [redacted] is licensed by the New York State Office of Mental Health (OMH), which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimonies of Attorney 1 and the Subject)

5. At the time of the alleged neglect, the Subject was employed by the facility as a Mental Health Associate (MHA) for twenty-five years. For the last fourteen years, the Subject worked twelve hour shifts three days a week. The Subject was responsible to draw patients' blood, perform EKG's, take vital signs, assist patients with their activities of daily living (ADL), and enter the medical information into the computer. (Hearing testimony of the Subject; Justice Center Exhibit 16) 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 66 years old and was admitted to the facility for approximately nineteen days after she displayed aggressive behavior at her assisted living facility. The Service Recipient was an adult female with a diagnosis of major neurocognitive disorder with behavioral disturbance and was also diabetic. The Service Recipient was receiving treatment for paranoia and behavioral problems at [redacted]. (Hearing testimony of the Subject; Justice Center Exhibits 15 and 16)

7. Service recipients from various psychiatric hospitals are transported via ambulance for hearings located in the [redacted] courtroom on [redacted]. (Hearing testimony of Attorney 1[3])

[2] The address provided in the allegations is the mailing address. (Hearing testimony of the Subject)
[3] Attorney 1 is [redacted].

8. The [redacted] courtroom is on the tenth floor. Directly across the [redacted] courtroom is the Secretary's[4] office. Between the courtroom and the Secretary's office is a door which leads to a hallway about 35 to 45 feet long. The door has a transparent window approximately three feet by four feet in the middle, and another transparent window on top. When the door is closed, only very loud voices can be heard on either side. After the door and on the right side of the hallway is another door that leads to the elevators. At the end of the hallway on the left is a waiting room that is approximately four feet by five feet (waiting room 1). Ten feet diagonally across waiting room 1 is another waiting room that is approximately two feet by two feet (waiting room 2). Waiting room 2 has a bathroom, while waiting room 1 does not. (Hearing testimony of Attorney 1; Justice Center Exhibit 10; ALJ Exhibit 1)

9. The Subject began her shift at 7:00 a.m. on [redacted]. The Subject and [redacted] Security Officer (Officer 1)[5] were assigned to transport the Service Recipient to [redacted]. The Subject packed the Service Recipient's lunch and medical chart and made sure the Service Recipient was dressed for her appointment. (Hearing testimony of the Subject)

10. The Service Recipient, the Subject and Officer 1 arrived to [redacted] prior to 10:00 a.m. via ambulance. Between 10:00 a.m. and 2:00 p.m., the Service Recipient went to the bathroom approximately five to six times. Each time, the Subject escorted the Service Recipient to the bathroom and waited for her near the bathroom door. (Hearing testimony of the Subject)

11. At approximately 2:00 p.m., the Service Recipient's case was heard in the [redacted] courtroom. The Service Recipient was not allowed to leave [redacted] despite her request for same. (Hearing testimonies of the Subject and Attorney 1)

12. While waiting for transportation back to the facility, the Service Recipient was

[4] The Secretary is [redacted].
[5] Officer 1 is Security Officer [redacted].

pacing in and out of waiting room 1. The Service Recipient wanted to remain in the bathroom until the transportation arrived, but the Subject and Officer 1 denied her request. The Subject called the [redacted] Business Associate Clerk[6] to expedite the ambulance arrival because the Service Recipient was "acting up." (Hearing testimony of the Subject and Justice Center Exhibits 8, 12 and 16)

13. At approximately 3:00 p.m., Attorney 1 was talking to the Secretary and Attorney 2[7] near the Secretary's office. Through the windows in the door, Attorney 1 observed the Service Recipient falling three times. The Subject was standing outside waiting room 1 on her telephone speaking with the Business Associate Clerk. [redacted] Security Officer (Officer 2)[8] was also outside waiting room 1 when the Service Recipient attempted to go from waiting room 1 to waiting room 2. Officer 1 shoved the Service Recipient in the chest and the Service Recipient fell on her buttocks. The Service Recipient sprung up, and started moving down the hallway on the right side. Officer 1 came from behind the Service Recipient and shoved the Service Recipient in the back resulting in the Service Recipient falling on her knee. The Service Recipient sprung up again and tried to move further down the hallway toward Attorney 1 when Officer 1 came in front of the Service Recipient and shoved the Service Recipient in the chest area again causing the Service Recipient to fall on her buttocks. (Hearing testimonies of Attorney 1 and the Subject)

14. Officer 2 asked the Service Recipient if she was hurt and the Service Recipient said that her knee hurt. Officer 2 directed the Subject and Officer 1 to take the Service Recipient to the bathroom. (Hearing testimony of Attorney 1, Justice Center Exhibit 13)

15. Shortly thereafter, the ambulance arrived to transport the Service Recipient, the

[6] The Business Associate Clerk is [redacted]. (Justice Center Exhibit 4)
[7] Attorney 2 is [redacted].
[8] Officer 2 is [redacted] Security Officer [redacted].

Subject and Officer 1 to [redacted]. The Service Recipient did not resist going to the ambulance. (Hearing testimony of the Subject)

16. The Service Recipient returned to the facility cursing and angry, requiring multiple staff intervention and medication. The Subject reported the [redacted] incident to the Registered Nurse, but did not tell the Registered Nurse that the Service Recipient fell three times. (Hearing testimony of the Subject)

17. The Service Recipient was evaluated by a medical doctor and a nurse practitioner the following day. A skin exam revealed ecchymosis (discoloration after bruising) on the back about two-and-a-half inches in width and four inches in length, a one square inch contusion behind the Service Recipient's left knee, and a one-inch by one-inch contusion on the Service Recipient's left hip/buttocks area. (Justice Center Exhibit 15)

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)(c), 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, described as "Allegation 1" and "Allegation 2" 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) The investigation underlying the substantiated report was conducted by [redacted], a [redacted] Senior Investigator for Audit and Compliance Services, and nurses [redacted] and [redacted]. (Justice Center Exhibits 8 and 16). Attorney 1 witnessed the alleged incident and testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and presented one document. (Subject Exhibit A)

The Administrative Law Judge presiding over the hearing admitted one document. (ALJ Exhibit 1)

Allegation 1 – Neglect

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 issue is whether the Service Recipient fell on the floor, and if so, whether the Subject had a duty to report that the Service Recipient fell.

There is no dispute that the Subject had a duty to report the incident. Once staff escort [redacted] patients outside the facility, they must report any incident, even if minor, to the Registered Nurse. (Hearing testimony of the Subject; Subject Exhibit A) The Subject reported the incident to the Registered Nurse, but denied that the Service Recipient fell in [redacted]. The Administrative Law Judge presiding over the hearing, having observed and evaluated the hearing testimony of the Subject on this material issue, does not find her testimony to be credible.

The credible evidence demonstrates that the Subject failed to report to the Registered Nurse that the patient had fallen multiple times, thereby breaching her duty of care to the Service Recipient. (Justice Center Exhibit 4) The Subject does not allege that her vantage point was insufficient to see the altercation. At the hearing, the Subject testified that she saw the Service Recipient's hand touch the floor, but that she never saw the Service Recipient's buttocks touch the floor. In a written statement, the Subject stated that the Service Recipient "stumble[d] back" two times. (Justice Center Exhibit 4 (p.21/21) and Subject Exhibit A) During her interview with Investigator [redacted], the Subject stated that the Service Recipient "fell back on her butt" and that by the second fall, Officer 2 intervened. (Justice Center Exhibits 8 and 11) The Subject's testimony is in stark contrast to her prior statements as well as every other witness, including Attorney 1, Attorney 2, Officer 1 and Officer 2, who all stated that the Service Recipient fell on her buttocks. (Justice Center Exhibits 9, 10, 11, 12 and 13) As such, Attorney 1's written statement and testimony, corroborated by three other individuals, is credited substantial weight in determining that the Service Recipient fell three times.

The Justice Center also proved by a preponderance of the evidence that the Subject's breach of duty resulted in a serious or protracted impairment of the physical, mental or emotional conditional of the Service Recipient. The Subject claimed that the Service Recipient sustained

injuries after the Service Recipient struggled with multiple staff and was sedated upon her return to the facility. However, the Subject's claims are contradicted by the Service Recipient's immediate vocal expression of pain in her knee to Officer 2, which is corroborated by the one square inch contusion behind the Service Recipient's left knee. (Justice Center Exhibits 13 and 15) The Subject's failure to report the Service Recipient falling three times delayed a medical professional from examining and/or evaluating the Service Recipient until the next day. Such untimely delay constitutes a serious or protracted impairment of the physical condition of the 66-year-old Service Recipient who was experiencing knee pain. (Justice Center Exhibit 15)

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.

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 3 act. Substantiated Category 3 findings of abuse and/or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to SSL § 496 (2). The report will be sealed after five years.

Allegation 2 – Neglect

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))

There is no dispute that the Subject was assigned to the Service Recipient and had a duty to render personal care to the Service Recipient, including permitting and escorting the Service Recipient to the bathroom. (Hearing testimony of the Subject; Justice Center Exhibit 4)

The issue is whether the Service Recipient requested to go to the bathroom and the Subject denied her access to the bathroom, thereby breaching her duty of care to the Service Recipient. The Subject vehemently disputes that she denied access and claimed that she was trying to prevent the Service Recipient from going to the elevators and eloping. (Hearing testimony of the Subject)

The Justice Center proved by a preponderance of the evidence that the Subject breached her duty by denying the Service Recipient access to the bathroom. Both Officer 1 and the Subject told Investigator [redacted] that the Service Recipient wanted to remain in the bathroom until the ambulance arrived. The Subject stated that it was "unacceptable" for the Subject to remain in the bathroom and Officer 1 stated that such denial caused the Service Recipient to be "annoyed." (Justice Center Exhibits 8 and 12) Officer 2 had to direct the Subject and Officer 1 to allow the Service Recipient to use the restroom after the altercation. (Justice Center Exhibit 13) It belies logic that the Subject allowed the Service Recipient access to the bathroom immediately before the altercation, but Officer 2 had to direct the Subject to allow the Service Recipient access to the bathroom after the altercation.

Officer 2 also told Attorney 1 that the staff did not allow the Service Recipient to use the bathroom. (Hearing testimony of Attorney 1; Justice Center Exhibit 9) There is no evidence that Attorney 1 had a motive to fabricate his observations, including his communication with Officer 2 immediately after the incident. Attorney 1 represented patients from psychiatric centers other

than [redacted]. Attorney 1 never met the Subject or the Service Recipient prior to the incident. (Hearing testimony of Attorney 1) As such, Attorney 1's written statement and testimony, as well as Officer 2's written statement, is credited substantial weight in determining that the Subject, as one of two [redacted] staff members assigned to work with the Service Recipient, refused to allow the Service Recipient access to the bathroom. (Hearing testimony of Attorney 1; Justice Center Exhibits 9 and 13)

Based on the facts and circumstances, the Justice Center also proved by a preponderance of the evidence that the Subject's breach of duty resulted in a serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. The denial of access to the bathroom is harmful to the Service Recipient's dignity as well as her health, safety and welfare. The Service Recipient is a diabetic and required more frequent urination than a non-diabetic. (Hearing testimony of the Subject) The situation escalated after the Service Recipient was denied access to use the bathroom. This ultimately resulted in the Service Recipient falling on her buttocks two times and on her knee one time. (Hearing testimony of Attorney 1; Justice Center Exhibits 9 and 13)

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.

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 3 act. Substantiated Category 3 findings of abuse and/or neglect will not result in the Subject's name

being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to SSL § 496 (2). The report will 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 Category 3 acts.

This decision is recommended by Susanna Requets, Administrative Hearings Unit.

DATED: August 16, 2018
Brooklyn, New York

Susanna Requets

Susanna Requets, ALJ